STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255313	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dugan Memorial Home	26894 East Main Street West Point, MS 39773

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41878 Based on staff interview, record review, and facility policy review, the facility failed to ensure the medical provider was notified of a resident refusing multiple doses of prescribed antibiotics for one (1) of six (6) residents reviewed for medication use. Resident #21 Findings include: Record review of facility policy titled Medication Administration dated 1/24, revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .18. Report and document any adverse side effects or refusals . During an interview on 9/25/24 at 3:50 PM, Registered Nurse (RN) #2 revealed Resident #21 had recently been in the hospital and diagnosed with pneumonia and was on antibiotics. She revealed the resident would often refuse her medications and that if a resident refused medications, the nurse was to notify the provider and the resident's representative. On 9/25/24 at 4:10 PM, an interview with the Director of Nursing (DON) revealed Resident #21 refused several doses of the antibiotic medication ordered for the treatment of pneumonia and the provider was not notified. She confirmed it was important to notify the provider so that appropriate care could be ordered. She confirmed the facility failed to notify the provider of the antibiotic medications refused by this resident. During a phone interview on 9/25/24 at 4:30 PM, the Nurse Practitioner stated she was in the facility last week and was aware the resident refused to take her medications for a few days but thought she had restarted taking them. She stated she was unaware that the resident refused her antibiotics which included the past two doses that would have completed her 10-day course of antibiotics. She stated it was important for the provider to be notified of refusals of medications so treatment could be reevaluated, and the treatment course could be changed to ensure the resident received appropriate care. She also stated that not receiving ordered antibiotic medications could lead to an infection not being treated effectively. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 9/26/24 at 8:20 AM, confirmed the facility failed to notify the provider that a resident refused multiple doses of an antibiotic ordered for pneumonia. She confirmed that notifying the provider was necessary so an alternate treatment could be ordered if the provider chose that option. During an interview on 9/26/24 at 12:10 PM, RN #2 stated she was not notified that Resident #21's antibiotic medication was not administered due to the resident refusing. She stated that typically the Licensed Practical Nurse (LPN) would notify the RN and the RN would notify the provider and enter any new orders that were given by the provider. She confirmed that since she was unaware of the resident refusing her last two doses of her antibiotics, the provider was not notified. A phone interview with LPN #1 on 9/26/24 at 12:15 PM, revealed she attempted to give Resident #21 her antibiotics on several different days and would attempt several times each day, but the resident refused each time. She stated during the previous week, she had notified RN #1 of the refusals, but on 9/23/24 and 9/24/24, she did not notify RN #2 of the refusals. She admitted she did not see RN #2 immediately after the refusals and she just forgot. She stated she did document the refusals in the Electronic Medication Administration Record (EMAR), but for the dates of 9/23/24 and 9/24/24, she did not notify the RN. She stated she had been in-serviced on medication administration and was aware of the process for notification to the RN if the resident refused medications and the RN would notify the provider. During a phone interview on 9/26/24 at 12:25 PM, RN #1 stated she had notified the provider of the resident's refusals of medications last week. She stated the process for refusals are for the LPN to inform the RN and the RN would notify the provider. During an interview on 9/26/24 at 12:45 PM, the DON confirmed the facility failed to notify the provider of the resident's refusal of her antibiotics. She confirmed a resident not receiving antibiotics as ordered could lead to the infection not being treated properly. She stated LPN #1 had been in-serviced on medication administration and should have notified the RN so the RN could have notified the provider. Record review of Progress Note of Registered Nurse (RN) #2 dated 9/13/24, revealed, Notified by Cart Nurse that resident was having chest pain. Asked resident if she (by pointing and verbally asking) resident was she having chest pain and resident nodded, 'yes'. Notified (proper name removed) Nurse Practitioner (NP), NP gave orders to send out the the ER (emergency room). Record review of Order Summary Report revealed an order dated 9/13/24 to send resident to ER for c/o (complaints of) chest pain. Record review of hospital Emergency Department Note dated 9/14/24, revealed a diagnosis of Pneumonia of left lower lobe due to infectious organism. Record review of nursing Progress Note dated 9/14/24, revealed, Elder returned from hospital per ambulance. Alert and oriented with eyes opened. Report received from ER. Elder x-ray showed pneumonia . Prescription given for Elder's condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #21's Order Summary Report revealed an order dated 9/14/24 for Cefdinir Oral Suspension 250 mg (milligrams)/5 ml (milliliters) give 12 ml by mouth in the morning for pneumonia for 10 days with start date of 9/15/24 and end date of 9/25/24. Record review of Resident #21's Electronic Medication Administration Record (EMAR) revealed on 9/23/24 and 9/24/24, the resident did not receive the ordered antibiotic with the reason documented as Drug Refused. Record review of Resident #21's Admission Record revealed the facility admitted the resident on 5/6/2016 with diagnoses that included Shortness of breath and Dementia. Record review of Resident #21's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/27/24, revealed Should Brief Interview for Mental Status be conducted? Response to this was, No (resident is rarely/never understood).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41878 Based on staff interviews, record review, and facility policy review, the facility failed to implement a care plan for one (1) of 18 sampled residents' care plans. Resident #21 Findings Include: Record review of facility's policy titled, Comprehensive Care Plans dated 10/22, revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Record review of Resident #21's care plan revealed a focus area dated 9/15/24 of Elder has pneumonia. Interventions listed included administer medications as ordered, Cefdinir for ten days for pneumonia, and to keep informed of changes and update MD as needed. An interview with the Director of Nursing (DON) on 9/25/24 at 4:10 PM, revealed Resident #21 refused several doses of the antibiotic medication ordered for the treatment of pneumonia and the provider was not notified. She stated the care plan gives information to care for the resident's needs and she confirmed the care plan for antibiotic medication administration as ordered for treatment for pneumonia and to keep informed of changes and update RP (Resident's Representative) and MD (Medical Doctor) as needed, was developed but was not followed. During an interview on 9/26/24 at 10:30 AM, the Minimum Data Set (MDS) Coordinator revealed she is one of the facility staff members responsible for developing the care plans for the residents. She stated the care plan is to inform staff of the needs of the residents and the care needed for the resident and should be followed to ensure the care is appropriate. She stated the care plan for Resident #21's diagnosis of pneumonia was developed and included the interventions to administer the medications as ordered, antibiotics each morning for 10 days for pneumonia, and to update Medical Doctor as needed and keep informed of changes. She confirmed the care plan was not implemented. Record review of Resident #21's Order Summary Report revealed an order dated 9/14/24 for Cefdinir Oral Suspension 250 mg (milligrams)/5 ml (milliliters) give 12 ml by mouth in the morning for pneumonia for 10 days with start date of 9/15/24 and end date of 9/25/24. Record review of Resident #21's Electronic Medication Administration Record (EMAR) revealed on 9/23/24 and 9/24/24, the resident did not receive the ordered antibiotic with the reason documented as Drug Refused. Record review of Resident #21's Admission Record revealed the facility admitted the resident on 5/6/2016 with diagnoses that included Shortness of breath and Dementia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #21's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/27/24, revealed Should Brief Interview for Mental Status be conducted? Response to this was, No (resident is rarely/never understood).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, interview, record review and facility policy review the facility failed to initiate contact isolation precautions for a resident with Methicillin-resistant Staphylococcus Aureus (MRSA) and failed to prevent the possibility of the spread of infection by not utilizing proper hand hygiene for one (1) of four (4) resident care observations. Resident #19. Findings Include: Review of the facility policy Clean Dressing Change dated 10/2022 revealed, It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Review of the undated facility policy Transmission-Based Precautions revealed, It is our policy to take appropriate precautions to prevent transmission of infectious agents Contact Precautions - Intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment . On 09/24/24 at 1:00 PM, on entrance into the facility, a brief interview with Administrator (ADM), revealed that there were no residents on Transmission Based Precautions (TBP). On 09/24/24 at 2:30 PM, an interview with Resident #19 revealed that he had two wounds on his bottom, that the nurses were cleaning them and changing the dressings every day. On 09/25/24 at 10:40 AM, an observation revealed Licensed Practical Nurse (LPN) #1, completed wound care to Resident #19's pressure ulcers to his sacrum and left buttock using enhanced barrier precautions (EBP). LPN #1 washed her hands and donned a gown and gloves. She removed the old dressing and then cleaned the sacral wound and cleaned the wound to his left buttock with normal saline without changing her gloves. LPN #1 changed gloves after cleaning both wounds, applied the ordered treatment to both wound beds and covered the wounds with bordered foam dressings. LPN #1 did not perform hand hygiene between glove changes, and she used the same gloves to clean both wounds. LPN #1 removed her gown and gloves, disposed of them in a trash can designated for Personal Protective Equipment (PPE) just inside the resident's door, and she washed her hands. There was no Contact Precaution signage observed on Resident #19's room door and there were no biohazard containers in his room. On 09/25/24 at 10:50 AM, an interview with LPN #1, revealed that Resident #19 had the wounds to his sacrum and left buttocks for several months and they were improving. She revealed that they used enhanced barrier precautions with any resident with wounds to protect the residents as well as themselves. LPN #1 confirmed that she did not change her gloves after removing the soiled dressing before cleaning both of the wound areas and also failed to change gloves between the two different wound care areas. She also confirmed that she had cleaned both wounds using the same gloves and agreed that she should have completed wound care on one wound before going to the next to prevent cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/25/24 at 10:55 AM, LPN #1 revealed that she Just remembered that Resident #19 was diagnosed with MRSA (Methicillin-Resistant Staphylococcus Aureus) to one of the wounds a couple weeks ago and she was Pretty sure he still had it. She also confirmed that any resident with MRSA should be on contact isolation precautions to prevent the spread of infection. On 09/25/24 at 11:00 AM, an interview with Infection Control Nurse (ICN) revealed that Resident #19 was on EBP because of his wounds. She revealed that Resident #19 had a wound culture a couple weeks ago and was on antibiotics. ICN pulled up Resident #19's wound culture results on his Electronic Medical Record (EMR) and confirmed the positive MRSA results and stated, I was not aware that he had MRSA, I didn't catch that. She revealed that Resident #19 should be on contact isolation precautions to prevent the spread of infection and that she would take care of that now. ICN revealed that contact precaution signage should be on the door and that there should be PPE outside the resident's door and they should have red barrels placed inside his room for staff to dispose of their used PPE. She revealed that they reviewed all antibiotics in their Quality Assurance (QA) meetings every month and went over antibiotics and infections weekly in their high-risk meetings. ICN revealed that it was important to follow the correct guidelines when doing wound care on a resident with MRSA to prevent the spread of infection. On 09/26/24 at 9:10 AM, an interview with Certified Nursing Assistant (CNA) #1, revealed that she had heard a couple weeks ago that Resident #19 had MRSA to one of his wounds. She revealed that she was already wearing masks, gloves and gowns and was not told to treat him any differently. She revealed that the ICN placed the contact precaution sign on his door and red barrels in the room yesterday. CNA #1 revealed that usually when a resident was placed on contact precautions, they had in-services, and the nurses let them know. She revealed that it must have been a miscommunication problem. On 09/26/24 at 12:22 PM, a phone interview with Registered Nurse (RN) #1, revealed that Resident #19 had wounds and that the wound center had called in positive MRSA culture results to her a couple weeks ago. RN #1 revealed that Resident #19 was currently taking two antibiotics for the MRSA and was ordered to take it for thirty days. She revealed that this resident should be on contact precautions to prevent the spread of infection in the facility. On 09/26/24 at 1:15 PM, an interview with Director of Nursing (DON) and Administrator (ADM), revealed that the person who took the call about the positive culture results, should have initiated the Contact Isolation Precautions for Resident #19. She revealed that it was everyone's responsibility who knew about the infection to get it initiated. She revealed if they had staff members in the room caring for a resident who they knew had MRSA, the staff should look at protecting the resident and ensuring that measures were in place to prevent the spread of infection. Record review of Resident #19's Wound Culture revealed that the culture of his left buttock pressure ulcer was collected on 08/30/24 and final MRSA results were received on 09/02/24. Record review of Resident #19's Admission Record revealed an admitted [DATE] and had diagnoses that included Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease, Stage 2 Pressure Ulcer of Sacral Region, and Stage 4 Pressure Ulcer of Left Buttock. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #19's Order Summary Report revealed an order with start date of 09/04/24 for Amoxicillin Oral Capsule 500 MG (milligrams) . Give 1 capsule by mouth three times a day for MRSA for 30 Days and Bactrim DS Oral Tablet 800-160 MG .Give 1 tablet by mouth two times a day for MRSA for 30 Days. Record review of Resident #19's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/12/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated that he was cognitively intact. Record review of Resident #19's Progress Note dated 09/03/24 revealed new order for antibiotics related to MRSA infection in wound and was signed by RN #1.