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 03/16/2022

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 Survey Agency (SSA) conducted an annual recertification along with a two (2) Complaint Investigations (CI), MS #18546 and CI MS #18547 from 03/06/2022 through 03/11/2022. During the survey, the SSA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SSA cited F567, F584, F604, F657, F679, F689, F690, F758, F812 and F880 during the survey. The SSA substantiated CI MS #18546 related medication diversion and cited F609 and F610 and CI MS #18547 related to the palatability of food and cited F804. The census at the time of the survey was 133 with a bed capacity of 180. The SSA returned to the facility on 3/16/22 to investigate CI MS #18593. The SSA did not substantiate the complaint regarding abuse.	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	F 609		4/27/22

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

Electronically Signed | 04/02/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 1 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. §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 and facility policy review the facility failed to report to the State Agency (SA) an allegation of possible medication diversion for one (1) of two (2) allegations reviewed. Findings include: Review of the facility reporting policy," Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan," revised 08/23/2017 revealed, "Reporting/Response ... mandates reporting of any suspected crimes against an elder in a long-term care facility. Covered individuals is any owner, operator, employee, manager, agent, or contractor of this facility. If a covered individual observes events or become aware of information that gives him/ her the reasonable suspicion that a crime has occurred against a resident or individual receiving care from this facility, he/she MUST notify BOTH 1) The Administrator of the facility. 2) The State Survey Agency and the Attorney General's Office ...3)A Local Law Enforcement Entity. The covered individual is	F 609	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. The investigation regarding Licensed Practical Nurse (LPN) # 7 was completed on 03/08/22. This instance was reported to the State Agency (SA) by the Ombudsman on 03/07/22. This instance was also investigated by the State Agency (SA) during the Annual Survey from 03/06/22 to 03/11/22. 2. All residents in the facility have the potential to be affected by this practice.	

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F 609	Continued From page 2 responsible for reporting to at least one (1) local law enforcement entities ... Report must be within 24 hours (if the allegation does not involve abuse or there is not serious bodily injury) after forming your reasonable suspicion. Within two (2) hours (if the allegation involves abuse or there is serious bodily injury) after forming our reasonable suspicion. It is the policy of this facility that persons employed by this facility with knowledge or reasonable cause to believe that any resident has been the victim of abuse, exploitation, neglect, or mistreatment must report or cause a report to be made to the appropriate state agencies as prescribed by the law of that state. Failure by staff including management and supervisory staff to report possible alleged incidents of abuse or neglect to the Administration per policy, will result in disciplinary action up to and including immediate termination ... All suspicious or alleged events will be reported to the (initials) management company and to the regional nurse as soon as possible ...In Mississippi- Report orally or telephonically to MS (Mississippi) Compliant Department and AGO (Attorney General's Office) online form ... within two (2) hours/or 24 hours of discovery as appropriate including Saturday's, Sunday and legal holidays with final report and conclusion of investigation in writing within seventy-two hours of the discovery to the Mississippi State Department of Health and the Medicaid Fraud Control unit of the Attorney General's Office ..." An interview on 3/7/22 at 10:00 AM, with the local Ombudsman confirmed the State Ombudsman received an anonymous letter on 2/24/22 stating that Licensed Practical Nurse (LPN) #7 allegedly was stealing medication off the cart from the	F 609	3. The Regional Director of Operations (RDO) completed a one-on-one in-service with the Administrator regarding Reporting and Investigations including policy and procedures that was completed on 03/30/22 to ensure any future incidents are reported. An in-service was initiated by the DON and Administrator and provided education to the nursing staff regarding reporting allegations of discrepancies to the Director of Nursing (DON) on 03/30/22 and is to be completed on 04/08/22. The Administrator will audit reportable events weekly for three (3) months to ensure that all reportable incidents are reported timely to the required agency(ies) beginning on 03/28/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. 4. The Administrator will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 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	

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F 609	Continued From page 3 Residents at this facility. The Ombudsman stated that the complainant in the letter said the administrative staff knew that LPN #7 is stealing the residents' narcotics. The complainant also said the administrative staff refused to do anything about it. The Ombudsman reported this allegation to the State Agency (SA). During an interview on 3/08/22 at 10:00 AM, with the Administrator and the Director of Nursing (DON) confirmed the facility received an anonymous letter under the DON's office door on 2/20/22 between 7:00 PM and 8:00 PM. The DON confirmed the letter said that LPN #7 was seen stealing medications from the facility. The DON said she notified the Administrator who instructed her to investigate and review the narcotic books. The Administrator confirmed she did not report the allegation to the State Agency (SA) or the Attorney General's office. The Administrator said after reviewing the narcotic logs on two (2) halls and not finding discrepancies, she didn't see the need to report the allegation. The Administrator stated on 3/1/22, a different letter was sent to the corporate office. This letter alleged that LPN #7 was stealing medication from the facility and that staff was covering it up. The Administrator said LPN #7 was suspended on 3/8/22, pending investigation. Upon completion of the investigation, the facility could not substantiate that a narcotic medication diversion occurred.	F 609	education.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		4/27/22

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F 610	Continued From page 4 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 reviews, and facility policy review, the facility failed to conduct a thorough investigation related to misappropriation for one (1) of two (2) allegations reviewed. Findings include: The facility policy, "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan Investigation," undated, revealed when an alleged incidents of abuse, exploitation, neglect, or misappropriation of resident's property is reported, the administrator or appointed representatives will investigate the incident. The investigation will include, at a minimum, the following: an interview with a statement from the person's reporting the incident, interviews with statements from any witnesses to the incident, an interview with statements from the resident and a repeat interview later to check the consistency of the information provided. A review of the resident's medical records. An interview with a	F 610	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. The facility Administrator reported this incident to the State Agency on 04/05/22. 2. All residents in the facility have the potential to be affected by this practice. 3. The Regional Director of Operations (RDO) completed a one-on-one in-service with the Administrator regarding the requirements of F610: Investigate/Prevent/Correct Alleged Violation to also include reporting and investigations policy and procedures that	

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F 610	Continued From page 5 statement from staff members on all shifts having contact with the residents during the period of the alleged incident. Interviews with and statements from the resident's roommate, family members, and visitors as needed. Interview within statements from other alert residents who have contact with an employee suspected of abusing neglecting or exploiting a resident. A review of circumstances surrounding the incident and completion of appropriate documentation. While the investigation is being conducted, employees of accused of resident abuse, Neglect, exploitation and or misappropriation of the resident's personal property will be suspended from duty until the results of the investigation have been reviewed by the administrator. After the investigation is complete the facility will determine the outcome. If the investigation concludes that the report is inaccurate or cannot be substantiated the facility will reinstate the employees. During an interview on 3/7/22 at 10:00 AM, with the local Ombudsman revealed the State Ombudsman received an anonymous letter on 2/24/22 stating that Licensed Practical Nurse (LPN) #7 allegedly was stealing medication off the cart from the Residents at the facility. The Ombudsman stated that the complainant in the letter said the administrative staff know that LPN #7 was stealing the residents' narcotics. The complainant also said the administrative staff refused to do anything about it. The Ombudsman reported it to the State Agency (SA). During an interview on 3/08/22 at 10:00 AM, with the Administrator and the Director of Nursing (DON) confirmed that they had received a letter under the DON's door on 2/20/22 between 7:00	F 610	was completed on 03/30/22 to ensure that any future investigations will be completed thoroughly. The facility will thoroughly investigate all alleged violations and have evidence by documentation, staff interviews, resident interviews (if applicable), chart reviews, and statements to prevent further occurrence. All of which will be done in a timely manner that follows state regulations. 4. The Administrator will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 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 610	Continued From page 6	F 610		

PM and 8:00 PM. The DON confirmed she received an anonymous letter addressed to her alleging that LPN #7 was seen stealing medications from the facility. The DON notified the Administrator who instructed her to investigate and review the narcotic book. The DON said on 2/21/22 she reviewed the narcotic book from two (2) units of four (4) units for discrepancies and there were no discrepancies. The Administrator stated on 3/1/22, a different letter was sent to the corporate office. This letter alleged that LPN #7 was stealing medication from the facility and that staff was covering it up. The Administrator said LPN #7 was suspended on 3/8/22 pending an investigation. The Administrator stated that on 3/1/22 - 3/4/22 all the nurses were interviewed by her, the DON, and LPN#2/Transitional Care Unit (TCU) Manager, however they did not obtain signed written statements from the nurses, but no one had any knowledge of or had seen LPN #7 taking medication from the facility. The Administrator said she interviewed a few CNA's that had worked with LPN #7, and no one had any knowledge of her or had seen LPN #7 take medication from the facility. The DON and LPN#2/TCU manager and Nurse Consultant checked the narcotic books on all four units and noticed a pattern of increase wasted medication. The investigation was completed and was unsubstantiated. The employee was no longer suspended as of 3/8/22 and returned to work on 3/9/22. The DON stated that a one on one in-service with LPN #7 on medication administration and medication waste verification was done by her before she could return to work. The DON said LPN #7 did not have a specific unit to work. The DON said the nurse was working in medical records and asked to be moved to the

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F 610	Continued From page 7	F 610		

floor because she was bored. The facility did not have a permanent unit available at that time. LPN #7 was willing to work every unit in the building on different shifts to replace the nurses that were scheduled off. The Administrator confirmed the facility failed to do a thorough investigation by not suspending LPN#7 when the facility received the first letter, leaving all the vulnerable residents at risk of not receiving their narcotics, and by not interviewing the staff and by not auditing the narcotic logs on every unit.

Record review of the facility's investigation confirmed the facility failed to complete a thorough investigation related to an allegation of License Practical Nurse (LPN)#7 stealing medication out of the medication cart. The investigation dated 2/20/22 revealed the Director of Nursing (DON) received a letter under the door of her office between 7:00 PM and 8:00 PM saying that LPN# 7 was seen stealing medication from the facility. The Administrator was notified, and the DON was instructed to investigate the allegation. The DON reviewed the narcotic books for the Rehab and Central units on 2/21/22 and there were no discrepancies.

During an interview on 3/8/22 at 10:30 AM, with LPN #2/TCU Manager confirmed she had looked at the narcotic sheets to see if there were any narcotic discrepancies when LPN #7 was suspended on 3/8/22. LPN #2 said she did not see any narcotic discrepancies only that the nurse had wasted narcotics on several occasions. LPN #2 also said she talked to the other nurses, but she did not receive statements. LPN #2 said the nurses did not report seeing LPN #7 taking narcotics. LPN #2 said she assisted the Administrator, DON, and Nurse Consultant in

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F 610	Continued From page 8 checking the narcotic logs. The Narcotic logs were compared to the Medication Administration Record (MARS) on all units, and no discrepancies were found. LPN #2 said no one has reported any narcotic discrepancies to her. During an interview on 3/10/22 at 7:00 PM, with LPN #7 confirmed she was called into the DON's office on 3/8/22 and was suspended pending investigation of a narcotic discrepancy. During an interview on 3/11/22 at 1:00 PM, with the Pharmacy Consultant said that the Administrator and the DON asked him to review the narcotics to see if there was any discrepancies or patterns. The Pharmacy Consultant said he was asked to check the narcotic sheets on the Central and Rehab Units. He said that he was given five (5) residents to look at their narcotics and match the MARS and the narcotics to make sure there were no discrepancies with those residents. The Pharmacy Consultant stated that he did not see any patterns when he reviewed the charts. He also revealed that he reviews the MARS and narcotic logs once a month.	F 610		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.	F 804		4/27/22

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F 804	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and test tray, the facility failed to ensure food was palatable were satisfactory for four (4) of 32 sampled residents. Residents #19, #23, #77 and #83. Findings Include: On 03/07/22 03:15 PM in the Resident Council meeting Residents #19, #23 and #83 stated continuously about receiving tasteless food daily. On 3/8/22 at 9:18 AM, in an interview with the Dietary Manager stated he is aware of the bland taste concerns. On 03/06/22 at 11:52 AM, in an interview with Resident # 83, she stated the food does not have any taste. It tastes like it is "right out of the can". On 03/06/22 at 12:08 PM, in an interview with Resident # 77, the resident stated the food does not taste good. On the 3/8/22 at 1:10 PM, the State Agency (SA) received a test tray for lunch. The meal consisted of country fried steak with white gravy, mashed potatoes, baked pork chop, buttered rice, collard greens, and carrots. The collard greens, buttered rice and carrots did not have any taste, were not seasoned, and were not palatable. On 3/9/22 at 11:02 AM, the SA asked the DM about the lunch meal on 3/8/22. The DM stated that he does not like collard greens. He stated the collard greens could use more garlic powder. The DM stated that he will try to put flavor in the food	F 804	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. The Dietary manager met with Residents # 19, 23, 77, and 83 on 04/05/22 to discuss food preferences. 2. All residents in the facility have the potential to be affected by this practice. 3. The Dietary Manager (DM) provided education to the dietary staff on food preparation procedures to include food items prepared according to the menu, production guidelines, and recipes that meet nutritional value and palatability beginning on 04/04/22 and ending on 04/08/22. The Administrator will sample one (1) test tray weekly for 4 weeks, then monthly for three (3) months to ensure the meals being served are palatable and satisfactory beginning on 03/29/22 and ending on 07/01/22. 4. The Administrator will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor	

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F 804	Continued From page 10 without adding salt. He stated the food could have been seasoned better and the rice could have been cooked a little less. The DM confirmed the food was bland. On 3/11/22 at 11:00 AM, in an interview with the Administrator, she stated there is no policy related to palatable food. She was aware that the residents had complaints related to satisfactory food temperature and palatability of the food that is served. Record review of the "Admission Record" for Resident #19, revealed an admission date of 7/1/2019, with diagnoses including Type 2 Diabetes Mellitus and Primary Hypertension. Record review of Resident #19's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/3/21 revealed a Brief Mental Status (BIMS) score of 12, which indicated the resident's cognition is moderately impaired. Record review of the "Admission Record" for Resident #23, revealed an admission date of 4/21/21 with diagnoses including Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris and Essential Hypertension. Record review of Resident #23's Quarterly MDS with and ARD of 12/7/21 revealed a BIMS score of 15, which indicated the resident was cognitively intact. Record review of Resident #77's "Admission Record" revealed a most recent admission date of 10/1/2019, with diagnoses including Pressure Ulcer of left buttock Stage 4, Pressure Ulcer of	F 804	compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 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.	

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 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF BILOXI	2279 ATKINSON ROAD BILOXI, MS 39531

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F 804	Continued From page 11	F 804		

right buttock Stage 4 and Neuromuscular Dysfunction of Bladder, unspecified.

Record review of Resident #77's Quarterly MDS with an ARD of 1/17/2022 revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Record review of Resident #83's "Admission Record" revealed with an admission date of 1/29/20, with diagnoses including Chronic Systolic (Congestive Heart Failure) and Diabetes Mellitus due to underlying conditions without complications.

Record review of Resident #83's Annual MDS with an ARD of 1/14/2022 revealed a BIMS score of 15, which indicated the resident is cognitively intact.