STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255093	A. BUILDING _____ B. WING _____	C 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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency 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 requirements of participation in Medicare and Medicaid. As a result of the CIs, F610 was cited. During the recertification survey, F565, F584, F623, F625, F645, F656, F677, F690, F732, F761, F812, F865, F880, F883, and F925 were cited. The facility held a license for 180 beds with a census of 144.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		4/25/24

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

Electronically Signed | 04/25/2024

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F 610	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to complete a thorough investigation regarding an injury of unknown origin for one (1) of six (6) residents reviewed for accidents. Resident #242 Findings include: Review of the facility's policy, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating", dated 10/22, revealed," Policy Statement All reports of resident's abuse (including injuries of unknown origin) ...are reported ...and thoroughly investigated by facility management. Findings of all investigations are documented and reported ...Investigating Allegations ...7. The individual conducting the investigation as a minimum ...j. interviews other residents to whom the accused employee provides care or services ..." Record review of facility's investigation incident report, dated 3/22/24 revealed Resident #242 was transferred to the hospital for an abdominal issue and the tests revealed she had bilateral pubic ramus fractures. The facility was made aware of the fractures and began an investigation which included interviewing the resident's medical providers, staff who were assigned to the resident prior to the transfer to the hospital, and the resident's roommate. There were no interviews with other residents who reside near or on the same hall as Resident #242 to possibly identify instances of abuse from staff, visitors, or other residents. On 04/3/24 at 3:40 PM, in a phone interview with	F 610	1. Administrator was educated by Regional Director of Operations (RDO) on Center for Medicare and Medicaid Services (CMS) guidelines for conducting a thorough investigation on 04/08/2024. Administrator was instructed to pursue questioning for all outside agencies that may be involved and all applicable residents as mandated by CMS guidelines. 2. All residents have the potential to be affected by this practice. 3. Administrator will collaborate with RDO and Quality Assurance (QA) committee to ensure a thorough investigation has been completed according to CMS guidelines on all reportable incidents prior to submission beginning 04/08/2024 and ending 07/08/2024. The Administrator began thorough investigation of incidents on 04/18/2024. 4. Administrator and QA committee will review the requirements set forth by CMS that dictate the criteria of a thorough investigation and review the most recent investigations monthly at Quality Assurance Performance Improvement (QAPI) meetings beginning 04/30/2024 and ongoing with all investigations to ensure the plan of correction is sustained.	

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F 610	Continued From page 2	F 610		

the Licensed Social Worker (LSW) for the local acute care hospital, she explained Resident #242 was transferred to the hospital on 3/16/24. She received x-rays within one (1) to one-half (1 1/2) hours of arriving at the hospital and had bilateral pelvic fractures.

On 04/04/24 at 11:45 AM, in an interview with the Administrator, she confirmed Resident #242 was transferred to the hospital on 3/16/24 and tests revealed she had fractures. The facility was unable to determine how or when the fractures occurred and stated they could have occurred either during ambulance transport or while in the hospital. She said she thought about visiting the resident while she was in the hospital but was unsure if she could interview her while at the hospital. The Administrator confirmed that she did not contact the ambulance service or the hospital to determine if an incident occurred that could have caused the fractures. She stated, "in hindsight I should have contacted them". The Administrator also confirmed Resident #242's roommate was interviewed during her investigation, but she did not conduct interviews with any other residents that lived near Resident #242 or on the same hall as Resident #242 to determine if there were any allegations of abuse or complaints made by those residents.

Record review of "Admission Record" revealed the facility initially admitted Resident #242 on 12/15/17 with current diagnoses including Cerebral Infarction.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 3/15/24, revealed Resident #242 required a staff interview for cognition and her cognitive skills were

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F 610	Continued From page 3 severely impaired. Record review of the Computed Tomography (CT) of the Abdomen/Pelvis, dated 3/16/24, revealed, "New minimal displaced bilateral pubic rami fractures."	F 610		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F 865		5/1/24

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F 865	Continued From page 4 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and	F 865		

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F 865	Continued From page 5 addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to ensure the program was sustained during transitions in leadership and failed to maintain implemented	F 865	1. On 04/08/2024 Regional Director of Operations (RDO) educated Administrator and the Quality Assurance (QA) committee on the Center for Medicare and Medicaid Services (CMS) guidelines	

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F 865	Continued From page 6 procedures and monitor the interventions the committee put into place in March 2022. This was for two (2) recited deficiencies originally cited in March 2022 on an annual recertification survey. The deficiencies were in the area of residents' rights/environment and investigations. The facility's continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee for two (2) of 16 deficient practice citations. Findings Include: Record review of the facility's policy, "Quality Assessment and Performance Improvement", undated, revealed, " ...The facility will implement and maintain a Quality Assessment and Performance Improvement program. Overview: The Quality Assurance and Performance Improvement (QAPI) committee will implement a process that is ongoing ...The primary purpose of the committee is to identify and analyze actual or potential quality issues, develop and implement appropriate plans to improve performance, to address identified quality issues, and monitor the effectiveness of implemented changes ..." F584: Based on observation, interviews, record review, and the facility policy review the facility failed to ensure residents' rights for a clean and comfortable environment were honored regarding soiled privacy curtains for two (2) of 30 sampled residents. Resident #6 and Resident #27 F610: Based on interviews, record review, and facility policy review, the facility failed to complete a thorough investigation regarding an injury of unknown origin for one (1) of six (6) residents reviewed for accidents. Resident #242	F 865	to implement and maintain an effective Quality Assurance Performance Improvement (QAPI) program. 2. All residents have the potential to be affected by this practice. 3. On 04/08/2024, the QA committee initiated a performance improvement project (PIP) to address resident rights regarding a safe, clean and home-like environment specifically regarding soiled privacy curtains. On 04/08/2024, the QA committee initiated a performance improvement project (PIP) to address any and all reportable investigations for adherence to CMS guidelines regarding what constitutes a thorough investigation on reportable incidents. 4. Beginning 04/30/2024 and ending 07/30/2024 the QA committee will review the previous 2567 citations to ensure the plan of corrections are being sustained and will take corrective action to address any gaps in the adherence to the original plan of correction according to CMS guidelines.	

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F 865	Continued From page 7 Record review of the Statement of Deficiencies and Plan of Correction (Form 2567) from the previous annual survey in March 2022, revealed F584 was cited due to shower rooms and resident wheelchairs in disrepair and F610 was cited regarding an investigation of misappropriation. During an interview with the facility's Administrator on 4/4/24 at 2:00 PM, she stated she was not working for the company at the time of the recertification survey that occurred in March 2022. The Administrator confirmed the interdisciplinary team met monthly for a QAPI meeting and discussed the high-risk issues in the facility and provided interventions. She confirmed she had reviewed Form 2567 and was aware of the facility's previous citations. The Administrator stated the QAPI committee had not discussed the soiled privacy curtains because she was unaware there was an issue. She also stated the QAPI committee did not discuss the pelvic fracture investigation because she felt she completed a thorough investigation and had ruled out neglect and abuse during the investigation.	F 865		