

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2025
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF BILOXI			STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Complaint Investigation (CI), MS #28378, a Facility Reported Incident (FRI), at the facility from 4/2/25 through 4/3/25, related to an elopement. The facility failed to provide supervision and ensure environmental safety to prevent Resident #1, a newly admitted and cognitively impaired resident, from opening a window and leaving the facility undetected on the morning of 3/23/25. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare or Medicaid, based on the facility's implementation of corrective actions on 3/23/25. The facility's failure to provide supervision and ensure environmental safety resulted in Resident #1 removing a window screen in his room and exiting the facility. He exited the facility unnoticed and was last seen inside the facility at 6:00 AM on 3/23/25. He was found on 3/23/25 at 6:30 AM by the Dietary Cook who was reporting work and observed the resident walking around side of the building, approximately 130 steps from the facility's entrance. Resident #1 was wearing shorts, with no shirt or shoes. During the investigation of the FRI, the SA identified Immediate Jeopardy (IJ) and Substandard of Quality of Care (SQC) that began on 3/23/25 and existed at: 42 CFR(S): 483.25(d)(1)(2)- Free of Accidents, Hazards/Supervision/Devices (F689) - Scope and Severity "J" The situation placed Resident #1 and other residents at risk for serious injury, serious harm,	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/29/2025

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.

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F 000	Continued From page 1 serious impairment, or death. The SA notified the facility's Administrator of the Past Non-Compliance (PNC) IJ and SQC on 4/2/25 at 2:40 PM and provided the IJ template. Based on the facility's implementation of corrective actions on 3/23/25, the SA determined the IJ and SQC to be PNC and the IJ removed on 3/24/25, prior to the SA's entrance on 4/2/25. At the time of the survey, the facility was licensed for 180 beds and had a census of 147 residents.	F 000			
F 689 SS=J	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 observation, interviews, record review, and facility policy review, the facility failed to provide adequate supervision and ensure environmental safety to prevent Resident #1, a vulnerable resident, from exiting the facility unnoticed and unsupervised for one (1) of three (3) residents reviewed. Resident #1 On 3/23/25, Resident #1, who had a Brief Interview for Mental Status (BIMS) score of eight (8), physically pushed out and removed the window screen in his room and exited the	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 2 building. Resident #1 exited the facility unnoticed and was last seen inside the facility at 6:00 AM by a Certified Nursing Assistant (CNA) and was found at 6:30 AM by facility staff (Dietary Cook) who was reporting to work. The resident was observed by the Cook walking around side of the building and was approximately 130 steps away from the building. Resident #1 was wearing shorts only and no shoes. The facility's failure to provide supervision and ensure environmental safety put Resident #1 and other vulnerable residents at risk for serious injury, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 3/23/25, when Resident #1 exited the facility. The State Agency (SA) notified the Administrator of the IJ on 4/2/25 at 2:40 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 3/23/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 3/24/25 prior to the SA's entrance on 4/2/25. Findings include: A review of the facility's policy, "Accident and Incidents," dated 2/19/2017, revealed, "...It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and those residents receive supervision and assistance devices to prevent accidents whenever possible..."	F 689			

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F 689	Continued From page 3 A review of the facility's policy, "Emergency Procedure-Missing Resident," dated 3/2023, revealed, " ...Resident elopement resulting in a missing resident is considered a facility emergency ..." A record review of the facility's investigation, dated 3/25/25, revealed that on 3/23/25 at 6:30 AM, the Dietary Cook was entering the facility and noticed a gentleman walking from the side of the building. The gentleman approached the dietary cook at this time, but he was unable to understand him. The Cook asked the man to sit on the curb so that he could get some assistance. A housekeeper was within range of the facility entry door and confirmed that the man was a resident of the facility. The housekeeper notified the nurse on duty that the patient was sitting outside his room on the curb. The resident was escorted back into the facility by the Nurse Supervisor and housekeeper. The resident was unable to explain what he was doing. Through staff interviews and investigation, it was determined that the Nurse on Duty last saw the resident at approximately 4:30 AM when she gave him his medications and treatment. The resident was calm and appeared to have no signs of any type of agitation or anxiousness. Certified Nurse Aide (CNA) #1 observed Resident #1 attempting to enter another resident's room at approximately 6:00 AM on 3/23/25 and re-directed the resident. At some point after the encounter with the Nurse on duty and the CNA, the resident opened a window, removed the screen, and exited the building to get air. The weather was approximately 63 degrees and he was wearing shorts. Upon re-entering the building, the resident was assessed with no signs or symptoms of any injuries and no psychosocial	F 689			

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F 689	Continued From page 4 harm found. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 3/5/25 with diagnoses including Squamous Cell Carcinoma of the Skin and Lip. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated his cognition was moderately impaired. A record review of the "Evaluation Bundle" dated 3/6/25, signed by Registered Nurse (RN) #2, indicated the resident was not identified as a wander/elopement risk. A record review of a weather report via https://www.timeanddate.com revealed the temperature at the time of the elopement was approximately 63 degrees On 4/2/25 at 6:40 AM, during an interview with the Assistant Director of Nursing (ADON), she confirmed that on 3/23/25 at 6:30 AM the Dietary Cook entered the back employee entrance and noticed a man dressed in shorts, no shirt, and no shoes walking from the west side of the facility. She stated the cook was unable to understand the man's speech and asked a housekeeper to confirm his identity. The housekeeper confirmed the individual was Resident #1. The cook stayed with the resident while the housekeeper retrieved the nurse, who assessed the resident for injuries. The resident was then able to walk back to his room independently. The nurse notified her immediate supervisor, who then contacted the	F 689			

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F 689	Continued From page 5 Administrator. On 4/2/25 at 7:00 AM, during an interview with RN #1, she explained that Resident #1 did not exhibit elopement behaviors prior to the incident. She stated that around 4:30 AM on 3/23/25, she found the resident in an empty room and redirected him back to his room, completed wound care, and administered pain medication. Later that morning, the housekeeper notified her that Resident #1 had been found outside near the back entrance. She assessed the resident, noted no injuries, and assisted him back to his room. On 4/2/25 at 7:20 AM, during an interview with Housekeeper #1, she confirmed that on 3/23/25 around 6:30 AM, the Dietary Cook asked her if the man outside was a resident. She confirmed that he was and immediately ran to get the nurse. On 4/2/25 at 7:30 AM, during an observation of the area from Resident #1's window to the area he was found, the Assistant Director of Nursing (ADON) confirmed the resident had walked approximately 130 feet from his room to the rear entrance of the facility. On 4/2/25 at 8:00 AM, during a phone interview with CNA #1, she reported that at approximately 6:00 AM on 3/23/25, she observed Resident #1 attempting to enter another resident's room. She redirected him back to his room. At 6:30 AM, she was informed by the housekeeper that the resident had been found outside. She and the nurse assisted him back inside. On 4/2/25 at 8:30 AM, during a phone interview, the Dietary Cook confirmed that on 3/23/25 at approximately 6:30 AM, he observed a man	F 689			

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F 689	Continued From page 6 walking around the back of the facility and was unable to understand him. He asked a housekeeper to confirm if the individual was a resident. Once confirmed, he remained with the resident until staff arrived. On 4/2/25 at 8:45 AM, during a phone interview with CNA #2, she confirmed that on 3/23/25, she saw Resident #1 sitting on the curb with the Dietary Cook as she parked her car. The resident's nurse and CNA #1 brought him back inside. On 4/2/25 at 12:00 PM, during an interview with the Administrator, she confirmed CNA #1 had redirected Resident #1 at 6:00 AM, and that he was later found outside at 6:30 AM. She stated the resident had not been previously identified as an elopement risk and he had been at the facility for a little over two weeks. She confirmed the facility performed a full assessment of the resident, accounted for all residents, conducted a Quality Assurance and Performance Improvement (QAPI) meeting the same day, and implemented corrective actions including in-services, reassessments, window safety checks, and elopement drills on all shifts. She confirmed that she reported the incident to the State Agency and the Attorney General's office. On 4/2/25 at 12:30 PM, during an interview with the Director of Nursing (DON), she stated Resident #1 was evaluated on admission and determined to not be at risk for elopement. She confirmed that he had not exhibited wandering or exit-seeking behavior since his admission, which was 18 days prior to the date of the incident. On 4/2/25 at 1:00 PM, during an interview with			F 689			

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F 689	Continued From page 7 the Maintenance Director, he confirmed that after being informed of the elopement, he inspected all doors, windows, and keypads. He installed L-brackets on resident room windows to prevent them from opening more than six inches and conducted elopement drills for all shifts. He also confirmed attending all required in-services. On 4/2/25 at 3:00 PM, during an interview with the Nurse Practitioner (NP), she confirmed that Resident #1 was not identified as an elopement risk and had not exhibited any behavioral issues since his admission date of 3/5/25. The facility submitted a corrective action plan as follows: On 3/23/2025 at 6:35 AM, the Registered Nurse (RN) escorted the resident into the facility and assessed him with no signs or symptoms of injuries with vitals within normal limits. On 3/23/2025 at 6:50 AM, the Director of Nurse (DON) was notified by the nurse supervisor that the resident was outside on the curb and escorted back into the building. DON instructed the nurse supervisor to transfer Resident #1 to the secured unit for increased observation; as well as using a current daily census to perform a head count on all residents, and all residents were accounted for. On 3/23/2025 at 7:50AM, the Administrator was notified of the incident. On 3/23/2025 at 7:55 AM, the Administrator contacted the Maintenance Supervisor to inspect all windows.	F 689			

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F 689	Continued From page 8 On 3/23/2025 at 9:15 AM, the Maintenance Director reported to the facility to inspect the windows, all doors, windows, and keypads were working properly. On 3/23/2025 at 9:28 AM, the Administrator notified the State Agency. On 3/23/2025 at 11:50 AM, Licensed Social Worker interviewed Resident #1; he stated he just wanted to get air, and the Licensed Social Worker found no psychosocial harm. On 3/23/2025 at 12:15 PM, the Maintenance Director placed L brackets on all resident windows, which are metal shaped so that the windows are unable to open greater than six inches. On 3/23/2025 at 12:30 PM, an Emergency Quality Assurance Performance Improvement (QAPI) meeting was held that included the Administrator, Medical Director, DON, Regional Director of Operations, Regional Nurse Consultant, Unit Manager, Infection Preventionist, and Staff Development. The QAPI team discussed the adverse event, reviewed the immediate actions taken, reviewed policy and procedures. No changes were made to the policies and procedures. It was determined through staff and resident interview Resident #1 exited the facility by opening the window and removing the screen and going out for air. It was determined the Maintenance Director placed L brackets on all resident windows, which are metal shaped so that the windows are unable to open greater than six inches. QAPI Minutes Included:	F 689			

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F 689	Continued From page 9 On 3/23/2025 an in-service was conducted by the Administrator for all staff prior to their oncoming shift and via telephone on missing residents, elopement risk policies, whom and when to notify if there is a missing resident, elopement books and arm band placement on each resident. On 3/23/2025 all windows were verified to be in proper working order by the maintenance supervisor. All windows were secured with L shape brackets to prevent residents from exiting the facility. Maintenance will perform weekly visual inspections for four weeks and monthly thereafter to ensure that all windows and screens are in proper working order. On 3/23/2025 Elopement drills were completed on all shifts (7A-3PM, 3P-11P, 11P-7A) by the maintenance supervisor and Assistant Administrator. Drills will be continued weekly for four weeks and monthly thereafter and will be brought in for review and recommendations during monthly QAPI. Any findings will be addressed immediately by the Administrator and/or Director of Nursing. On 3/23/2025, all staff will be in-serviced for elopement/wandering. No staff will be allowed to work until they have received the in-service. On 3/23/2025, the Nurse on duty moved Resident #1 to the secure unit, every one hour checks were put into place and fresh air walks were initiated. On 3/23/2025 100% of all residents were assessed by the Licensed Practical Nurse to verify that anyone deemed at risk for wandering	F 689			

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F 689	Continued From page 10 or elopement proper interventions were in place. In-house census of 146 residents reviewed at this time and there was a total of 58 residents deemed at risk. On 3/23/2025 100 % audit completed for all care plans to verify that any resident deemed a wandering or elopement risk were identified and updated. On 3/23/2025 the Licensed Social Worker assessed Resident #1 to determine that there were no findings of psychosocial harm. Validation: The SA validated through interview and record review view, that all corrective actions had been implemented as of 3/23/25, and the facility was in compliance as of 3/24/25, prior to the SA's entrance on 4/2/25.			F 689			