STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24KI	A. BUILDING: _____ B. WING _____	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) COMPLETE DATE
M 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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements at M. The SSA cited M500, M620, M640, M780, M815 and M1210 during the survey. The SSA substantiated CI MS #18546. The SSA substantiated CI MS #18547 related to the palatability of food and cited M855. 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.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for	M 500		4/27/22

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M 500	Continued From page 1 services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule,	M 500		

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M 500	Continued From page 2 regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;	M 500		

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M 500	Continued From page 3 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available	M 500		

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M 500	Continued From page 4 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observations, family and staff interviews, record review and facility policy review, the facility failed to identify the use of a Geri chair with a tray as a physical restraint for one (1) of three (3) residents reviewed. Resident 101. Findings include: Record review of the facility's policy "Physical Restraints" dated August 18,2005 revealed "It is the policy of this facility that our residents have the right to be free from physical restraints not required to treat the residents symptoms. Physical restraints are not to be used for the convenience of the facility ..." A record review of Resident #101's "Admission Record" revealed the facility admitted him on 06/18/2019 with the diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, Aphasia following other Nontraumatic Intracranial Hemorrhage, Repeated Falls, and Anxiety Disorder, unspecified. A record review of Resident #101's Comprehensive Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/23/22 revealed no Brief Interview for Mental Status (BIMS) was conducted. The Staff Assessment for Mental Status revealed the resident had memory problems and was severely cognitively impaired.	M 500	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. Resident 101 had the tabletop removed by the Director of Nursing (DON) on 03/11/22. 2. All residents in the facility have the potential to be affected by this practice. 3. An in-service was initiated by the DON and provided education to the nursing staff regarding restraints and to report any issues to the DON on 03/31/22 and completed on 04/08/22. The DON completed a 100% audit on all Geri chairs to ensure no other restraints were found; none found. The Occupation Therapist (OT) completed an evaluation on Resident 101 related to positioning on 03/14/22. The Director of Nursing (DON) will audit all geri-chairs weekly for three (3) months to ensure that no other resident gets an unnecessary restraint beginning on 03/28/22 and ending on 07/01/22 and will	

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M 500	Continued From page 5 A record review of the Comprehensive Care Plan for Resident #101 revealed a "Focus" of "I am at risk for falls/injuries ..." with an "Intervention/Task" that included "Up in Geri-chair with table top for positioning/poor truck control. Every shift for when up". A record review of Resident #101 ' s "Order Recap Report" with "Order Date: 08/01/2021 - 03/31/2022" revealed a physician order for "Up in Geri-chair with table top for positioning/poor trunk control. every shift when up" with an order date of 8/10/2021 and end date of 3/11/22. On 03/06/22 at 1:00 PM, the State Survey Agency (SSA) observed Resident #101 in a Geri chair in the hallway, using his left arm to hold on to the handrails and propel himself forward. When the resident reached a doorway in which there were no handrails, he would lean over the side of the chair and reach down to turn the actual wheel and push off the floor with his left hand to propel himself toward the next section of the handrail. The SSA observed that his right arm appeared to be contracted and there was a tray attachment to the front of the Geri chair. At 1:03 PM on 03/06/22, during an interview with LPN #3, who was coming onto the unit, he explained Resident #101 goes up and down the hall in the Geri chair all day. LPN #3 was not sure why Resident #101 was in a Geri chair with tray attached, but he thought it was because Resident #101 had numerous falls in the past. LPN #3 confirmed that Resident #101 usually gets up every day in his Geri chair with the tray attached and will move himself up and down the hallway using the handrails or by using whatever is close by to propel himself. He also reaches down and pushes off the floor to move his chair. He stated	M 500	document any findings and take immediate corrective action as necessary. 4. The DON 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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M 500	Continued From page 6	M 500		

the resident eats his meals in his room and usually sits up on the side of the bed. He does not require assistance with meals and LPN #3 confirmed that Resident #101 does not have issues related to leaning while sitting on the side of the bed.

On 03/06/22 at 1:25 PM, during an interview with CNA #3, she explained Resident #101 usually does not get up until after lunch, so he doesn't sit all day in the Geri chair with the tray attached. CNA #3 stated Resident #101 had been using the Geri chair and tray for a long time, but she was unable to say exactly how long. She confirmed Resident #101 propels up and down the hallway by using the handrails and reaching down and pushing off the floor. She also confirmed the resident is unable to remove the tray attachment to his chair and requires assistance from staff to remove it. He is unable to use his right arm due to a stroke. She reported he sits up on the side of the bed with no problems.

On 03/06/22 at 2:00 PM, two (2) SSA observed Resident #101 in a Geri chair with the tray attached, pulling on the handrails propelling himself in the hallway.

On 03/07/22 at 10:33 AM, during an interview Resident #101's sister, she explained the resident had been having a lot of falls and was placed in a Geri chair with a tray to prevent falls, but he cannot remove the tray by himself.

On 03/08/22 at 11:25 AM, during an interview with CNA #5, she explained she is not aware of any falls Resident #101 may have had. She confirmed he can sit on the side of his bed, without leaning, and eat his meals. Resident #101 was in a wheelchair for some time when she first started

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M 500	Continued From page 7	M 500		

working at the facility and she was not sure why he was changed to a Geri-chair.

At 2:20 PM on 03/08/22, SSA observed Resident #101 sitting on the side of his bed. He was not leaning and there were no trunk control problems observed.

On 03/09/22 at 8:25 AM, SSA observed Resident #101 sitting on the side of his bed, feeding himself breakfast with his left hand. Resident was not leaning and appeared to have no problems related to trunk control.

On 03/09/22 9:00 AM, during an interview with the Physical Therapist, he explained the therapy department has never worked with Resident #101 since he has been working at the facility for two and half years.

On 03/09/22 9:25 AM, during an observation and interview with CNA#5, she advised Resident #101 would be getting a shower today. He requires a full body lift for transfers, and he tolerates the transfers well and follows her directions. The SSA observed CNA #6 and CNA #5 transfer Resident #101 to the shower chair. He sat in the shower chair with no problems leaning or issues with controlling the trunk of his body. Resident #101 was transferred back to bed and then to his Geri chair with the tray attached.

On 03/10/22 at 9:30 AM, during an interview with LPN #9/Restorative Nurse, she explained Resident #101 is not on restorative services.

At 9:10 AM on 03/11/22, during an interview with the Administrator, she explained the facility is a restraint-free building, and currently do not have any residents with a restraint. She confirmed she

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M 500	Continued From page 8 has seen Resident #101 in the Geri chair with the tray attached. She also confirmed that if the resident cannot remove the tray by himself, it is a restraint. On 03/11/22 at 9:30 AM, during an interview with Director of Nursing, she explained Resident #101 has been in the Geri chair with the tray since she started in November 2021. SSA shared observations of that the Geri chair with the tray attached that restricted Resident #101 ' s ability to move freely. She confirmed that Resident #101 leans over the side of the chair because he is propelling himself, and not because of poor trunk control as the physician order states. She also confirmed Resident #101 can feed himself while sitting on the side of his bed without issues and she and she knows the resident does not have poor trunk control. The DON stated she is aware of the definition of a restraint and confirmed Resident #101 cannot remove the tray on the Geri-chair and that is considered a restraint. The resident has not received therapy or restorative services recently, and the facility did not implement effective interventions or try other least restrictive measures before using the tray attachment. She said the facility is a "no restraint facility", but admitted the tray is a restraint.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.	M 640		4/27/22

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M 640	Continued From page 9 This Statute is not met as evidenced by: Level II Based on observations, interviews, record review, and facility policy review, the facility failed to reassess the resident fall risk, determine the root cause of a fall, address the risk factors for the fall, and implement an intervention to reduce the likelihood of another fall for (1) of three (3) residents reviewed for falls. Resident #13. Findings include: A record review of the facility's policy "Fall Risk Management" (undated), " ...residents will be assessed for fall risk potential, interventions will be implemented ...and interventions will be re-evaluated for effectiveness ... Procedures ...1. A fall risk assessment needs to be completed on admission, after each fall, and quarterly. 2. Follow guide of Fall evaluation. 3. Update the care plan with Fall risk and inventions. Interventions ... interventions should be appropriate to the resident's cognitive and physical abilities with the root cause of falls considered." On 03/06/22 at 01:45 PM, State Survey Agency (SSA) observed Resident #13 from the hallway lying in bed and calling for help. Licensed Practical Nurse (LPN) #3 who was also in the hallway stated to the SSA that he would check on the resident. On 03/06/22 at 1:50 PM, SSA walked into the resident's room. During an observation and an interview with the resident, the SSA observed Resident #13 to have fading bruises, which had discolorations of brown, green, yellow, and red to	M 640	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 care plan for Resident # 13 was reviewed and revised on 03/11/22. 2. All residents in the facility have the potential to be affected by this practice. 3. The Director of Nursing (DON) determined the cause of the fall that occurred on 02/27/22 for Resident # 13 and put interventions in place to reduce the likelihood of another fall and put a note in Point Click Care (PCC) on 03/11/22. An in-service was initiated by the Administrator and provided education to the DON, Assistant Director of Nursing (ADON), and Minimum Data Set (MDS) nurses regarding completing fall interventions and care plans and was completed on 03/30/22. The MDS Nurse completed a 100 % audit on fall care plans for all residents who had sustained a fall from 01/01/21 through 04/01/22 to ensure proper interventions. This audit was completed on 04/01/22. Falls are discussed during meeting daily.	

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M 640	Continued From page 10 the left orbital area. Resident #13 explained he doesn't know what happened and thinks he might have fallen. At 2:00 PM on 03/06/22, during an interview with Certified Nursing Assistant (CNA) #3, she explained Resident #13 had the black eye when she returned on Monday, 2/28/22, and was told by other staff that the resident had fallen out of the bed. On 03/06/22 at 2:20 PM, during an interview with LPN #3, he explained Resident #13 had fallen last Sunday, 2/27/22, around 8:00 AM. The resident was found on his fall mat on the floor, and he sustained a raised contusion above his left eye. He notified the physician of the fall and received orders to monitor the resident. On 03/08/21 at 1:00 PM, during an interview with CNA #5, she explained on Sunday, 2/27/22, in the morning while she was making rounds, Resident #13's roommate came out of the room and told her the resident had fallen. When she went into the room, Resident #13 had fallen on the floor onto the fall pad and was lying on his left side. A record review of the facility's log "Incidents by Incident Type" revealed Resident #13 had a fall on 2/27/22. A record review of the facility's report of the fall, revealed, "#2232 Fall Date: 2/27/2022 15:03 (3:03 PM) Resident: (Proper Name of Resident #13) ...Incident Description: Resident noted on floor mat beside bed. Small amount of blood noted in nostril @ 0800 (8:00 AM). Residents left eye swollen @ 0830 (8:30 AM). Notified (Proper Name of Physician) and he stated to monitor resident ...Injuries Observed at Time of Incident	M 640	The MDS nurses or DON will audit two (2) residents fall care plans weekly beginning on 04/01/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. 4. The MDS Nurses and/or DON will report findings of the audit 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. 5. Completion date 04/27/22.	

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M 640	Continued From page 11 ...No injuries observed at time of incident ...Injuries Report Post Incident ...No injuries Observed Post Incident ...Witnesses ...No Witnesses found ...Agencies/People Notified ...No Notifications found." Resident's Mental Status, Level of Pain, Predisposing Environmental Factors, Predisposing Physiological Factors, and Predisposing Situation Factors were not checked which indicated the nurse did not address the risk factors for the fall. The fall report did not include an intervention that was implemented to prevent the reoccurrence of a fall. A record review of the "CES Quarterly Evaluation Bundle (Clinical) - V-11" revealed "Section 2: Fall Risk Evaluation", was completed for Resident #13 on 2/24/22 in which his "Score" was listed as "13" and "Category" was listed as "Moderate Risk". This was the last Fall Risk Evaluation noted in the medical chart which indicated the facility did not reassess the resident fall risk after Resident #13's fall that occurred on 2/27/22. A record review of the "Progress Notes" by LPN #3 for Resident #13 with an effective date of 2/27/2022 at 2: 49 PM, revealed " ...@ 0810 (8:10 AM) Resident noted on pad by bed on floor. This nurse assessed for injuries. Small amount blood noted at nostril ...This nurse assisted resident back into bed with staff. Left eye swelling noted @ 0830 (8:30 AM). This nurse informed (Proper Name of Physician) and MD stated to monitor resident." The progress note did not address an intervention to prevent the reoccurrence of a fall. A record review of "Progress Notes" by the Director of Nursing (DON) for Resident #13 with an effective date of 2/27/22 at 3:14 PM, revealed, " ... Resident noted to be on the fall mat next to	M 640		

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M 640	Continued From page 12	M 640		

bed. Resident assessed with swelling noted to left eye, and small amount of blood noted in left nostril. Vitals obtained. MD notified with orders to monitor resident. Action: Not Applicable Response: Will continue to monitor." The progress note did not address an intervention to prevent the reoccurrence of a fall.

At 9:00 AM on 03/11/22, during an interview with the Director of Nursing (DON), she explained Resident #13 had fallen on the fall mat on 02/27/22. She reported she does not remember why or how Resident #13 fell and does not remember the root cause of the fall. The DON reviewed the fall incident report for Resident #13 dated 02/27/22 and confirmed the report is incomplete because it did not indicate the risk factors and mental status of the resident. There was no identification of the root cause of the fall and there was no intervention put in place that would decrease the likelihood for another fall. She stated it just was not done. The nurse did notify the physician and the DON regarding the fall on 02/27/22, but no investigation of the root cause of the fall or a revision of the care plan was completed. The DON also confirmed there was no fall risk assessment completed after the fall on 02/27/22.

On 03/11/22 at 10:00 AM, during an interview with LPN #1, she reported she thought the new intervention for Resident #13's fall on 2/27/22 was a fall mat. However, she was unable to explain how it was a new intervention if the resident was found lying on a fall mat. LPN #1 confirmed she was the person who completed the fall report for on 02/27/22, but she was not Resident #13's assigned nurse. She had only helped by entering the information into the fall report for LPN #3. She agreed the fall report was incomplete.

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M 640	Continued From page 13 A record review Resident #13's "Admission Record" revealed the facility admitted Resident #13 on 11/24/21 and has current diagnoses including Unqualified Visual Loss one eye, Contusion of other part of head, and Alcohol Abuse. A record review of Resident #13's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/30/21 revealed he had Brief Interview for Mental Status (BIMS) score of 4 which indicated he is severely cognitively impaired.	M 640		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record reviews, and facility policy review the facility failed to clean the thermometer between each food item during tray line temperature testing and failed to record tray line temperatures for breakfast and lunch two (2) out of six (6) days of survey. Findings Include: Record review of the facility's policy, "Food Temperature", dated 11/13/2009, revealed, "Food is served at the correct temperature. Foods of both plant and animal origin must be cooked,	M 815	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 (DM) provided education to the dietary staff on recording tray line temperatures for all three (3) meals that was completed on 03/21/22. 2. All residents in the facility have the	4/27/22

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M 815	Continued From page 14 maintained and stored at appropriate temperatures. Procedure... 1. b. Check temperatures of food on the steam tables before it is served...3. Use a sanitized thermometer to evaluate food temperatures of all food items to be served..." On 3/8/22 at 10:45 AM, State Agency (SA) reviewed the tray line temperature check logs and found that there was no evidence that tray line temperatures were recorded for breakfast and lunch on 3/3/22 and 3/4/22. On 3/8/22 at 11:03 AM, in an interview with the Dietary Manager (DM) stated he should follow up with to make sure tray line temperatures are being done. He stated that that falls on him. He stated if days are missing, he should follow and talk to staff. He stated it is important that food is checked to make sure food is cooked thoroughly and hot when residents get their tray. He stated that food not cooked thoroughly could cause the residents to get sick. During an observation on 3/8/22 at 11:00 AM, tray line temperature checks were done by Dietary #2. He did not calibrate the thermometer. He first checked the country fried steak, mashed potatoes, and carrots. SA asked the DM if they cleaned the thermometer after each food item. The DM stated "yes" and handed Dietary #2 the wipes to clean the thermometer. Dietary #2 cleaned the thermometer and continued to check each item. On 3/8/22 at 4:44 PM, in an interview with Assistant Dietary Manager #3 stated that if it is not charted it is not done. She stated that the temperatures were checked and put on a clip board. She stated its very important that tray line	M 815	potential to be affected by this practice. 3. The Dietary Manager (DM) provided education to the dietary staff on food temperature policy and procedure including calibrating and cleaning the thermometer between each food item during tray line temperature testing beginning on 04/04/22 and ending on 04/08/22. The Dietary Manager (DM) completed a one-on-one education to dietary aide # 2 on food temperature policy and procedure including calibrating and cleaning the thermometer between each food item during tray line temperature testing completed on 04/04/22. The Administrator will audit the tray line temperature logs for completion two (2) times a week for 4 weeks, then monthly for three (3) months to ensure the that tray line temperatures are being recorded per guidelines beginning on 04/01/22 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 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	

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M 815	Continued From page 15 temperatures are done daily. I apologize for that and will pay more attention next time. She stated a resident could get sick from meat not being cooked completely. She stated anything could happen. She stated the resident could get stomach virus, diarrhea, vomiting and salmonella poisoning. She stated the cook is responsible and that she should go behind them to make sure it is done. She stated she should not just take the cooks word that it is done. On 3/9/22 at 10:45 AM, in an interview with the DM stated the steps for testing tray line temperatures are: wash hands, apply gloves, calibrate thermometer in ice water, temp food, clean thermometer, and test next item. The DM stated that the thermometer not being clean after testing each food is cross contamination. On 3/9/22 at 10:50 AM, in an interview with Dietary #2/ Assistant Dietary Supervisor stated that he did not clean the thermometer after testing each food item. He stated that his actions were cross contamination. He stated he should have calibrated the thermometer before testing food temperature. On 3/9/22 at 11:02 AM, in an interview with the DM, the SA asked the DM if he had any more tray line temperature logs for 3/2/22, 3/3/22, 3/4/22 and 3/6/22. He stated that staff was used to recording tray line temperatures on a clip board. The DM stated he has a book he places sheets in after tray line temps are done. The DM presented logs for 3/2/22 and 3/6/22. SA observed the DM look in binders for the above dates. He did not have tray line temperatures for breakfast and lunch recorded on 3/3/22 and 3/4/22. The DM confirmed they were not done on 3/3/22 and 3/4/22 for breakfast and lunch.	M 815	submit solutions and/or changes to make as needed and complete further in-service education.	

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M 815	Continued From page 16 Record review of an in-service on 2/1/22 revealed Dietary Supervisor #2 and Dietary Assistant Manager #3 signatures on the sign in sheet. The in-service was on calibrating thermometers. Record review of the DM #1 training revealed infection control passed 10/29/21 cleaning and sanitizing passed 11/10/21, time and temperature control recording passed 11/10/21, and cross contamination passed 9/15/21.	M 815		
M 855	45.30.7 Food Preparation Food Preparation. Foods shall be prepared by methods that conserve optimum nutritive value, flavor, and appearance. Also, the food shall be acceptable to the individuals served. A file of tested recipes shall be maintained to assure uniform quantity and quality of products. This Statute is not met as evidenced by: Level II 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	M 855	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	4/27/22

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M 855	Continued From page 17 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 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.	M 855	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 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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M 855	Continued From page 18 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 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	M 855		

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M 855	Continued From page 19 intact.	M 855		
M1210	45.40.7 Walls and Ceilings Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be maintained in good repair. Generally the walls and ceilings should be painted a light color. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record review and facility policy review, the facility failed to maintain and provide a safe and sanitary shower room for Shower Room #1 and Shower Room # 2 for two (2) of six (6) days of survey. Findings include: Record review of the facility's policy "Maintenance Service" dated 06/2000, revealed Policy Statement, "It is the policy of this facility that maintenance service be provided to all areas of the building, grounds, and equipment. Procedure 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times; 2. The following functions are performed by maintenance, but are not limited to: a. Maintaining the building in compliance with current federal, state, and local law regulations and guidelines; b. Maintaining the building in good repair and free from hazard; ... j. Providing routinely scheduled maintenance service to all areas ..." Shower Room #1	M1210	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. Shower Room #1 is no longer in service and was shut down for repairs on 03/07/22. Shower Room # 2 the wall with the hole and loose tiles was repaired on 03/22/22. For both Resident # 57 and Resident # 39 the wheelchair arm cushions were replaced on 03/10/22. 2. All residents in the facility have the potential to be affected by this practice. 3. An in-service was initiated by the Maintenance Director and Maintenance Assistant and provided education to the staff that if they see any environmental issues or anything that maintenance needs to fix, they are to complete a work order in the maintenance work order	4/27/22

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M1210	Continued From page 20 On 03/07/22 at 11:10 AM, an observation revealed Shower Room #1 had an extreme malodorous smell. Shower Room #1 had two shower stalls. There was a rectangle which measured fifty (50) inches by twenty-three (23) inches on the ceiling in the back left corner of the room, sagging and being black in color. There was a one inch by one inch (1x1) crack between the wall and the flooring of the back wall near the back left corner of the room. There was a rusted handrail attached to the wall behind the tub. There was a black discoloration on the tiles in the back left corner of the floor. There were black discolorations on all sides of the tiles on the floor of the two (2) shower stalls. There was dark brown to black discoloration up to the top of the third (3rd) four by four (4x4) inch ceramic tile along the grout along from floor level up all around the whirlpool tub and under the cabinet (previously described) in the back left corner of the room and around the bottom of both shower stalls where the floor and the shower stall walls met. There were tiles pulled away from the wall studs, with the studs exposed and discolored black; the tiles protrude out away from the studs approximately two (2) inches for approximately six by sixteen (6x16) inches four (4) inches from the floor next to the corner of the shower stall. There was no signage posted on the shower room door indicating the shower room was not in operating order. On 03/07/22 at 11:30 AM, an interview with Certified Nursing Assistant (CNA) #1 revealed, she has been using Shower Room #1 every day for showering residents. CNA #1 stated she had told someone about the discolored area of the ceiling and the odor of the shower room a few months ago, but she was unable to recall who she had reported it to.	M1210	binder that is located at each nurse station, front office, or kitchen on 03/30/22 and completed on 04/08/22. The Maintenance Director and/or Assistant will make rounds weekly to assess for environmental issues beginning 03/30/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. 4. The Maintenance Director and/or Assistant will report any adverse environmental 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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M1210	Continued From page 21 On 03/07/22 at 11:20 AM, an interview with CNA #2 confirmed Shower Room #1 was used every day except on Sundays. CNA #2 revealed Shower Room #1 had an extreme odor. On 03/07/22 at 11:25 AM, an interview with Housekeeping #1 revealed, she believed the black colored rectangle in the back left corner of the ceiling of the Shower Room #1 hall shower room was "mildew". On 03/07/22 at 2:00 PM, an interview and observations made with the Maintenance Supervisor, revealed he stated the black discolored area of the ceiling in the back left corner of Shower Room #1, to be microbial growth caused by water damage in the roof. On 03/07/22 at 2:15 PM, an interview with the Administrator, she confirmed Shower Room #1 had an odor, but she was not aware the staff were utilizing the shower room for showering residents. The Administrator confirmed Shower Room #1's ceiling had the appearance of "mildew". She then closed the shower room until it received repairs. On 03/09/22 at 2:07 PM, an interview with the Maintenance Supervisor revealed Shower Room #1 is now closed temporarily for maintenance repair. Shower Room #2 On 03/09/22 at 9:25 AM, an interview with CNA #5 and observation of Shower Room #2, revealed that Resident #101 had received a shower today (03/09/22). SA noted there were tiles missing, and there was a large hole in the wall with loose	M1210		

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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) COMPLETE DATE
M1210	Continued From page 22 tiles noted on the left side of the room. SA also noted damage around all tiles in the shower room. CNA #5 stated she did not know how long the hole has been in the shower room wall. On 03/09/22 at 2:00 PM, during an interview with the Maintenance Supervisor, he stated he had just observed Shower Room #2 and the "shower room needs a makeover". He confirmed Shower Room #2 had water damage and there are missing tiles with a hole in the wall with loose tiles. He explained he had replaced the tiles in the shower room before and had to replace all the doorknobs in the shower rooms. There is a maintenance binder located at each nurse's station that includes work orders. He checks the binders at each station and picks up the work orders and completes them as needed. He reported he has not had any work orders for repairs needed to Shower Room #2.	M1210		