

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

PRINTED: 01/29/2021
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 02/19/2020
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 survey, MS #16599 and MS #16612, at the facility from 02/17/2020 to 02/19/2020. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated #16612 for Quality of Care related to Supervision of residents and cited F689. The SA did not substantiate MS #16599 for Quality of Care, Misappropriation of Property, and Physical Environment, and cited no deficiencies. At the time of the survey, the facility had a census of 128, and held a license for 180 beds.	F 000			
F 689 SS=D	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 staff interview, record review, and facility policy review, the facility failed to provide adequate supervision to prevent a resident from leaving the facility unsupervised, for one (1) of four (4) residents reviewed for risk of wandering/elopement. A review of the facility's, "Elopement/Unsafe Wandering" policy, dated 02/07/2012, revealed, it is the policy of the facility to protect the resident	F 689	Resident #1 was assessed by the Charge Nurse on 2/2/20 upon return to the facility with no signs of injury noted. Resident #1 was placed on one on one supervision on 2/2/20 and visual monitoring on 2/4/20. All residents with risk for elopement have the potential to be affected by the deficient practice. All residents were assessed for elopement risk by licensed nurses on	3/31/20	

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

TITLE

(X6) DATE

Electronically Signed

04/14/2020

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 689	Continued From page 1 from harm while providing care in a manner that helps promote quality of life in a safe environment. Visual supervision may be necessary in some instances. The nursing staff will complete and document the visual checks as needed. A review of the Brief Interview for Mental Status (BIMS), dated 11/18/2019, revealed Resident #1 had a score of 13, which indicated cognitively intact. The facility admitted Resident #1 on 11/18/2019. Review of Resident #1's Wandering Evaluation, dated 11/18/2019, revealed he was assessed and determined to be at risk for wandering/elopement. A review of Resident #1's comprehensive care plan, revealed a focused problem, initiated on 01/02/2020, for elopement risk/wanderer related to being mobile without assistance. The goal revealed the resident's safety would be maintained through the next review date. Interventions included to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, etc., and intervene as appropriate. There were no interventions in place for visual checks until 02/04/2020. Resident #1's care plan also revealed an intervention for a "yellow arm band to remain in place at times indicating resident is at risk for wandering", initiated on 02/02/2020. A review of (Name of Hospital) Emergency Documentation, revealed, Resident #1 was seen at the facility on 02/02/2020 at 6:30 AM with the chief complaint of "escaped from nursing home." The document revealed that Resident #1 was found down the road by the local ambulance	F 689	2/2/20. Fifty-Seven (57) residents were identified at risk for elopement. All residents identified at risk for elopement were placed on visual monitoring on 2/2/20 by the Assistant Director of Nursing (ADON). The Minimum Data Set (MDS) Coordinator revised the care plans for all residents identified at risk for elopement on 2/2/20. All staff were in-serviced beginning on 2/2/20 and ending on 2/9/20 regarding elopement and missing resident policies by the Director of Nursing (DON) and ADON. All employees will receive in-service regarding elopement policies upon hire beginning 2/2/20. The Medical Records Nurse will ensure all residents are evaluated upon admission for elopement risk and placed on visual monitoring beginning 2/2/20. The MDS Coordinator will evaluate all residents for elopement risk quarterly and with significant changes beginning 2/2/20 and place on visual monitoring as needed. The MDS Coordinator will audit records of all residents identified at risk for elopement monthly to ensure visual monitoring is in place, take immediate action as needed and document findings beginning 3/20/20. The MDS Coordinator will report findings from monthly audits of all residents identified at risk for elopement to the Quality Assurance and Performance Committee monthly beginning 3/31/20 for review, revision and/or resolution of the plan.		

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F 689	Continued From page 2 service. The document revealed the ambulance service called the facility and inquired if Resident #1 was missing. The facility told the ambulance service that Resident #1 was not missing, but called back a few minutes later and told them that he was missing. The documentation revealed Resident #1 was discharged back to the facility on 02/02/2020 at 7:28 AM with what appeared to be a baseline mental status, vital signs normal, and no evidence of trauma or acute abnormally. Review of a hand-written statement by Registered Nurse (RN) #1, dated 02/02/2020, revealed during the 6:00 AM medication pass, she discovered Resident #1 was not in his bed. RN #1 alerted the Certified Nursing Assistant (CNA) #1 that Resident #1 was not in his room. She stated they started a room to room search for Resident #1. She stated the nurse from another unit came onto RN #1's unit and asked if they had Resident #1 on their unit. RN #1 stated that they were looking for Resident #1 at that time. RN #1 stated that the nurse from the other unit stated that the local ambulance service had called saying they had Resident #1 at a gas station and the other nurse told them they did not have a resident by that name. RN #1 called the local ambulance service and was told that the local ambulance service was in route to the hospital with Resident #1 related to disorientation. She stated that the local Emergency Room (ER) called for information on Resident #1. RN #1 stated that she reported to the Director of Nursing (DON) that CNA #1 had noticed cold air coming through the window and that the plexiglass window had been mostly pushed out. A review of a hand-written document by Licensed Practical Nurse (LPN) #1, dated 02/02/2020 at	F 689			

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F 689	Continued From page 3 6:10 AM, revealed a lady from the local ambulance service had called and reported they had a gentleman (Resident #1) at the local convenience store wearing an arm band indicating he was from the facility. LPN #1 stated she did not think they had anyone with that name missing, but they would do a head count and would call them back. LPN #1 documented she went to the different units at the facility. LPN #1 revealed when she went into the "Cove" unit, with Resident #1's name and room number, in which they had found on the computer, the staff were told they needed to do a head count. LPN #1 revealed at that time, Resident #1 was noted to be missing. Review of a hand-written document by LPN #2, dated 02/02/2020, revealed Resident #1 returned from the hospital on 02/02/2020 at 9:15 AM and she asked Resident #1 what happened. LPN #2 documented that Resident #1 answered by stating he "went out to see his girl, she said she loved him". LPN #2 revealed Resident #1 told her he went out of the window, but he wouldn't do it again. LPN #2 documented she spoke with Resident #1's Resident Representative (RR), and she told LPN #2 that Resident #1 had done the same thing when he lived with her. LPN #2 documented the RR stated Resident #1 "climbed out of the window to go see his girl." A review of a hand-written statement by CNA #1, dated 02/02/2020, revealed she saw Resident #1 at 4:20 AM and he was lying in his bed. CNA #1 documented that at around 5:45 AM, RN #1 asked her where was Resident #1, and they began to search for Resident #1. CNA #1 revealed a few minutes later, LPN #1 came and asked if they had a resident by the name of	F 689			

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F 689	Continued From page 4 Resident #1. CNA #1 documented LPN #1 stated that Resident #1 was at the store. Review of a hand-written statement by CNA #2, dated 02/02/2020, revealed she did not see Resident #1 through the night of 02/02/2020. CNA #2 documented that around 5:45 AM, Resident #1 was reported missing. CNA #2 revealed she assisted with the search for Resident #1, and during the search, LPN #1 came to the floor and asked did they have a resident by the name of Resident #1. During an interview, on 02/17/2020 at 12:20 PM, the facility's Administrator stated she received a call on 02/02/2020 at approximately 6:22 AM, from the Director of Nursing (DON) stating Resident #1 had left the facility through a window, and the local ambulance service had taken him to the emergency room at the local hospital, and Resident #1 appeared confused. The Administrator stated when she got to the facility around 7:30 AM, she went and inspected Resident #1's room. She stated that part of the window in Resident #1's room was plexiglass and appeared to have been pushed out. The Administrator revealed the blinds were pulled down over the window to hide the opened window. She stated Resident #1's bed was fixed to look like there was a person lying under the covers of the bed. The Administrator stated she spoke to Resident #1's niece, who was the Resident Representative (RR), and she said Resident #1 would go out her window all the time and go to the hospital to look for his girl, and that was why she had to put him in the nursing home. The Administrator stated when Resident #1 returned to the facility by the local ambulance service, he was not confused, but was his same	F 689			

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F 689	Continued From page 5 old self. She stated Resident #1 has a diagnosis of Aphasia following a Cerebral Infarction and his speech is not clear. The Administrator revealed since Resident #1 has been at the facility, they have learned to understand what he says. The Administrator stated that when Resident #1 returned to the facility, around 9:15 AM on 02/02/2020, she went and talked with Resident #1, and he told her that he was going to see his girl. The Administrator stated she asked Resident #1 if he went out the door and he said "no" She stated that she then asked him if he went out the window, and he said "yes." An observation and interview, on 02/17/2020 at 1:45 PM, revealed Resident #1 sitting on the bed, near the door, talking with his roommate. Resident #1's roommate bed was located in front of the window. The Administrator, who was present in the room, asked Resident #1 if he remembered getting out, and Resident #1 smiled and nodded his head to gesture "yes." The Administrator asked Resident #1 if he went out the door when he left the facility, and he shook his head to indicate "no." The Administrator then asked Resident #1 if he went out the window, and he smiled and nodded his head to gesture "yes." Resident #1 pointed down at his yellow bracelet on his left wrist and smiled. The Administrator told him that he had to leave the bracelet on, and Resident #1 shook his head to indicate "no." During an interview, on 02/17/2020 at 3:50 PM, the Administrator revealed, she thought they had done everything in place they could do to keep Resident #1 in view, except to put him one on one at all times and that was not possible. She stated they had no idea Resident #1 would go through the window. The Administrator stated she	F 689			

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F 689	Continued From page 6 had no reason to expect Resident #1 to leave the facility. She stated that when Resident #1's niece placed him at the facility, she did not tell them he had previously left her home through a window. The Administrator stated they found that out when she spoke to Resident #1's niece the day (02/02/2020) he went out of the window at the facility. On 02/19/2020 at 9:23 AM, during an interview with CNA #1, she stated on the morning of 02/02/2020 at 4:20 AM, she entered Resident #1's room to take care of his roommate. She stated Resident #1 was pretty self-sufficient to toilet himself, so she just peeked in on him at times to make sure he was okay. CNA #1 stated she doesn't wake Resident #1 up, if he is asleep. CNA #1 stated RN #1 went into the room around 5:40 AM to give Resident #1 his medicine and he wasn't in the room. She stated RN #1 asked her where was Resident #1, and she told RN #1 that he was in his bed earlier. CNA #1 stated RN #1 told her that Resident #1 was missing. CNA #1 stated they began to look for Resident #1, when LPN #1 came in and asked if they had Resident #1 on the unit. CNA #1 stated LPN #1 said that the local ambulance service had called and asked if they had Resident #1 at the facility, and LPN #1 told them that she didn't think so, but would check. CNA #1 stated RN #1 called the local ambulance service and verified it was Resident #1. She stated they began to try and figure out how Resident #1 got out of the locked door unit, knowing that there was no way he could have gotten out, without someone opening the door. CNA #1 stated they went into Resident #1's room, and he had blankets and covers piled under the cover like he was in the bed. CNA #1 stated she went over to the window to check and see if	F 689			

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F 689	Continued From page 7 Resident #1 had opened the window, because the window slid from left and right. CNA #1 stated she leaned against the left side of the window, which was plexiglass, and it was loose at the bottom, like it wasn't sealed or something. She stated she pushed on it just a little and it went open. CNA #1 stated Resident #1 had even pulled the blinds down over the window, so it looked closed. She stated that she would have never found the open area of the window, if she hadn't leaned on it.	F 689			