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 12/07/2021

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 survey, MS #18322, MS #18334, MS #18319, MS #18320, MS #18323, and MS #18324 at the facility from 11/29/2021 to 12/7/2021. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. MS #18319 was substantiated related to insufficient supplies concerning inadequate quantities of mechanical lift slings and equipment not maintained related to mechanical lift batteries. The SA cited deficiencies at F761. The SA did not substantiate MS #18332 related to Quality of Care/Treatment concerning care not received per physician orders and resident left wet for extended periods. MS #18334 was not substantiated due to insufficient evidence related to Quality of Care/Treatment concerning improper infection control practices and Care/Services not Received. MS #18320 was unsubstantiated related to Physical Environment concerning insufficient supplies of linens and unsubstantiated regarding Physical Environment concerning infection control practices and Quality of Care/Treatment concerning resident not groomed properly. MS #18323 was unsubstantiated concerning Resident Abuse and Neglect, and MS #18324 was unsubstantiated related to Quality of Care concerning residents dressed inappropriately, residents not groomed adequately and inappropriate feeding assistance for a resident with weight loss. During the survey, the facility was cited for improper drug storage and F908 was cited. The census at the time of survey was 143 residents with the facility licensed for 180 beds .	F 000		

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

Electronically Signed | 12/30/2021

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to provide for safe, secure storage of all medications for one (1) medication room of four (4) medication rooms observed. Findings included: On 11/30/21 at 6:05 PM, the State Agency (SA) observed the Medication Room at "Central Hall"	F 761	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. On 11/30/21, The Director of Nursing	1/20/22

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F 761	Continued From page 2 nurses' station had a self-closing, self-locking door which had been 'propped' open twelve (12) inches using a gray plastic garbage can. There were no staff at the nurses' station or in the area, however, the SA noted an ambulatory resident walking with a resident in a wheelchair down the hallway. The SA was able to inspect the medication room. The medication room at the "Central Hall" nurses station had twelve (12) medium sized cardboard boxes full of bubble packaged medications. The SA was able to read the labels on the medication cards on the top of three of the boxes; Metoprolol 35 tablets, Lasix 20 MG 28 tablets, Tamsulosin 0.4 MG 14 capsules. There was an open (no top or lid or covering of any type) sharps container sitting on the countertop which had the appearance of being one quarter (1/4) full of various capsules and tablets. There were also medications which did not appear to have safety lids on a shelf approximately five (5) feet off the floor which included topical medications. There was an additional stack of six bubble-wrapped medication cards on the top of the refrigerator. At 6:15 PM, a Certified Nurse's Aide, CNA #1 passed the nurses station and did not appear to notice the open door. The SA observed the medication room to be propped open for twenty minutes. On 12/01/21 at 11:40 AM, during an interview with the complainant, who is a former staff member, she stated the staff on "Central Hall" were in the habit of propping the medication room door open. On 12/01/21 at 3:20 PM, during an interview with CNA #5 who is the facility's Central Supply Clerk, she stated she was responsible for ordering and stocking the over-the-counter (OTC) medications. She stated she stocked the OTC medications in	F 761	(DON) closed and secured the med room on the central unit. The DON confirmed that none of the medications that were found in the med room on Central unit were tampered with. The box of 12 medications found was just delivered by pharmacy and was due to be put out on the med carts within the next two days. The DON confirmed that all the medications in the 12 boxes were secured and put out on the med carts the next day. The medications in the sharp's container, on the shelf, and on top of the refrigerator were all properly disposed of the same day the surveyor saw. 2. All residents in the facility who can ambulate or propel themselves have the potential to be affected by this practice. 3. The Director of Nursing (DON) and Staff Development Registered Nurse (RN) started an education in-service with nursing staff on 12/20/21 regarding Labeling and Storage of Drugs and Biologicals and the Med Room door that was completed on 12/28/21. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager(s), Staff Development Registered Nurse (RN), or Minimum Data Set (MDS) Nurses will complete audits to ensure that all four (4) unit's med rooms are secured properly by making rounds to check all four (4) med rooms during any shift, to begin on December 20, 2021, to end on March 20, 2022. The Director of Nursing (DON), Assistant Director of	

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F 761	Continued From page 3 the facility's main supply room, which was kept locked and in a locked cabinet. She stated medications had to be kept "locked up". On 12/02/21 at 10:08 AM, during an interview with LPN #2, she stated medications were supposed to be kept in a locked and secure location. On 12/07/21 at 3:25 PM, during an interview with the DON, she stated the Central Nursing Station Cart key chain had a key to the "main" supply closet "in case the nurses needed OTC medications. She confirmed medications were to be kept in locked compartments.	F 761	Nursing (ADON), Unit Manager(s), Staff Development Registered Nurse (RN), or Minimum Data Set (MDS) Nurses, will complete an audit to ensure for all four (4) med rooms are secured by making rounds during any shift two (2) times a week for four (4) weeks; then two (2) times once a month for three (3) months to ensure proper medication storage. Any concerns related to medication storage, or the med room door will be addressed immediately. Completion date as of January 20, 2022. 4. The results of such audits will be reviewed by the DON monthly for three (3) months by reviewing all the audits for the month for compliance and follow up and will sign off on and date once reviewed. The results of such audits will also be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of three (3) months to end on March 20, 2022. The first Quality Assurance Performance Improvement (QAPI) meeting to review such audits will be held in January 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical,	F 908		1/20/22

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F 908	Continued From page 4 and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and facility policy review, the facility failed to ensure mechanical lift batteries were adequately charged in order to maintain safe operating condition for one (1) of three (3) residents reviewed who required mechanical lift transfers. Resident #12. Findings include: A review of the facility's policy titled "Mechanical Lift Evaluation" dated November 20, 2017, stated "Rational/Purpose In order to facilitate a safe lifting environment for staff and residents. Mechanical lifts are to be utilized for lifting and transferring residents ...Battery Power Mechanical lifts will be connected for recharging when not in use. Additional batteries are to be charged and ready for use. On 11/30/21 at 4:45 PM, during an interview with Certified Nurse Aide (CNA) #4, she described the procedure for charging the mechanical lift batteries was "when we get through with the lifts, there's usually someone else waiting to use the lift". She stated there were no mechanical lift battery chargers on the hall she worked on. She was not aware of a schedule or printed procedure for charging the lift batteries. She stated there is a place on the central hall behind the nurse's station set up for the charging of batteries, and the lifts were kept in the respiratory department. On 12/01/21 at 11:40 AM, during a telephone interview with the complainant, who is a former	F 908	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. On 12/2/21, Resident #12 was able to get up using the mechanical lift; the Administrator brought the Director of Nursing (DON) and Certified Nursing Assistants (CNAs) utilizing the mechanical lift a charged lift battery from another unit to use. Resident #12 showed no signs of discomfort or distress from the encounter. 2. All residents in the facility who the staff utilize mechanical lifts for have the potential to be affected by this practice. 3. The Director of Nursing (DON) started an education in-service with nursing staff on 12/2/21 regarding Mechanical Lifts, Policy, Batteries and Charging, and Cleaning that was completed on 12/20/21. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager(s), Staff Development Registered Nurse (RN), or Minimum Data Set (MDS) Nurses will complete an audit to ensure that all mechanical lifts have	

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F 908	Continued From page 5 employee of the facility, she stated residents who required mechanical lifts were sometimes not allowed to get up out of bed or go back to bed because the batteries (for the lifts) were not charged correctly by staff and the lifts would not work without charged batteries. On 12/02/21 at 2:10 PM, an interview with CNA #6 and CNA #7 revealed both CNAs stated there were occasional times when residents had to wait to get up or to go to bed because the batteries to the mechanical lifts were not charged. On 12/02/21 at 3:50 PM, the SA observed staff performing a surface-to-surface transfer using a mechanical lift. During the transfer, CNA #4, and the Director of Nursing (DON) entered the room of Resident #12. The mechanical lift sling was placed beneath the resident. The lift was positioned to begin to lift the resident, but the lift battery ran out of charge. The DON left the room to get another battery. The DON was unable to locate a charged battery for the lift. The Administrator was notified of the difficulty performing the transfer and went to another unit to get a charged lift battery, but did not locate one. The Administrator then went to the central hall nurses' station and did not find a charged battery. The Administrator went elsewhere in the facility and returned to the resident's room with a charged battery for the lift. The transfer was completed at 4:13 PM, which was 23 minutes after the transfer process was initiated and with the assistance of the Administrator and DON searching the facility for a charged battery. On 12/02/21 at 3:57 PM, during an interview with the CNA #4, she stated the occurrence of a resident having to wait to get out of bed or get	F 908	charged batteries. This will be accomplished by making rounds to check all four (4) units during any shift, to begin on December 20, 2021, to end on March 20, 2022. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager(s), Staff Development Registered Nurse (RN), or Minimum Data Set (MDS) Nurses, will complete an audit on all four (4) units during any shift, weekly, two (2) times a week for thirty (30) days; then two (2) times a month for three (3) months to ensure mechanical lift batteries are adequately charged in order to maintain safe operating conditions. Any concerns related to mechanical lifts will be addressed immediately. Completion date as of January 20, 2022. 4. The results of such audits will be reviewed by the DON monthly for three (3) months by reviewing all the audits for the month for compliance and follow up and will sign off on and date once reviewed. The results of such audits will also be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of three (3) months to end on March 20, 2022. The first Quality Assurance Performance Improvement (QAPI) meeting to review such audits will be held in January 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	

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F 908	Continued From page 6	F 908		

into bed was not uncommon. She was unable to estimate how often this occurred, but she stated it happened "at least multiple times per week".

On 12/02/21 at 4:15 PM, during an interview with the Resident #12, she stated she had been asking to get out of bed since 2:30 PM. She stated staff transferred her to bed to perform incontinent care and the battery for the mechanical lift died and "they couldn't get me back up." She stated that was not the first time she had to wait for a transfer due to lift batteries not being charged. She stated she did not understand why the staff could not keep the batteries charged. She stated it "bothered" her when she "wanted to go to an activity and couldn't because the lift batteries were not charged".

On 12/02/21 at 4:44 PM, during an interview with the DON, she stated, "The dead batteries were there but not charged." She was not able to answer how many batteries per lift were in the facility. She stated there was no specific staff member responsible for making sure the mechanical lift batteries were charged. She stated, "The CNAs know they are supposed to put them on the charger when they get low or die".

On 12/06/21 at 5:16 PM, during an interview with CNA #5, who is the facility's Central Supply Clerk, she stated she was not sure how many mechanical lift batteries were in the facility.

On 12/07/21 at 3:25 PM an interview with the Director of Nurses (DON) revealed she had been the DON for three (3) days. She stated the CNAs were responsible for placing 'dead' mechanical lift batteries on the chargers. She stated the CNAs

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F 908	Continued From page 7	F 908		

were "supposed to put a battery on the charger every time they take one off", but there was no printed or posted schedule or procedure for the CNAs to refer to. She stated, "They know they are supposed to do that". She stated she believed the batteries took eight (8) hours to fully charge. She stated there were three (3) chargers in the building. She stated there were no chargers on two halls in the facility. When asked what happened with the surface-to-surface transfer for Resident #12, the DON stated the CNA "put Resident #12 to bed" at 2:30 PM to perform incontinence care, the mechanical lift battery died, and the resident remained in bed until 3:50 PM. She stated when she and the CNA went to transfer Resident #12 from bed, the mechanical lift battery still wasn't charged enough. She stated she did not know where the Administrator got the charged battery to complete the transfer. The DON stated the facility had provided an in-service to staff over the weekend regarding charging the mechanical lift batteries. When asked if keeping the mechanical lift batteries charged was part of maintaining equipment", the DON responded "Yes".

A record review of the "Admission Record" for Resident #12 revealed the resident was admitted by the facility on 7/01/19, with diagnoses including cerebrovascular accident (stroke), hemiplegia and hemiparesis.

A record review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/17/21 revealed Resident #12 required extensive two-person assistance for Activities of Daily Living (ADLs), toileting and personal hygiene. She was non-ambulatory and used a wheelchair for mobility. The resident had a Brief

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F 908	Continued From page 8 Interview of Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.	F 908		