MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24KI	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF BILOXI	2279 ATKINSON ROAD BILOXI, MS 39531

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey along with two (2) Complaint Investigations (CIs), MS #24542 and CI MS #24561, at the facility from 4/1/24 to 4/4/24. CI MS #24542 and CI MS #24561 were investigated related to an injury of unknown origin. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M610, M620, M815, M970, and M1570.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or	M 500		5/1/24

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M 500	Continued From page 1 nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M 500		

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M 500	Continued From page 2	M 500		

transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care,

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M 500	Continued From page 3 and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on interviews, record review, and facility policy review the facility failed to ensure resident council concerns were resolved in a timely	M 500	1. Administrator attended emergency Resident Council meeting held on 04/17/2024 to discuss previously reported grievances and the lack of resolution regarding those grievances. All residents	

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M 500	Continued From page 4 manner for six (6) of 6 months reviewed. (November 2023, December 2023, January 2024, February 2024, March 2024, April 2024) Findings Include: Review of the facility's policy, "Grievances and/ or Concerns", dated 11/23/2016, revealed, " Policy Statement: It is the policy of this facility to support each resident's right to voice grievances to the facility ... After receiving a concern or grievance, the facility will actively seek a resolution and keep the resident appropriately appraised of its progress toward resolution ...Upon receipt, the grievance or concern will be reviewed within 24 hours of receipt. The resident has the right to obtain a written decision regarding the grievance or concern within 10 working days ..." Record review of the documentation instructions on the "Guidelines for Documentation of Resident Council Responses" form revealed, "Please review attached list of issues brought up at Resident Council and write your response in the appropriate section. Be sure to sign and date your response and give sheet to a department head who has not yet filled in his/her section. The response form should go to the administrator last before going to the social worker. Please help keep this form moving along as the responses should be returned to the council within two weeks of the above date ..." Housekeeping Record review of the "Guidelines for Documentation of Resident Council Responses", dated 1/4/24, revealed the resident council voiced a concern related to toilet paper. The form did not include a date or signature of the responding	M 500	in attendance were explained their right to organize and participate in resident groups, express grievances and recommendations with the expectation that the facility will act promptly to resolve to the best of its ability, any grievance or recommendation. Residents were advised that there are grievance forms that were available for them to complete in the activity room as well as a box to submit them. The residents were also informed that there is a facility grievance officer and the location of that office where they could also file a formal grievance. Residents were informed that they had a right to a response to their grievance within twenty-four hours and a written response within ten days. 2. All residents have the potential to be affected by the practice. 3. The Administrator collaborated with the Housekeeping Supervisor on 04/16/2024 to discuss unresolved grievances regarding housekeeping services. The Housekeeping Supervisor educated all housekeeping staff on 04/17/2024 and 04/18/2024 on ensuring ample supply of toilet paper is provided in resident bathrooms as well as community bathrooms, rooms are to be thoroughly cleaned and not "just pulling trash" and that clothes return from the laundry in a timely manner to the appropriate owner. On 04/16/2024, the Administrator met with the Activity Director that facilitates the Resident Council meetings and educated	

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M 500	Continued From page 5 department and did not include a resolution. Record review of the "Guidelines for Documentation of Resident Council Responses", dated 2/2024, revealed the resident council voiced a concern related to "just pulling trash". There was no date or signature of the responding department and did not include a resolution to the concern. Record review of the "Guidelines for Documentation of Resident Council Responses", dated 3/5/2024, revealed the resident council voiced a concern related to "not cleaning". There was no date or signature of the responding department and did not include a resolution to the concern. Laundry Record review of the "Guidelines for Documentation of Resident Council Responses", dated 12/2023, revealed the resident council voiced a concern related to "clothes not coming back." There was no date or signature of the responding department and did not include a resolution to the concern. Record review of the "Guidelines for Documentation of Resident Council Responses", dated 1/4/24, revealed the resident council voiced a concern related to "clothes don't come back on time." The form did not include a date or signature of the responding department and did not include a resolution. Record review of the "Guidelines for Documentation of Resident Council Responses", dated 2/2024, revealed the resident council voiced a concern related to "bringing other	M 500	her on the facility policy and procedure for reporting grievances and/or concerns expressed during Resident Council meetings and the requirement to resolve reported grievances. The Activity Director was further educated on completing resident council minutes according to instructions and policy and procedure. On 04/16/2024 the Administrator collaborated with the Dietary Manager to discuss resident grievances regarding the quality of the food and special request meals. Dietary Manager and Administrator with permission from Resident Council will attend monthly Resident Council meetings beginning 04/17/2024 and ending 07/17/2024 to directly hear and address any grievances and concerns regarding the quality of food being served. 4. The facility will monitor these grievance issues to ensure the plan of correction is sustained by the Administrator meeting with the Activity Director and the Grievance Officer monthly to ensure that all expressed grievances have been resolved or thoroughly attempted to be resolved and that the findings have been conveyed t the residents involved beginning 04/17/2024 and ending 07/17/2024. These findings will be discussed at the monthly Quality Assurance Performance Improvement (QAPI) meetings beginning 04/30/2024 and ending 07/17/2024. The Housekeeping Supervisor will make	

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M 500	Continued From page 6 laundry to the wrong person." There was no date or signature of the responding department and did not include a resolution to the concern. Record review of the "Guidelines for Documentation of Resident Council Responses", dated 3/5/2024, revealed the resident council voiced a concern related to "put clothes in wrong room... clothes comes back on time but not getting the right things." There was no date or signature of the responding department and did not include a resolution to the concern. Dietary Record review of the "Guidelines for Documentation of Resident Council Responses", dated 11/2023, revealed the resident council voiced a concern related to "no fried chicken no more." The form did not include a date or signature of the responding department and did not include a resolution. Record review of the "Guidelines for Documentation of Resident Council Responses", dated 1/4/24, revealed the resident council voiced a concern related to requests for "big bowl of grits and ribs." The form did not include a date or signature of the responding department and did not include a resolution. Record review of the "Guidelines for Documentation of Resident Council Responses", dated 2/2024, revealed the resident council voiced a concern related to "different food" and "hot dogs, hamburgers, green bean casserole". There was no date or signature of the responding department and did not include a resolution to the concern.	M 500	weekly rounds beginning 04/17/2024 and ending 07/17/2024 to inspect resident rooms and community bathrooms to ensure ample supply of toilet paper is provided and that the rooms are being cleaned thoroughly and will bring the results to the monthly QAPI meetings beginning 04/30/2024 and ending 07/17/202 to sustain the plan of correction (POC). The Dietary Manager will make weekly rounds to audit meal satisfaction beginning 04/17/2024 and ending 07/17/2024 and address any complaints or concerns immediately and bring the results of the audit to monthly QAPI meetings beginning 04/30/2024 and ending 07/17/202 to ensure the POC is sustained.	

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M 500	Continued From page 7 Record review of the "Resident Council Meeting" minutes, dated 4/2/24, recorded on a notebook pad revealed "Food". There was no indication that "Old Business" was discussed and there was no follow up from the previous month's minutes. On 04/02/24 at 10:00 AM, during the resident council meeting, the resident council members revealed they have complained for over 6 months about the poor flavor of the food, including complaints the meat was tough and vegetables were unseasoned. The residents said they had expressed their concerns to the Dietary Manager on several occasions. Each month they voiced concerns regarding food and the lack of flavor. They stated they never heard back from the facility with any responses for their dietary concerns and they were not pleased with the lack of follow-up. During an interview on 04/2/24 at 11:00 AM, with the Activities Director (AD), she confirmed the residents had complained about the food for the last six (6) months. The AD stated that she did not record the food complaints every month because she had been eating the food at the facility sometimes and she thought it tasted better. The AD confirmed that she did not complete the "Old Business" section of the meeting minutes and did not include information that would let the residents know how the facility was attempting to resolve their concerns. The AD explained that she reported the concerns of the resident council to the department heads and the Administrator. On 4/2/24 at 1:00 PM, in an interview with the Dietary Manager (DM), she confirmed the residents had complained about the food being tough and lacking flavor. The DM also said that	M 500		

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M 500	Continued From page 8 she attended several of the resident council meetings to discuss the food concerns with the residents. The DM confirmed she received a copy of the resident council concerns monthly. On 04/4/24 at 1:30 PM, in an interview with the Administrator and the Director of Nursing (DON), they confirmed the residents had complained about the food for the last six months. The Administrator stated she had not attended a resident council meeting in several months, however she had talked to the residents individually in their rooms. The Administrator said she was unaware the residents had concerns regarding the food and thought the dietary issue had been resolved. The Administrator confirmed that she received a copy of the resident council concerns monthly.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review the facility failed to	M 610	1. Residents #53 and #74 were given showers on 04/04/2024. Certified Nursing Assistant (CNA) #3 was directly in-serviced by Director of Nursing (DON)	5/1/24

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M 610	Continued From page 9 provide Activities of Daily Living (ADL) care related to showers and baths for residents who require assistance for two (2) of three (3) residents reviewed for ADL care. Resident #53 and Resident #74 Findings include: A record review of the facility's policy "Bath, Shower/Tub" dated 8/25/14, revealed " ... The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observes the condition of the resident's skin ... Reporting 1. Notify the supervisor if the resident refuses the shower/tub bath ..." Resident #53 On 04/01/24 at 11:18 AM, in an observation, Resident #53 was asleep in bed. There was a strong odor noted in the room. On 04/03/24 at 09:05 AM, during an interview and observation with Certified Nurse Aide (CNA) #3, there was a strong odor of feces in Resident #53's room. CNA #3 removed Resident #53's brief and there was a strong body odor and there were dried feces noted to the sacrum and rectal area. The resident was wearing a white tee shirt and pajama pants. On 04/03/24 at 02:45 PM, during an interview with CNA #3, she explained Resident #53 did not go to shower today and she had given him a bed bath. She reported that he did not refuse a shower, but she had chosen to give him a bed bath. At 02:55 PM on 04/03/24, during an interview and observation, Resident #53 was lying in bed and	M 610	on 04/04/2024 regarding Activity of Daily Living (ADL) performance, following direction of the shower schedule, the responsibility to provide services, and to seek guidance from the nurse if a resident refuses or they have any difficulties that impedes their ability to perform scheduled ADL's and the importance of documenting when services are provided. Licensed Practical Nurse #6 was provided education by the DON on 04/04/2024 on the responsibility of the nurse to ensure CNA tasks for their residents were completed prior to the end of the shift and documented as complete. 2. All residents have the potential to be affected by this practice. 3. All CNA's were educated beginning 04/09/2024 and ending on 04/12/2024 by Director of Nursing (DON) regarding Activity of Daily Living (ADL) performance, following direction of the shower schedule, the responsibility to provide services, and to seek guidance from the nurse if a resident refuses or they have any difficulties that impedes their ability to perform scheduled ADL's and the importance of documenting when services are provided. All nurses were educated by the DON beginning 04/09/2024 and ending 04/12/2024 on the responsibility of the nurse to ensure CNA tasks for their residents were completed prior to the end of the shift and documented as complete and that the residents received the ADL assistance they required dictated by the Center for Medicare and Medicaid	

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M 610	Continued From page 10 was wearing a white tee shirt and the same pajama pants from the observation at 9:05 AM. Resident #53 explained that he did not get a shower today and commented that maybe the CNA washed him off a little, but he did not receive a complete bath. He reported that it had been a long time since he had gotten a shower and the CNAs have never asked him if he wanted to get a shower. At 03:05 PM on 04/03/24, during an interview with Licensed Practical Nurse (LPN) #6, he explained he did not follow up with residents or the CNAs to ensure resident's get a bath or shower. He stated he was so busy during the day doing his job and he expected the CNAs to do their job. He confirmed that he had not been notified that Resident #53 had refused showers or baths. A record review of the "Bathing: Self Performance" sheet revealed Resident #53 received two (2) showers or baths in the past 30 days, which occurred on 03/16/24 and 03/25/24. A record review of the "Documentation Survey Report" for March 2024 and April 2024 revealed Resident #53 resident received one (1) documented shower on 03/16/24. A Record review of the "Admission Record" revealed the facility initially admitted Resident #53 on 4/26/18 with current diagnoses including Alzheimer's Disease and Need for Assistance with Personal Care. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/25/24 revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated his cognition was	M 610	Services (CMS) guidelines. 4. The DON, the Assistant Director of Nursing (ADON) and the staff development nurse will be auditing the shower schedules weekly for completion, ADL documentation and overall ADL performance based on observation of the condition of the residents beginning 04/09/2024 and ending 07/09/2024. The DON will bring the findings of these audits to the monthly Quality Assurance Performance Improvement meetings beginning on 04/30/2024 to evaluate the sustainability of the plan of correction according to CMS guidelines.	

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M 610	Continued From page 11	M 610		

moderately impaired.

Resident #74

On 04/01/24 at 10:34 AM, in an observation, Resident #74 was lying in bed and was wearing a gown. The room had a strong urine odor.

On 04/01/24 at 03:42 PM, during a phone interview with the family of Resident #74, the family member complained that the resident always had a urine odor, was dirty, and appeared as if no one washed his face.

At 1:55 PM on 04/02/24, during an interview with CNA #4, she explained that Resident #74 did not like to get showers and that she gave him bed baths because he refused a shower.

On 04/03/24 at 9:35 AM, during an interview with Social Services #3, she explained that Resident #74's family attended a care plan meeting in March and had complaints regarding the resident not receiving showers. The Director of Nursing (DON) explained to the family they could not force the resident to go to the shower and they were unaware that the family was still dissatisfied.

At 9:50 AM on 04/03/24, during an interview and observation with CNA #3, she confirmed Resident #74 was dependent upon staff for bathing and showers. CNA #3 cleaned the resident's groin area with a white washcloth. A moderate amount of brown and black discolored grime was noted on the washcloth. CNA #3 stated that it was not feces, but the resident was dirty. CNA #3 explained Resident #74 should receive showers on Tuesday, Thursday, and Saturday on the day shift, but he did not like to go to the shower. CNA #3 confirmed Resident #74 received bed baths

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M 610	Continued From page 12	M 610		

and that he should have gotten a bed bath yesterday (4/2/24) and would receive one tomorrow (4/4/24).

A record review of the "Bathing: Self Performance" sheet revealed documentation that Resident #74 received five (5) showers or baths in the past 30 days with total dependence of staff.

A record review of the "Documentation Survey Report" for March 2024 and April 2024 bathing revealed Resident #74 received one (1) shower on 03/17/24 and had two (2) documented bed baths in March 2024 and one (1) documented bed bath in April 2024.

Record review of the facility's "Daily Bath Schedule All Units" revealed " ...Baths must be completed daily per the schedule ... Notify nurse of any refusals immediately ..."

A record review of the "Admission Record" revealed the facility initially admitted Resident #74 on 4/28/20 with current diagnoses including Hemiplegia and Cerebral Infarction.

Record review of the Comprehensive MDS with an ARD of 3/16/24 revealed Resident #74 had a BIMS score of 7, which indicated his cognition was severely impaired.

On 04/03/24 at 9:30 AM, during an interview with LPN #7, she explained residents receive showers on the day shift for residents on the "A" side of the room for even numbered rooms on Monday, Wednesday, and Friday (MWF) and for odd numbered rooms on Tuesday, Thursday, and Saturday (TTHS). She further explained that the evening shift provided showers for the "B" side of the room using the same rotation. She confirmed

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M 610	Continued From page 13	M 610		

that she did not check behind the CNAs to ensure residents were given showers.

On 4/03/24 at 3:00 PM, during an interview with LPN #5, she explained Resident #53 and #74 received showers according to the schedule at the nurse's station. She reported that if a resident refused a shower, the CNAs were to notify the nurse and the nurse would encourage the resident to take a shower. If the resident continued to refuse, the Resident Representative (RR) would be notified.

On 04/04/24 at 12:30 PM, during an interview with the Director of Nurses (DON) and the Administrator, both explained they expected staff to provide ADL care to the residents. The DON explained she was aware Resident #74's sister (RR) had complained about resident not getting showers and having a body odor, but he refused to go to the shower, and they could not force him to go. She told the sister she would try to convince Resident #74 herself when he refused showers but confirmed she was not aware of the missed documentation or showers and bed baths not given. She stated the staff needed to be educated and she was unsure if staff had notified the RR that Resident #74 had missed showers. The DON was unaware Resident #53 was not given showers, and there was missed documentation indicating he did not receive his showers as was scheduled. The Administrator explained that staff cannot force residents to go to the shower, but she expected the staff to make several attempts to encourage the resident and to notify the RR that the resident has rejected care. The Administrator reported she expected all staff to do their job and to provide quality care to all residents at all times.

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M 620	Continued From page 14	M 620		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to ensure indwelling catheter tubing was secured to prevent complications for one (1) of 10 residents reviewed for indwelling catheters. Resident #53 Findings include: A record review of the facility's policy "Catheter Care, Urinary" dated 8/25/14, revealed, " ...The purpose of this procedure is to prevent catheter-associated urinary tract infections ... Changing Catheters 1. Ensure that the catheter remains secured with a leg strap to reduce friction and movement ... catheter tubing should be strapped to the resident's inner thigh ..." A record review of the "Admission Record" revealed the facility initially admitted Resident #53 on 4/26/18 with current diagnoses including Neuromuscular Dysfunction of Bladder. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference	M 620	1. On 04/03/2024, the Director of Nursing (DON) ensured a leg strap was attached to resident #53's catheter to comply with the comprehensive care-plan according to the Center for Medicare and Medicaid Services (CMS) guidelines. 2. All residents have the potential to be affected by this practice. 3. The DON and Staff Development nurse provided education to all Certified Nursing Assistants (CNA) and Nurses beginning on 04/17 and ending 04/19/2024 regarding catheter care and the importance of following the comprehensive care-plan. On 04/04/2024 an audit was conducted by the DON and Assistant Director of Nursing (ADON) on all residents with catheters to ensure no additional deficient practice was demonstrated. None were found. The charge nurses were educated on 04/11/2024 and 04/12/2024 on their responsibility to monitor catheters to	5/1/24

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M 620	Continued From page 15 Date (ARD) of 03/25/24, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated his cognition was moderately impaired. Record review of the "Order Summary Report" with active orders as of 4/3/24 revealed Resident #53 had a Physician's Order, dated 1/17/24, to "Check urinary catheter leg strap every shift and replace as needed ..." On 04/02/24 at 10:30 AM, during an interview and observation, Resident #53, had an indwelling catheter drainage bag attached to his wheelchair. He was unsure how long he had the catheter and reported that he did not have a leg strap to secure the catheter tubing. At 9:05 AM on 04/03/24, during an interview and observation of catheter care with Certified Nurse Aide (CNA) #3, Resident #53 had a suprapubic indwelling catheter but did not have a leg strap to secure the tubing. CNA #3 confirmed that Resident #53 was not wearing a leg strap to secure the catheter tubing and commented that he had not known him to ever wear one. At 3:15 PM on 04/03/24, during an observation and interview with Registered Nurse (RN) #5, she confirmed Resident #53 did not have a leg strap to secure the catheter tubing and stated that she would get one for the resident. She explained Resident #53 should wear the leg strap to secure the tubing to prevent the tubing from pulling or becoming dislodged. On 04/04/24 at 12:30 PM, during an interview with the Administrator and the Director of Nursing (DON), the DON reported that all residents with an indwelling catheter should have a leg strap to	M 620	ensure the leg strap is secure and in place as well as the adherence to the comprehensive care plan. 4. The facility will sustain its plan of correction by reviewing and discussing CNA supervisor weekly audits at the monthly Quality Assurance Performance Improvement (QAPI) meetings beginning 04/30/2024 and ending 07/30/2024 and addressing any deficient practice immediately. The CNA Supervisor will perform weekly audits of catheter care to ensure compliance beginning 04/08/2024 and ending 07/12/2024 report her findings to the DON and charge nurse for immediate action if necessary. The facility will provide routine education on the importance of following the comprehensive care plan according to CMS guidelines beginning 04/17/2024 and ending 09/17/2024.	

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M 620	Continued From page 16 secure the tubing. The Administrator reported that she expected the staff to always provide quality care to the residents.	M 620		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not dated with a use-by-date, food items without an identifying label, and produce that was overly ripe and exposed for one (1) of two (2) kitchen observations. Findings include: A review of the facility's policy, "Food Storage", revised 08/29/23, revealed, "Policy...Any expired or outdated food products should be discarded ...Procedure ...All products should be inspected for safety and quality and dated upon receipt, when open, and when prepared ...Any expired or outdated food products should be discarded ...Fresh Fruits ...1. Fresh fruit should be checked and sorted for ripeness ..." On 04/01/24 at 07:44 AM, an observation of the kitchen and interview with the Certified Dietary Manager (CDM), revealed the following:	M 815	1. On 04/01/2024 all food items found unlabeled or expired were disposed of immediately. 2. All residents have the potential to be affected by this practice. 3. On 04/01/2024 a complete inspection of the food storage was completed by the Dietary Manager (DM). No other issues were found. Beginning 04/10/2024 and ending 04/12/2024 education was provided to all dietary staff regarding proper storage, labeling and disposal of expired food and beverage products by the DM and Registered Dietician (RD). 4. The DM and Assistant Dietary Manager (ADM) will be auditing food storage daily beginning 04/08/2024 and ending 07/08/2024 to identify and correct any non-compliance to the Center for Medicare and Medicaid Services (CMS) guidelines related to food safety. The DM will report findings of audits at the	5/1/24

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M 815	Continued From page 17 Refrigerator #2 had one (1) portioned glass of orange juice, undated; One (1) portioned glass of apple juice, undated; Three (3) trays containing 24 portioned glasses each of what the CDM identified as sweet tea, with no label or date; One (1) opened 46-ounce carton of thickened lemon-flavored water with no opened date; one (1) opened 46-ounce carton of thickened lemon-flavored water with no opened date; one (1) opened 46-ounce carton of thickened lemon-flavored water with no opened date, and a manufacturer's use by date of March 17, 2024. The CDM acknowledged the unlabeled, undated, and expired foods and stated whoever opened the food items were responsible for labeling them with the date they were opened. An observation of the freezer revealed three (3) frozen pie crusts in tins, with no use-by date and no manufactures date. An observation of the pantry revealed five (5) bananas in which the peelings were discolored black, not intact, and exposed the inside of the bananas. The CDM acknowledged the bananas were overly ripe. The CDM reported it was her responsibility to inventory foods for quality and this was typically done twice weekly when the food truck made deliveries to the facility. She stated that she held in-service training's monthly with the kitchen staff regarding food safety. On 04/01/24 at 08:20 AM, in an interview with the Dietary Aide Supervisor (DAS) he reported it was the responsibility of the CDM to inventory foods for expiration dates. The DAS confirmed that the person who opened a food item was responsible for putting an open date on that item. The DAS also confirmed the kitchen dietary staff receive in-service training monthly.	M 815	monthly Quality Assurance Performance Improvement beginning 04/30/2024 and ending 07/30/2024 to discuss the sustainability of the plan of correction according to the Center for Medicare and Medicaid Services (CMS) guidelines related to food safety.	

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M 815	Continued From page 18 On 04/02/24 at 2:30 PM, in an interview with the Administrator, she acknowledged there was a lapse in the protocol by the kitchen staff to monitor for unlabeled, undated, and expired food items. The Administrator reported she expected the staff to make a daily inventory of the kitchen foods to assure food quality standards were safe for the residents.	M 815		
M 970	45.33.4 Control of insects, rodents, etc. Control of insects, rodents, etc. The facility shall be kept free of ants, flies, roaches, rodents, and other insects and vermin. Proper methods for their eradication and control shall be utilized. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to provide effective pest control related to roaches for two (2) of four (4) days of survey. Findings Include: Review of the facility's policy, "Pest Control", reviewed 04/10/23, revealed, " Policy Statement Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation. 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents ..." On 4/1/24 at 12:10 PM, a large roach was observed moving under the door from the kitchenette to the dayroom where the residents were eating lunch. The roach continued down the hall and entered a resident's room.	M 970	1. Pest control services are provided by an outside licensed company with the most recent date of service being dated as 03/20/2024. Pest control services were being provided monthly as measures to eradicate and contain common household pests according to The Center for Medicare and Medicaid Services (CMS) guidelines. The Pest Control was contacted on 04/04/2024 by the Administrator to arrange for additional services. The Administrator attended an emergency Resident Council Meeting to discuss pest control concerns with the residents on 4/17/2024. The Administrator informed the residents that the facility has routine pest control services and would be taking additional measures to eradicate and contain any pests. 2. All residents have the potential to be	5/1/24

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M 970	Continued From page 19 During an interview on 4/1/24 at 12:20 PM, with License Practical Nurse (LPN) #2, she confirmed the roach came from the kitchenette to the dayroom, and into a resident's room. LPN #2 said she had seen roaches at times inside the building but had not seen them lately. LPN #2 said the pest control service was in the facility a couple of weeks ago. During an interview on 4/1/24 at 12:30 PM, with Certified Nursing Aide (CNA) #2, she stated she had seen roaches several times and explained that it had gotten better but they are still in the facility. CNA #2 said she has seen pest control services in the building. She doesn't know how the roaches were getting into the building. During the resident council meeting 4/2/24 at 10:00 AM, the residents complained about roaches in the building. The residents said the roaches are large and some of them are afraid of them because of their size. The resident said pest control came and sprayed but it did not seem to help. During an observation and interview on 04/2/24 at 01:45 PM, a large roach moved across the dining room floor. Resident #128 was in the dining room and stated they see roaches sometimes because they come in from the outside. During an interview on 4/3/24 at 3:00 PM, with the facility's pest control vendor's technician, he confirmed he had seen roaches in the building on 3/21/24, in several residents' rooms. He explained that he had changed the pesticide to a stronger pesticide to help with the roaches and stated the roaches must be coming from outside the building. He confirmed the facility had not	M 970	affected by this practice. 3. On 04/17/2024, the Administrator met with the pest control services to discuss additional services needed and the facility was treated for common household pests such as roaches inside and the outside was provided a "blow-out" service to prevent pests such as roaches from entering the facility. On 04/08/2024 the Administrator met with the Maintenance Supervisor to arrange for an outside inspection of the facility to determine any point of entrance for pests. Maintenance completed the inspection and made all necessary repairs to prevent to the best of its ability, the entrance of pests from outside. 4. Pest control services will be providing monthly interior and exterior services beginning 04/17/2024 and on-going according to CMS guidelines. The Administrator educated the Interdisciplinary Team to monitor for the presence of pests during their weekly environmental rounds beginning on 04/09/2024 and continuing until 07/09/2024. The IDT will bring their environmental rounds finding to the monthly Quality Assurance Performance Improvement meetings beginning 04/30/2024 and ending 07/30/2024 to evaluate the sustainability of the plan of correction according to CMS guidelines.	

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M 970	Continued From page 20 advised him that there were issues with roaches inside the building and he explained that they were scheduled to return to the facility on 4/9/24 for their regular monthly visit and could perform a "blow out" outside of the building if the facility was interested. He reported that a "blow out" outside of the building would help keep roaches from coming inside the building. During an interview with the Director of Nursing (DON) and Administrator on 4/4/24 at 2:00 PM, the Administrator stated that she had not seen roaches and advised a pest control service sprayed the facility monthly. The Administrator confirmed she had not reported an issue with roaches to the pest control service.	M 970		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable	M1570		5/1/24

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M1570	Continued From page 21 diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review the facility failed to handle dinnerware in a manner to prevent the possible spread of infection for one (1) of one (1) resident observed for contact isolation. Resident #8 Findings include: A record review the facility's policy "Contact Precautions", dated 6/6/2013, revealed " Purpose: It is the intent of this facility to use contact precautions in addition to standard precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment ..." On 04/01/24 at 09:45 AM, during an observation, Resident #8's had signage on the door to the room indicating "Contact Isolation." A record review of the "Admission Record" revealed the facility admitted Resident #8 on 3/4/24 and was initially admitted on 4/19/17. Current diagnoses include Extended Spectrum Beta Lactamase (ESBL) Resistance, Proteus (Mirabilis) (Morganii), Pseudomonas (Aeruginosa) (Mallei) (Pseudomallei), and Streptococcus.	M1570	1. The Certified Dietary Manager (CDM) made immediate corrections on 04/01/2024 to ensure resident #8 and any other resident on contact isolation was receiving disposable food service products to prevent the spread of infection. On 04/01/2024 the CDM reviewed all tray tickets to ensure they were labeled to reflect any precautions. 2. All residents have the potential to be affected. 3. Beginning on 04/02/2024 and ending 04/05/2024, all direct care staff and dietary staff were educated on isolation protocols regarding the delivery of food service products to residents on contact isolation precautions. Beginning on 04/02/2024 and ending on 04/05/2024 all nurses were educated on the protocol to notify the dietary department of any resident admitted or started on contact isolation precautions. Beginning on 04/02/2024 and ending on 04/05/2024 all direct care staff were educated on identifying and confirming that the proper food service products were provided to residents on contact isolation before serving the resident and reporting	

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M1570	Continued From page 22 A record review of the "Order Summary Report" with active orders as of 4/4/24, revealed Resident #8 had a Physician's Order, dated, 3/4/24, for "Contact precautions for ESBL urine every shift for ESBL until 04/12/24." At 12:20 PM on 04/01/24, during an observation and interview, a lunch meal tray was delivered to Resident #8 and there was washable dinnerware and silverware on his tray. Licensed Practical Nurse (LPN) #6 explained that Resident#8 recently returned from the hospital and was on contact isolation. He stated he had not noticed until now that the resident's meal tray was not disposable. On 04/01/24 at 01:00 PM, during an interview and observation, Certified Nurse Aide (CNA) #6 came out of Resident #8's room with his meal tray and placed it on the tray cart with all other residents' trays from the hall. The cart was transported back to the kitchen. There was no distinction made to indicate to other staff the tray was retrieved from an isolation room. CNA #6 confirmed the meal tray for Resident #6 contained washable dinnerware and silverware. 04/01/24 at 1:10 PM, during an interview with Dietary Manager #1, she explained she was not aware Resident #8 was on contact isolation. She stated the admission nurse sends a "ticket" to the kitchen as communication to make the kitchen staff aware that a resident was on contact isolation. When a resident was on isolation, all meals were delivered with disposable containers and plastic utensils to prevent the trays from being placed with the other trays and coming back to the kitchen. On 04/01/24 at 02:31 PM, during an interview	M1570	and correcting any discrepancies with the dietary department immediately. Beginning on 04/03/2024 the CDM and the Assistant Dietary Manager were educated by the Registered Dietician to review tray tickets prior to issuing them to the dietary staff for accuracy and to ensure that isolation protocols were clearly visible to staff. 4. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) will audit food trays weekly beginning 04/08/2024 and ending on 07/08/2024 for accuracy regarding isolation precautions. The CDM and Assistant Dietary Manager will do weekly tray audits for accuracy related to isolation precautions beginning 04/08/2024 and ending 07/08/2024. The DON, ADON, and CDM will bring their findings to the monthly Quality Assurance Performance Improvement meetings to evaluate the sustainability of the plan of correction according to the Center for Medicare and Medicaid Services (CMS) guidelines beginning 04/30/2024 and ending 07/30/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24KI	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF BILOXI	2279 ATKINSON ROAD BILOXI, MS 39531

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M1570	Continued From page 23	M1570		

with Resident #8, he confirmed he had received all his meals with regular washable dinnerware and silverware.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/25/24 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

On 04/03/24 at 10:10 AM, during an interview with the Infection Preventionist (IP), she reported she was unsure what happened with Resident#8's contact isolation precautions regarding meals or how the "ball got dropped." The IP explained that when a resident was on contact isolation, the facility used disposable dinnerware and utensils. She stated she expected the kitchen staff to continue with contact isolation until they were told differently.

On 04/03/24 at 11:00 AM, during an interview with the Admission Nurse RN #4, she explained when a resident was newly admitted and had orders for isolation precautions, she completed a tray card for the resident and gave the information to the dietary staff. She did not remember if she notified the dietary department regarding contact isolation for Resident #8.

At 12:25 PM on 04/04/24, during an interview with the Director of Nursing (DON), she explained when a resident had contact isolation, whatever is taken into the room should remain in the room and not be taken out of the room. The DON stated that the meals for Resident #8 should have been served with disposable dinnerware and utensils. The utensils and trays should not have been returned to the kitchen to be handled and washed with the other items. She explained

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M1570	Continued From page 24 these procedures are completed to help prevent the spread of infection, and she expected the staff to follow the policy and procedures to prevent the spread of infection. At 12:30 PM on 04/24/24, during an interview with the Administrator, she explained stated that she expected the staff to follow policy and procedures to prevent the spread of infection.	M1570		