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 02/18/2021

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 The State Agency (SA) conducted a complaint investigation (CI MS #17466, CI MS #17561) from 02/17/21 through 02/18/21. During the survey, the SA substantiated CI MS #17561 for failure to clean scissors that was used before and after wound care for Resident #1 and Resident #3, and cited F880 at an "E" level. The facility also failed to perform incontinent care before and during wound care for Resident #1 and cited F686 at a "D" level. CI MS #17466 was not substantiated for failure to give medications per Professional Standards. The facility held a license for 180 beds, with a census of 136.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow Standard Infection Control Precautions related to performing incontinent care prior and/or during wound care to prevent the possible spread	F 686	Resident # 3 was assessed by the Assistant Director of Nursing (ADON) on 2/18/2020 and noted to have no adverse findings. Registered Nurse (RN) # 1 was educated by the ADON on 2/18/2021	3/18/21

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

Electronically Signed | 03/02/2021

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F 686	Continued From page 1 of infection for one (1) of three (3) wound care observations. [Resident #3] Findings Include: The facility's, "Infection Prevention/Procedure for Major Wounds ", revised June 2013, to provide guidelines for good infection prevention technique in wound care. The resident must not be soil when the dressing change is done. If the resident is soiled, wound care should not be done until her/she is cleaned. Resident # 3 . On 02/18/21 at 10:10 AM, observed Registered Nurse (RN) #1 perform wound care to the coccyx for Resident #3. RN #1 failed to provide incontinent care for Resident #3 prior to wound care being provided. Resident #3 was observed oozing feces, prior to and during wound care. Record review of Transfer/Discharge Report revealed the facility admitted Resident #3 on 03/01/2019, with the diagnoses of Osteoporosis and Hypertension. In a review of Resident #3's care plan revealed Resident #3 had a self-care deficit with the intervention for staff to perform activities of daily living. In a record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ADR) of December 4, 2020, revealed Section C-0500, the Brief Interview for Mental Status (BIMS) score was nine (9), which indicated moderate cognitive impairment. Section G, Item G 0110 (I) listed extensive assistance with toilet	F 686	regarding wound care and infection control including providing incontinence care before and during wound care. All residents with pressure ulcers have the potential to be affected by the deficient practice. 14 (fourteen) residents identified with pressure sores were assessed by the Wound Care Nurse and Wound Care Nurse Practitioner on 2/25/2021 with no negative outcomes identified. All licensed nurses were in-serviced regarding wound care policies and infection control, including providing incontinence care prior to and during wound care beginning 2/19/21 and ending 3/2/2021 by the ADON. The ADON will perform two wound care observations weekly beginning 2/25/21 for 8 (eight) weeks then resume 1 (one) wound care observation monthly ongoing, take immediate action as necessary and document findings. The ADON will report findings from weekly wound care observations for 2 (two) months, then monthly wound care observations ongoing to the Quality Assurance and Performance Committee monthly beginning 3/2/2021 for review, revision and/ or resolution of the plan.	

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F 686	Continued From page 2 use. On 02/18/21, at 11:58 AM, in an interview with RN #1, stated she did perform wound care when Resident #3 was soiled with feces. RN #1 stated Resident #3 was oozing bowel during wound care and confirmed she covered the feces with a towel to not contaminate the wound but did not clean Resident #3 and continued to perform wound care. On 2/18/21, at 1:22 PM, in an interview with Registered Nurse (RN) #2/Infection Preventionist (IP), confirmed RN #1 should have stopped the wound care and provided incontinent care for Resident #3 prior to and during wound care. On 02/18/21, at 1:53 PM, an interview with the Director of Nurses (DON), revealed the wound care nurse should have followed the facility's infection control policy and cleaned Resident #3 prior to wound care. The DON confirmed if there is feces or a wet brief ,the staff should clean the resident prior to wound care to prevent any type of cross contamination.	F 686		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		3/18/21

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F 880	Continued From page 3	F 880		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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F 880	Continued From page 4 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record reviews, and facility policy reviews, the facility failed to follow Standard Infection Control Precautions related to cleaning or disinfecting reusable medical equipment (scissors) before and after wound care to prevent the possible spread of infection for two (2) of three (3) wound care observations. [Resident #1 and Resident #3] Findings Include: The facility's policy titled, "Infection Prevention/Procedure for Major Wounds ", revised June 2013, provided guidelines for good infection prevention technique during wound care. Care must be taken to prevent contamination of the supplies and surfaces used in wound care. Clean the scissors with 60 seconds of contact with alcohol and place on a clean corner of your setup and remove gloves. The policy did not indicate the facility should use a Germicidal cleanser, only alcohol.	F 880	Resident #1 was assessed by the Registered Nurse (RN)Unit Manager on 2/18/2021 and noted to have no adverse findings. Resident # 3 was assessed by the Assistant Director of Nursing (ADON) on 2/18/2020 and noted to have no adverse findings. Registered Nurse (RN)#1 was educated by the ADON on 2/18/2021 regarding wound care and infection control including cleaning scissors before and after wound care with germicidal bleach wipe. All residents receiving wound care have the potential to be affected by the deficient practice. 14 (fourteen) residents identified receiving wound care were assessed by the Wound Care Nurse and Wound Care Nurse Practitioner on 2/25/2021 with no negative outcomes identified. All licensed nurses were in-serviced	

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F 880	Continued From page 5 The facility's policy, "Cleaning/Disinfection of Resident Care Items and Equipment" revised June 2010, noted resident care equipment, including reusable items and durable medical equipment, will be cleaned, and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for infections and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. Durable medical equipment must be cleaned and disinfected before reuse for another resident. Reusable resident care equipment will be decontaminated between residents according to manufacturers' instructions. Only equipment that is designated reusable shall be used by more than one resident. Resident #1 On 02/18/21 at 10:50 AM, observed Registered Nurse (RN) #1 perform wound care on Resident #1. RN #1 did not clean or disinfect the scissors used to cut the dressing, before and after wound care. RN #1 then placed the scissors back into the wound cart without cleaning or disinfecting them. Record review of the Admission Record revealed Resident #1 was admitted to the facility on 08/10/20, with the diagnoses of Depressive Disorder and Pressure Ulcer of Buttocks. Resident # 3 On 02/18/21, at 10:10 AM, during wound care, RN #1 failed to clean and disinfect the scissors she was using to perform wound care before and after use. RN #1 was observed, placing the	F 880	regarding wound care policies and infection control, including cleaning scissors before and after wound care with germicidal bleach wipe, beginning 2/19/21 and ending 3/2/2021 by the ADON. The ADON will perform two wound care observations weekly beginning 2/25/21 for 8 (eight) weeks then resume 1 (one) wound care observation monthly ongoing, take immediate action as necessary and document findings. The ADON will report findings from weekly wound care observations for 2 (two) months, then monthly wound care observations ongoing to the Quality Assurance and Performance Committee monthly beginning 3/2/2021 for review, revision and/ or resolution of the plan.	

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F 880	Continued From page 6	F 880		

scissors back into the wound cart after completion of wound care without cleaning or disinfecting them.

Record review of the Transfer/Discharge Report revealed Resident #3 was admitted to the facility on 03/01/2019, with the diagnoses of Osteoporosis and Hypertension.

On 02/18/21, at 11:58 AM, in an interview with RN #1, she confirmed she did not clean and disinfect the scissors prior to or after providing wound care and placed them back onto the wound care cart. She stated she usually cleans her scissors with soap and water prior to performing wound care but stated she just forgot to do it today before providing wound care for Resident #1 and Resident #3.

On 2/18/21, at 1:22 PM, an interview with RN #2/Infection Preventionist (IP), regarding wound care concerns performed by RN #1, she stated RN #1 should have disinfected the scissors prior to and following the wound care. RN #2 stated failure to disinfect the scissors could cause contamination of the wound.

On 02/18/21 at 1:53 PM, an interview with the Director of Nurses (DON), revealed the wound care nurse should have followed the facility's infection control policy and cleaned the scissors for 60 seconds with alcohol before and after wound care. The DON revealed failure to clean the scissors between residents would be an infection control issue that could cause cross contamination.

A review of the in-service on Infection Control, dated 11/18/20, revealed RN #1's signature on

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F 880	Continued From page 7 the Infection Control Orientation Checklist.	F 880		