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 _____	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) COMPLETE DATE
M 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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. 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 M640 was cited as PNC.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III 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:	M 640	Past Non Compliance	3/31/25

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M 640	Continued From page 1 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." 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	M 640		

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M 640	Continued From page 2	M 640		

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 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,

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care plans, and incident reporting. Additionally, the facility performed an emergency Quality Assurance Performance Improvement (QAPI) on 2/14/25.

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

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M 640	Continued From page 4 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 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.	M 640		