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 04/01/2021

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 CI MS #17687 The State Agency (SA) conducted a complaint investigation, (CI MS #17687) at the facility from 4/1/21 to 4/1/21. During the investigations, the SA determined that the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA did not substantiate CI #17687 for physical abuse but did cite F609 when a Certified Nursing Assistant #2 (CNA) failed to report to the facility an alleged physical abuse within two (2) hours of the alleged event. The facility held a license for 180 with a census of 143.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		4/25/21

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

Electronically Signed | 04/25/2021

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F 609	Continued From page 1 §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. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review the facility failed to report alleged physical abuse to State Agency (SA) in a timely manner for one (1) of five (5) residents reviewed for abuse. Resident #4. In a review of the facility's, "Freedom from Abuse, Neglect, and or Exploitation Prevention Plan Policy" revised 8/23/17, revealed the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined. The policy also states the facility will report alleged violations, conduct investigations of alleged violations, report the results to proper authorities, and take necessary corrective actions. The facility policy states any employee aware of abuse, neglect, mistreatment, or misappropriation of resident property or any allegation of the same and fails to report immediately may result in disciplinary action up to and including termination. The policy also stated if a staff member witnesses any allegations of abuse, verbal abuse, physical abuse, sexual abuse, and /or neglect towards a patient /resident you should immediately protect and remove the resident from the situation or person, report immediately to your supervisor, and failure to report will result in termination and is subject to be punishment by	F 609	The Administrator notified the State Agency and Attorney General of the allegation of abuse to Resident #4 by Certified Nursing Assistant (CNA) #1 on 3/29/2021.CNA #1 and CNA #2 were suspended on 3/29/2021 pending investigation.The Charge Nurse assessed Resident #4 on 3/29/2021 and noted no signs of abuse. The investigation was completed on 4/1/2021 and the allegation of abuse was unsubstantiated. CNA # 1 returned to work on 4/2/2021. CNA #2 was terminated on 4/1/2021 for failure to report abuse per facility policy. All residents have the potential to be affected by the deficient practice. The Social Service Director (SSD) interviewed all interviewable residents on 3/29/2021 regarding abuse and documented no negative outcomes. All residents were assessed by the Administrative Nursing Staff on 3/29/2021 for signs of physical abuse and documented no negative outcomes. All staff were in-serviced regarding abuse including reporting abuse immediately to the Director of Nursing (DON) and Administrator by the DON, Assistant	

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F 609	Continued From page 2 law enforcement. This policy also noted for a staff member to immediately step away and get the nurse immediately, if a resident is combative. Record review of the facility's in-services revealed Certified Nursing Assistance (CNA) #2 signed the policy on 2/24/21 acknowledging he had complete understanding of the freedom from abuse neglect and/or exploitation prevention plan as well as the Elder justice act of 2009. Review of the facility's in-service, "Freedom from abuse, neglect and/or exploitation education", dated 3/15/21 revealed CNA #2's signature on the sign in sheet as having attended the in-service. In an interview on 4/1/21 at 06:30 AM, with Licensed Practical Nurse (LPN) #1 revealed CNA #2 did not report any physical abuse for Resident #4 by CNA #1 on 3/28/21. LPN #1 said CNA #1 and CNA #2 took care of the residents and she did not know there was a problem or any concerns of abuse by CNA #1. In an interview on 4/1/21 at 06:40 AM, with LPN #2 revealed he is the day shift charge nurse. LPN #2 said nobody reported allegations of abuse for Resident #4 to him. The charge nurse said he came in on the morning of the alleged abuse to Resident #4 and talked to both CNA #1 and CNA #2 and reports he did not know there was a problem. During an interview, on 3/31/21 at 2:00 PM, with the local Ombudsman revealed CNA #2 called the District Ombudsman's office on 3/29/21 saying he witnessed CNA #1 slap Resident #4. The Local Ombudsman said CNA #2 revealed both CNA's were providing care when Resident	F 609	Director of Nursing (ADON) and Assistant Administrator beginning 3/29/2021 and ending 4/1/2021. All staff will continue to receive in-service training regarding abuse and reporting of abuse upon hire. The SSD will interview five (5) employees weekly X eight (8) weeks then monthly x three (3) months beginning 3/30/21 regarding abuse policy including reporting , document findings and take corrective action as necessary. The SSD will report findings from weekly staff interviews regarding abuse policy for two (2) months then monthly staff interviews regarding abuse policy for three (3) months to the Quality Assurance and Performance Committee monthly beginning 3/30/21 for review, revision and/or resolution of the plan.	

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#4 scratched CNA #1 on the arm and then CNA #1 slapped Resident #4 on the right side of his face really hard. CNA #2 said he told CNA #1 not to do that. CNA #2 said he did not tell anybody in the facility because he was not aware of who to report to. CNA #2 said the incident happened on 3/28/21 at 06:00 AM. The local Ombudsman said CNA #2 called the District Office the next day after the incident occurred. The Local Ombudsman said he immediately notified the Administrator at the facility. The Local Ombudsman said the Administrator said she was going to report the incident to the SA and start an investigation immediately.

Record Review of Resident #4's most recent Minimum Data Set (MDS) revealed the resident's Brief Interview for Mental Status (BIMS) score was 3 which indicates the resident is cognitively impaired. Record review of Resident #14's Admission record revealed diagnoses included Dementia with behavioral Disturbance, Diabetes Mellitus(DM), Hypertension (HTN), Heart Disease and Benign Prostate Hypertrophy (BPH). Record review of the Order Summary Report included an order dated 2/26/21 for Buspirone HCL 5 milligrams (mg) by mouth (po) three times a day (TID) (agitation). Record Review of the facility care plan revealed the resident is at risk for self-care deficit r/t limited mobility, dementia with behavioral disturbance.

Interview with Resident #4 on 4/1/21 08:05 AM reveal the resident is confused, unable to make needs known. The staff anticipates the resident's needs.

During an interview on 4/1/21 at 09:00 AM, CNA #2 confirmed he failed to notify the nurse,

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F 609	Continued From page 4	F 609		

Director of Nursing (DON) and the Administrator of witnessing an alleged abuse by CNA #1 when she slapped Resident #4. CNA #2 said he and CNA #1 was assisting Resident #4 with putting on his pants. CNA #2 said Resident #4 scratched CNA #1 on the hand then CNA #1 slapped Resident #4 on his right cheek. CNA #2 said he told CNA #1 not to do that. CNA #2 said he left the facility and decided later to call the District Ombudsman to let them know he witnessed abuse because he felt nothing would be done at the facility. CNA #2 said he did not know who to report abuse to at the facility. However, CNA #2 confirmed he signed the facility in-service on Abuse/neglect and exploitation upon hire on 2/24/21 and 3/15/21. CNA #2 said he read the in-services, but he did not think about what he read because he was shocked when he saw the abuse.

During an interview on 4/1/2021 at 09:30 AM, with the Administrator, confirmed she failed to report to the SA within two (2) hours of the incident because her employee failed to report the alleged abuse to the facility. The Administrator said the local Ombudsman called to report he received a call from CNA #2 alleging he witnessed CNA #1 slap Resident #4 on the right cheek. The Administrator said she reported the incident to the SA immediately and started an investigation. The Administrator said CNA #1 was immediately pulled off the unit and was suspended pending investigation. CNA #2 called in for his next shift after he reported the incident to the Ombudsman with car problems.