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	03/18/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents were provided with a dignified dining experience when one (1) of three (3) residents at the table did not receive their meal at the same time. Resident #11 Findings include: Record review of facility policy titled, Promoting/Maintaining Resident Dignity During Mealtimes dated March 2025, revealed, It is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident. During an observation of lunch in the dining room on 3/16/26 from 12:10 PM through 12:15 PM, it was noted that the two residents sitting at the table with Resident #11 both had their meal and were eating their lunch. Resident #11 was observed without food. She continued to sit and watch the other two residents at her table as they ate their lunch. At 12:15 PM, Resident #11 reached to her right and slid that resident's piece of iced cake in front of herself and started eating it with her hands. There was no silverware in her area. During an interview on 3/16/26 at 12:15 PM, Licensed Practical Nurse (LPN) #1 revealed it was unacceptable for Resident #11 to be without her meal while other residents at the table were eating their meals. She acknowledged that each resident at a table should be served at the same time to promote dignity during mealtime. During an interview with the Director of Nursing on 3/18/26 at 8:30 AM, it was revealed that each resident at a community table in the dining room should be served their meals at the same time. She acknowledged that one resident should not have to watch their tablemates eat their meal for an extended period of time and not have their own meal to enjoy. She confirmed that each resident had the right to be treated with dignity during meals and the facility failed to honor this right by not serving meals to all residents at a table at the same time. Record review of Resident #11's admission Record revealed she was admitted to the facility on [DATE] with diagnoses which included Dementia. Record review of Resident #11's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/15/25 indicated a Brief Interview for Mental Status (BIMS) of 5 which indicated the resident had a severe cognitive impairment.

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

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	03/18/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure informed consent was obtained prior to the initiation of a psychotropic medication for one (1) of five (5) residents reviewed for unnecessary medications. Resident #9 Findings include:Record review of facility policy titled, Use of Psychotropic Medications, with an implemented date of 10/2025, revealed, .9. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medications .11. The facility will document that the resident or resident representative was informed in advance (e.g., written consent form, narrative note, etc.)Record review of Resident #9's Order Summary Report revealed an order dated 7/28/25 for Trazadone Hydrochloride (HCL) oral tablet 50 milligrams (mg) to be given by mouth at bedtime for sleep.Record review revealed no signed informed consent for Trazadone was present in medical record.On 3/18/2026 at 12:33 PM, during an interview with the Administrator, she confirmed there should have been a signed consent for Trazadone, but she was unable to locate one. Record review of Resident #9's admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease and Depression.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/2025 revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating the resident was severely cognitively impaired.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on resident and staff interviews, record reviews, and facility policy review, the facility failed to ensure a cognitively intact resident was provided the opportunity to participate in and make informed decisions regarding her advance directive, including end-of-life preferences for one (1) of 24 advance directives reviewed. (Resident #1) Findings Include:Review of the facility policy titled Advance Directives Policy and Acknowledgment, updated 9/3/25, revealed, Resident has the right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.Record review of the facility's Advance Directives/Medical Treatment Decisions form, dated 2/17/22, revealed Resident #1 was designated as Do Not Resuscitate (DNR); however, the form was not signed by Resident #1 and was instead signed by her sister.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #1 was cognitively intact.During an interview on 3/17/26 at 10:35 AM, Resident #1 revealed the facility had never discussed end-of-life decisions with her and revealed her sister had made those decisions on her behalf. During an interview on 3/17/2026 at 3:10 PM, the Social Services Director confirmed that although cognitive assessments are completed through the MDS Section C and a BIMS score of 13 or higher indicated a resident can make their own decisions, Resident #1, who was assessed as cognitively intact, was not provided the opportunity to discuss or complete her own advance directive.During an interview on 3/17/2026 at 3:30 PM, the Executive Director (ED) acknowledged that, based on Resident #1's cognitive status, she should have been able to make her own end-of-life decisions, but we deferred to the sister, who is the conservator. The ED confirmed that she has struggled with balancing resident rights and conservatorship, but expressed that the decision should have been Resident #1's.In an interview on 3/18/2026 at 9:32 AM, the Nurse Practitioner (NP) confirmed Resident #1 should have been allowed to make her own advance directive decisions.Record review of the admission Record revealed the facility admitted Resident #1 on 2/17/22 with medical diagnoses that included Rheumatoid arthritis, Paraplegia, and Major depressive disorder.