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	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pillars of Biloxi	2279 Atkinson Road Biloxi, MS 39531

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure residents received care and services in accordance with physician orders and professional standards of nursing practice for two (2) of three (3) residents reviewed, as evidenced by the facility did not discontinue narcotic medication as ordered and continued administration for four (4) days after discontinuation for Resident #2 and did not timely implement a newly ordered antibiotic following hospital return for Resident #1, resulting in a five (5) day delay in treatment for a urinary tract infection (UTI). Findings include: A review of the facility's Physician Order Policy, with a revision date of 1/20/2026 revealed .To ensure that residents' medication and treatments are ordered by a licensed physician or other licensed health care professional as permitted by state law. Procedure: Physician orders are carried out.Physician orders are to be recorded in the medical record for each resident.Each order should have the month, day, year and time of receipt.A review of the facility's Medication Administration - General Guidelines Policy and Procedure revised 10/09/2025, revealed .Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.c. Eight Rights - Right resident, right drug, right dose, right route, right time, right reason, right documentation.Resident #2A record review of the Order Entry, dated 12/17/25, revealed Resident #2 had a new order for Oxycodone-Acetaminophen Oral Tablet 5-325 Milligrams (MG) to give one (1) tablet by mouth every 6 hours and discontinue Norco (Hydrocodone-Acetaminophen) 10/325 MG (milligrams) when Oxycodone-Acetaminophen tablets come available. A record review of the Order Summary Report with active orders as of 12/29/25 revealed Resident #2 had a Physician's Order, dated 5/2/25 for Hydrocodone-Acetaminophen 10-325 mg (1) table four times a day for pain and an order for Oxycodone-Acetaminophen 5-325 mg, dated 12/16/25, (1) tablet every six (6) hours. A record review of the Medication Administration Record (MAR) for December 2025, revealed both medications Oxycodone-Acetaminophen 5-325 mg and Hydrocodone-Acetaminophen 10-325 mg was administered to Resident #2 from 12/26/25 through 12/29/25. In a record review of the Controlled Drug Receipt/Record/Disposition Form revealed, Oxycodone-Acetaminophen Oral Tablet 5-325 Milligrams (MG) to give (1) tablet by mouth every (6) hours were delivered to the facility on [DATE] at 8:00 AM, signed out and administered to Resident #2. On 12/26/25 at 6:00 AM Hydrocodone/APAP (Acetaminophen) was signed and given to Resident #2. On 2/23/26 at 10:00 AM, during an interview with License Practical Nurse (LPN) #2, revealed on 12/17/25 the Medical Provider provide new orders for Resident #2 to receive Oxycodone-Acetaminophen Oral Tablet 5-325 (MG) to give (1) tablet by mouth every 6 hours and when the facility received the medication, they were to discontinue the Hydrocodone/APAP (Acetaminophen), upon the facility receiving the medication. On 12/26/25 the facility received the medication, according to the Controlled Drug Receipt/Record/Disposition Form but the staff continue to give both medications from 12/26/25 through 12/29/25. A record review of the admission Record revealed the facility admitted Resident #2 on 6/4/25 (continued on next page)

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.

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

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	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pillars of Biloxi	2279 Atkinson Road Biloxi, MS 39531

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with his diagnoses including Intervertebral Disc Degeneration, Lumbar Region without Mention of Lumbar Back Pain or Lower Extremity Pain.A record review of the Quarterly Minimum Data Set (MDS) with and an Assessment Reference Date (ARD) of 2/5/26 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately impaired. Resident# 1A record review of a Progress Note, dated 12/24/25 at 1:15 PM, revealed Resident #1 was transferred to a local hospital for pupils non-reactive, left pupil larger than right, and feels hot to touch. A record review of a Progress Note, dated 12/24/26 at 8:30 PM, revealed Resident #1 returned to the facility on medication for UTI. A record review of the local emergency room After Visit Summary, dated 12/24/25, revealed Resident #1 transferred back to the facility for UTI with medications to START taking listed as nitrofurantoin (Macrobid). A record review of the Order Summary Report revealed Resident #1 had a Physician's Order, dated 12/29/25 with a start date of 12/30/29 for Macrobid 100 (MG) per percutaneous endoscopic gastrostomy (PEG) tube two times a day for infection UTI. The order was clarified on 12/30/25 with a start date of 12/30/25 and an end date of 1/9/25 to take the antibiotic medication for (10) days.A record review of the MAR for Resident #1 revealed that Macrobid Oral Capsule was not administered until 12/29/25, which was (5) days after the order was received on 12/24/25. A record review of the admission Record revealed the facility admitted Resident #1 on 10/22/24 and her diagnoses included Anoxic Brain Damage.A record review of the Quarterly (MDS) with an (ARD) of 1/22/26 revealed Resident #1 was comatose and in a persistent vegetative state/no discernible consciousness. On 2/23/26 at 10:40 AM, during an interview with the Director of Nursing (DON), she confirmed that on 12/24/25 Resident #1 was sent to the local hospital for symptoms consistent with a UTI. The resident returned to the facility later that evening with new physician orders to initiate Macrobid twice daily. The DON confirmed the facility failed to implement the new antibiotic order upon the resident's return. She stated the order was missed during the readmission process and the Macrobid was not initiated until 12/29/25. The DON acknowledged this was not in accordance with facility policy or professional standards of practice, which require timely transcription and implementation of all new physician orders upon a resident's return from the hospital. She further confirmed the delay should not have occurred and stated the expectation is that discharge orders are reviewed, reconciled, and initiated immediately upon return to the facility. The DON reported the issue was identified during a subsequent chart review and corrective education was provided to the nursing staff regarding proper hospital return reconciliation procedures. Additionally, during the interview, the DON reviewed record findings related to Resident #2 those new orders dated 12/17/25, Oxycodone-Acetaminophen Oral Tablet 5-325 Milligrams (MG) to give 1 tablet by mouth every 6 hours and discontinue Norco (Hydrocodone-Acetaminophen) 10/325 MG when Oxycodone-Acetaminophen tablets when the Oxycodone-Acetaminophen becomes available. According to Pharmacy the Oxycodone-Acetaminophen did not became available or delivered to the facility until 12/26/25, at that time, the nurse should have discontinue the Hydrocodone-Acetaminophen 10/300 mg. On 12/26/25 the nursing staff did not discontinue the Hydrocodone-Acetaminophen as directed. Resident #2 was receiving both medications on 12/26/25, 12/27/25, 12/28/25, and 12/29/25. She revealed that according to the Controlled Drug Receipt/Record/Disposition Form revealed nursing staff continued to sign out and document administration of Hydrocodone/APAP 10/325 mg four times daily from 12/26/25 through 12/29/25 despite the discontinuation order. The DON acknowledged the medication should not have been administered after the discontinuation date and confirmed this was not consistent with facility policy or accepted standards of medication administration. She confirmed the expectation from her staff is that discontinued medications are immediately removed from active MARs and reconciled with controlled substance records to prevent continued (continued on next page)

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	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pillars of Biloxi	2279 Atkinson Road Biloxi, MS 39531

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration.On 2/23/26 at 2:00 PM, during an interview with Registered Nurse (RN) #2, she confirmed that she administered both narcotic medications to Resident #2 because both were active and listed on the Medication Administration Record (MAR). She stated she did not question the duplicate opioid orders at the time of administration and assumed the medications were intended to be given as documented. RN #2 acknowledged that she did not verify whether the Hydrocodone-Acetaminophen had been discontinued upon receipt of the new Oxycodone-Acetaminophen order and confirmed she did not notify the charge nurse, pharmacy, or the DON regarding the duplicate narcotic therapy.

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	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pillars of Biloxi	2279 Atkinson Road Biloxi, MS 39531

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure nursing services were provided by qualified and licensed personnel when a graduate practical nurse (GPN) continued to function in the capacity of a licensed nurse for approximately five and one-half (5 1/2) days after receiving notification of failure of the National Council Licensure Examination (NCLEX) nursing exam for one (1) of three (3) facility nursing staff reviewed.Findings include: A review of the facility's policy Compliance and Ethics - Risk Areas for Fraud and Abuse, revised [DATE], revealed .Resident Quality of Care.2. A. Sufficient staffing - staffing is provided in sufficient numbers and with staff who have appropriate clinical training, licensure and/or expertise to meet the needs of residents. A record review Board of Nursing License Verification for GPN #1 revealed she had a License Type of LPN (License Practical Nurse) Temporary Permit that was issued on [DATE] and expired on [DATE]. A record review of the NCLEX-Practical Nurse (PN) Candidate Report, test date [DATE], results revealed GPN #1 had not passed the exam. A record review of the Board of Nursing website ww.msbn.ms.gov/licensure/applications-and-forms revealed Temporary Permits for New Graduates indicated .if the new graduate fails NCLEX, the temporary permit becomes invalid and the new graduate is no longer able to work off the temporary permit.A record review of the facility's Personnel Action Notice (PAN), dated [DATE], Graduate Practical Nurse (GPN) #1 was terminated on [DATE], due to did not pass state boards.A record review of the facility's Employee Time Cards revealed GPN #1 punched in on [DATE] at 6:50 AM and punched out on 7:16 PM, on [DATE] at 6:55 AM and punched out on 7:17 PM, punched in on [DATE] at 6:53 AM and punched out on 7:21 PM, punched in on [DATE] at 6:50 AM and punched out on 7:22 PM, punched in on [DATE] at 6:55 AM and punched out on 7:13 PM, and punched in on [DATE] at 6:52 AM and punched out on 11:07 AM.A review of GPN #1 staffing schedules and assignment sheets revealed GPN #1 was assigned a full resident assignment during the period [DATE] through [DATE] and functioned in the capacity of a licensed nurse. On [DATE] at 2:00 PM, during an interview with GPN #1, she confirmed that she was notified by the State Board of Nursing and issued a temporary graduate permit on [DATE], with an expiration date of [DATE]. She stated she took the NCLEX-PN on [DATE] and received notification from the State Board of Nursing on [DATE] that she did not pass the examination. GPN#1 confirmed she continued working as a licensed nurse at the facility after [DATE] despite receiving notice of the failed examination. She stated she believed she could continue practicing under the temporary permit until its expiration date of [DATE]. She acknowledged she did not verify with the State Board of Nursing whether the permit remained valid after failing the exam, nor did she notify facility administration of the failed examination results. She confirmed that between [DATE] and [DATE] she continued to function in the role of a licensed nurse, including administering medications, performing treatments, and documenting in the medical recordOn [DATE] at 2:30 PM, during an interview, the Director of Nursing (DON) confirmed she was not aware that GPN #1 failed the NCLEX examination on [DATE]. The DON stated she believed the temporary permit remained valid through [DATE]. She acknowledged the facility did not have a system in place to verify examination results with the State Board of Nursing and relied on the nurse to self-report results. The DON confirmed that had she been aware of the failed examination, GPN #1 would have been immediately removed from the schedule, as practicing without a valid license or permit is not permitted under State law or facility policy. She further confirmed that during the period following the exam failure, GPN #1 continued to administer medications, perform treatments, and document in residents' medical records. The DON stated that upon learning of the failure, she assessed residents assigned to GPN #1 and (continued on next page)

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	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pillars of Biloxi	2279 Atkinson Road Biloxi, MS 39531

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified no adverse outcomes.