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	255093	A. BUILDING _____ B. WING _____	C 03/21/2025

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 (SA) conducted two (2) Complaint Investigations (CI MS #27598 and CI MS #27971), at the facility from 3/17/25 through 3/21/25. CI MS #27598 was investigated related to resident safety. CI MS #27971 was investigated regarding neglect, accidents, and resident safety. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. Based on the facility's implementation of corrective actions on 2/14/25, the SA determined the facility to be Past Non-Compliance (PNC) on 2/14/25, prior to the SA's entrance on 3/21/25 and cited F656 and F689 for CI MS #27971. The facility held a license for 180 beds, with a census of 144.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		

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

Electronically Signed | 03/31/2025

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F 656	Continued From page 1 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to implement comprehensive care plan interventions for a resident who was identified as a fall risk, resulting in a fall that caused the resident to sustain a mildly displaced fracture of the proximal right humerus, for one (1) out of three (3) sampled residents. Resident #1.	F 656	Past noncompliance: no plan of correction required.	

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F 656	Continued From page 2	F 656		

Findings include:

A review of the facility's "Care Plans, Comprehensive Person-Centered", reviewed 10/2022, revealed: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas..."

A record review of the care plan revealed: "...Date Initiated: 09/22/2015: Focus: Resident has self-care deficit..." "...Interventions/Tasks: Transfer: Extensive, (X2) times two (2) Assist (w) with/sit to stand lift..." Date initiated: 03/21/2023.

The record review of the facility investigation revealed Resident #1 had a witnessed fall on 2/13/25 at 6:49 AM. Certified Nurse Assistant (CNA) #1 reported that during the transfer of the resident from her bed to the wheelchair, the resident slipped, and CNA #1 lowered the resident to the floor. The facility sent the resident to the hospital for evaluation and treatment due to bruising and swelling to her right hand. The resident's x-rays showed a mildly displaced, slightly impacted fracture of the proximal right humerus with overlying soft tissue swelling. Following the investigation, CNA #1 was terminated because she did not follow the care plan for transferring the resident, resulting in a fall with injury.

Record review of the "Progress Notes" revealed on 2/13/25 at 6:00 AM, while CNA #1 was

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F 656	Continued From page 3	F 656		

attempting to transfer the resident, her foot slipped, and she fell on top of the CNA. The resident was assessed with no apparent injuries. Vital signs were taken, and the medical provider, Assistant Director of Nurses (ADON) and Resident Representative (RR) were notified.

Record review of the "Progress Note" revealed on 2/13/25 at 5:47 PM, the resident complained of pain to her right arm. The resident's hand was swollen and bruised, and she was sent to the local emergency department.

Record review of the "Emergency Documentation" report dated 2/13/25 at 3:23 PM reveled that patient is a patient of the nursing facility. Patient is unsure how she fell but has right upper arm pain. She has significant bruising to her right upper arm and was placed in a sling by local ambulance. The assessment was completed with a fracture of the proximal end of the humerus. The resident was prescribed a sling and pain medication, then transferred back to the facility.

Record review of the diagnostic radiology on 2/13/25 revealed "Impression: Mildly displaced, slightly impacted fracture of the proximal right humerus with overlying soft tissue swelling. No definitive evidence of additional fracture of the right upper extremity."

Record review of the "Admission Record" revealed the facility admitted the resident on 8/27/2013 with diagnoses including Hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.

During a phone interview on 3/21/25 at 10:40 AM,

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F 656	Continued From page 4	F 656		

CNA #1 confirmed that on 2/13/25, during the transfer of Resident #1, the resident's foot slipped, and she fell, landing on the CNA #1, who was taught to break her fall. CNA#1 stated she did not use the sit-to-stand lift for her transfer because the battery was not charged, and that was the way she transferred the resident that morning. CNA #1 confirmed that according to the care plan, she should have used the lift, but since the resident requested to get up to go smoke, she felt as if she could have transferred her without problems.

On 3/21/25 at 12:00 PM, during an interview with the Minimum Data Set (MDS)/Licensed Practical Nurse (LPN) #1, confirmed that she expects all staff to follow the comprehensive care plan interventions for residents. The care plans are person-centered and address residents' needs and safety. She explained that care plans are accessible to staff through computerized charting and are reviewed periodically. MDS/ LPN #1 reported that in-service training is provided to the staff regarding following care plans but acknowledged that some staff may not consistently follow them and disciplinary action is taken when necessary.

On 3/21/25 at 12:30 PM, during an interview with the Director of Nurses (DON), she confirmed that CNA #1 did not follow the care plan for the transfer of Resident #1 by using the sit-to-stand lift. She expected all staff to follow the residents' care plans, which are designed to provide each resident with care based on their individual needs. She confirmed that the resident's care plan includes the use of a sit-to-stand lift for transfers. She agreed that if this intervention had been implemented, the incident may have been

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F 656	Continued From page 5 prevented. Validation: The SA validated on 3/21/25, through interview and record review, that all corrective actions had been implemented as of 2/14/25, and the facility was in compliance as of 2/14/25, prior to the SA's entrance on 3/17/25.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide adequate supervision to prevent Resident #1, who was identified as a fall risk, from falling and causing the resident to sustain a mildly displaced fracture of the proximal right humerus for one (1) out of three (3) sampled residents, Resident #1. Findings include: A review of the facility's "Safety and Supervision of Residents", reviewed 8/2023, revealed: "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities."	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 6	F 689		

The record review of the facility investigation revealed Resident #1 had a witnessed fall on 2/13/25 at 6:49 AM. Certified Nurse Assistant (CNA) #1 reported that during the transfer of the resident from her bed to the wheelchair, the resident slipped, and CNA #1 lowered the resident to the floor. The facility sent the resident to the hospital for evaluation and treatment due to bruising and swelling to her right hand. The resident's x-rays showed a mildly displaced, slightly impacted fracture of the proximal right humerus with overlying soft tissue swelling. Following the investigation, CNA #1 was terminated because she did not follow the care plan for transferring the resident, resulting in a fall with injury.

Record review of the "Progress Notes" revealed on 2/13/25 at 6:00 AM, while CNA #1 was attempting to transfer the resident, her foot slipped, and she fell on top of CNA #1. The resident was assessed with no apparent injuries. Vital signs were taken, and the medical provider, Assistant Director of Nurses (ADON), and Resident Representative (RR) were notified.

Record review of the "Progress Note" revealed on 2/13/25 at 5:47 PM, the resident complained of pain to her right arm. The resident's hand was swollen and bruised, and she was sent to the local emergency department.

Record review of the "Emergency Documentation" dated 2/13/25 at 3:23 PM revealed patient is a patient of the nursing facility. Patient is unsure how she fell but has right upper arm pain. She has significant bruising to her right upper arm and was placed in a sling by local

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F 689	Continued From page 7	F 689		

ambulance. The assessment was completed with a fracture of the proximal end of the humerus. A sling and pain medication were prescribed, and the resident was transferred back to the facility.

Record review of the diagnostic radiology on 2/13/25 revealed "Impression: Mildly displaced, slightly impacted fracture of the proximal right humerus with overlying soft tissue swelling. No definitive evidence of additional fracture of the right upper extremity."

Record review of the "Admission Record" revealed the facility admitted the resident on 8/27/2013 with diagnoses including Hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.

On 3/17/25 at 11:15 AM, during an interview with the Administrator in Training (AIT), he revealed that Resident #1 had a witnessed fall on 2/13/25. CNA #1 reported that during the transfer from her bed to her wheelchair, the resident slipped, and CNA #1 lowered the resident to the floor. The facility sent the resident to the hospital for evaluation and treatment due to bruising and swelling to her right hand. The resident's x-rays showed a mildly displaced, slightly impacted fracture of the proximal right humerus with overlying soft tissue swelling. Following the investigation, CNA #1 was terminated because she did not follow the care plan for transferring the resident, resulting in a fall with injury. The facility provided in-services to all care staff following the incident on accidents, transfers, care plans, and incident reporting. Additionally, the facility performed an emergency Quality Assurance Performance Improvement (QAPI) on 2/14/25.

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F 689	Continued From page 8	F 689		

On 3/21/25 at 10:20 AM, during an interview with the ADON, she confirmed that on 2/13/25, as she was arriving at the facility at approximately 6:30 AM, Registered Nurse (RN) #2 informed her that Resident #1 had a witnessed fall by CNA #1. RN #2 did not witness the fall but observed Resident #1 lying on top of CNA #1. According to CNA #1, Resident #1 was slipping during the transfer, and she caught her and let her land on CNA #1. RN #2 assessed the resident and informed the Nurse Practitioner (NP) and Resident Representative (RR). Later in the day, the resident had noticeable bruising on her right hand. New orders were received, and she was transferred to the local hospital, where she was diagnosed with a mildly displaced, slightly impacted fracture of the proximal right humerus with overlying soft tissue swelling.

On 3/21/25 at 10:40 AM, during a phone interview, CNA #1 confirmed that on 2/13/25, during the transfer of Resident #1, the resident's foot slipped, and she fell, landing on CNA #1, who was taught to break her fall. She revealed that the resident never touched the floor and landed on the CNA#1. She stated she did not use the sit-to-stand lift for the transfer because the battery was not charged, and that was the way she transferred the resident that morning.

During an interview on 3/21/25 at 12:30 PM, the Director of Nurses (DON), confirmed that she was not in the facility on 2/13/25, but Resident #1 did have an accident, resulting in a mildly displaced, slightly impacted fracture of the proximal right humerus with overlying soft tissue swelling. She confirmed that CNA#1 did not follow the care plan to use the sit-to-stand lift and

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F 689	Continued From page 9 that the accident may not have occurred if she had used the lift. Validation: The SA validated on 3/21/25, through interview and record review, that all corrective actions had been implemented as of 2/14/25, and the facility was in compliance as of 2/14/25, prior to the SA's entrance on 3/17/25.	F 689		