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	08/21/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and facility policy review, the facility failed to prevent the possible spread of infection, as evidenced by, failure to follow proper hand hygiene for Resident #26 and by placing soiled linen directly onto the floor for two (2) of four (4) days of survey.Findings include:A review of the facility's policy, Handwashing/Hand Hygiene, revised June 2010, revealed . This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation.2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water . n. Before and after assisting a resident with toileting . r. after handling soiled or used linens .A review of the facility's policy, Infection Control Program, reviewed 7/16/22, revealed, .Purpose.Decrease the risk of infection for residents and staff.On 8/18/25 at 10:06 AM, during an observation walking in the hallway with the facility's Licensed Social Worker (LSW), Registered Nurse (RN) #2 provided incontinent care for Resident #26. RN #2 cleaned the resident's buttocks, placed soiled linens in a clear plastic bag, applied a clean brief, and assisted the resident with dressing and covering with bed linens, while wearing the same gloves used to clean the resident. On 8/18/25 at 10:09 AM, during an interview, the LSW confirmed RN #2 did not change gloves or perform hand hygiene after cleaning the resident. The LSW stated this was an infection control issue that should be addressed.On 8/18/25 at 10:26 AM, during an interview, RN #2 confirmed she failed to change gloves or wash her hands after cleansing loose stool. She stated she was focused on cleaning the resident and acknowledged that placing clean linens and clothing while wearing soiled gloves could cause the spread of infection.On 8/18/25 at 10:57 AM, during an interview, the Director of Nursing (DON) stated RN #2 should have changed gloves and washed her hands after cleaning stool from Resident #26. The DON confirmed not changing gloves could spread infection. On 8/20/25 at 10:10 AM, during an observation and interview while walking in the hallway, CNA #5 exited room [ROOM NUMBER], and there was soiled linen placed directly on the floor visible from the hallway, CNA #5 explained she did not bring a bag into the room and admitted she should have placed the linen in a soiled linen bag and transported it directly to the soiled linen room. She acknowledged placing soiled linen on the floor could spread infection.On 8/21/25 at 10:50 AM, during an interview, RN #1 stated CNA #5 had told her about placing soiled linen on the floor. RN #1 confirmed staff were in-serviced on infection control procedures, including bagging soiled linen immediately.On 8/21/25 at 4:44 PM, during an interview, the Administrator stated she expected staff to follow the facility's infection control policies at all times.A record review of the admission Record revealed the facility admitted Resident #26 on 8/6/25 with diagnoses including Chronic Obstructive Pulmonary Disease.A record review of the Comprehensive admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/25 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated his cognition was moderately impaired.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide Activities of Daily Living (ADL) care to ensure a resident was kept clean after episodes of incontinence, as evidenced by staff requiring multiple wipes to remove dark residue from the groin area during incontinent care for one (1) of 29 sampled residents, Resident #74.Findings include: On 8/19/25 at 3:35 PM, during an observation and interview, Certified Nurse Aide (CNA) #3, reported that Resident #74 was always incontinent of bowel and bladder and dependent on staff for ADL care, including personal hygiene. During incontinence care with CNAs #2 and #3, Resident #74's groin area required extensive cleaning, with multiple wipes showing brown and black discoloration before the skin was clean. CNA #3 confirmed this was not bowel movement but an accumulation of dirt and residue, commenting the resident had not been adequately cleaned prior to their providing this care. On 8/19/25 at 4:00 PM, during an interview, the Director of Nursing (DON) reported she expected all residents to be properly cleaned after each incontinence episode and not left with soiled or dirty skin. She confirmed care must be provided until the washcloths are clean and no residue remains.On 8/19/25 at 5:00 PM, during a phone interview, CNA #4, who had been assigned to Resident #74 earlier in the day, stated she last changed the resident around 3:00 PM. She reported the resident had not had a bowel movement at that time but had earlier in the day. She explained the resident did not receive a shower that day, as his scheduled showers were on Monday, Wednesday, and Friday.On 8/21/25 at 10:02 AM, during a phone interview with the resident's Resident Representative (RR), she reported she visited every Saturday, and the resident himself had reported the staff did not clean him properly. She noted that his cleanliness varied depending on which aide was assigned.On 8/21/25 at 10:30 AM, during an interview with Resident #74, the resident confirmed his sister visited every weekend. He reported that aides did not always clean him thoroughly, stating some of them go too fast when providing hygiene care.A record review of the admission Record revealed the facility admitted Resident #74 on 4/28/20 with diagnoses including Cerebral Infarction.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/25 revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated his cognition was moderately impaired. A review of Section GG revealed he was dependent on staff for toileting, hygiene care, and showering.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure food items were properly stored, dated, and labeled in the dry goods room, freezer, and cooler for one (1) of two (2) kitchen observations. Findings include:A review of the facility's policy, Food Storage, dated 8/18/2011, revealed . It is the policy of this facility that food storage areas be maintained in a clean, safe, and sanitary manner. Procedure.2. All food not requiring refrigeration shall be stored above the floor . 8. All food stored in refrigerators and freezers that have been opened, will be covered and labeled with the date and name of the food . 11. All condiments that have been opened should be refrigerated and discarded after 30 days .On 8/18/25 at 9:25 AM, during an observation of the kitchen and interview with the Dietary Manager (DM), in the dry goods room, a broken scoop was stored inside the cornmeal, plastic cups were stored directly on the floor, a 16- pound container of cream cheese icing was observed with no opened date and the lid not secured, and an opened bag of Raisin Bran cereal was noted to be repackaged but undated. In Freezer #1, two (2) boxes of frozen cookie dough were opened and left exposed without repackaging or dating. Additional improperly stored items included opened fish patties, Tony's pizza, and corn on the cob, all found exposed without adequate packaging or labeling. In Cooler #2, an opened package of muffins was observed exposed, not repackaged, and undated. The DM acknowledged the findings and confirmed the observed food storage practices were not in accordance with facility policy. He stated facility policy required staff to repackage, and date opened food products, and for frozen foods to be securely closed in their packaging.On 8/21/25 at 3:58 PM, during an interview, the Administrator stated her expectation was that kitchen and dietary staff follow facility policies related to food storage in the refrigerator, freezer, and dry goods room.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to respect a resident's privacy during incontinent care (Resident #26) for one (1) of four (4) days of survey. Findings include:A review of the facility's policy titled, Dignity, revised 7/24/23, revealed, .Each resident shall be cared for in a manner that promotes and enhances their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation 1. Residents are treated with dignity and respect at all times.11. Staff promote, maintain, and protect residents' privacy, including bodily privacy during assistance with personal care and treatment procedures.On 8/18/25 at 10:06 AM, during an observation while walking in the hallway with the Licensed Social Worker (LSW), Registered Nurse (RN) #2 was observed providing incontinent care for Resident #26 with the resident's door open. Resident #26's buttocks and genital area were exposed, and privacy was not maintained during the provision of care.On 8/18/25 at 10:09 AM, during an interview, the LSW confirmed she observed RN #2 provide incontinent care with the resident's door open and the resident's buttocks and genital area exposed. The LSW acknowledged that residents, staff, families, and visitors frequently pass by the hallway and confirmed this was a dignity concern that should be addressed.On 8/18/25 at 10:26 AM, during an interview, RN #2 confirmed she failed to close the door while cleaning the resident and admitted the resident's buttocks and genitals were exposed. RN #2 stated she became focused on cleaning the resident and forgot to close the door. On 8/18/25 at 10:57 AM, during an interview, the Director of Nursing (DON) stated the nurse should have closed the door during care and confirmed the resident's body should not have been exposed to anyone who could pass by in the hallway.On 8/21/25 at 4:44 PM, during an interview, the Administrator stated she expected staff to follow the dignity policies.A record review of the admission Record revealed the facility admitted Resident #26 on 8/6/25 with diagnoses including Chronic Obstructive Pulmonary Disease.A record review of the Comprehensive admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/25 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated his cognition was moderately impaired.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review, interviews, and facility policy review, the facility failed to resolve a grievance in a timely manner for one (1) of (29) sampled residents (Resident #59). Specifically, the facility failed to replace a broken tablet reported on 5/29/25 until nearly three (3) months later, which did not ensure timely grievance resolution in accordance with facility policy.Findings include:A review of the facility's policy, Grievances, Complaints, Recording and Investigating, dated 7/24/23, revealed, .All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance.Policy Interpretation and Implementation.7. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation.within 5 working days of the filing of the grievance or complaint .On 8/18/25 at 11:14 AM, during an interview, Resident #59 stated a staff member knocked her tablet off of a surface and broke it. She stated the facility was to replace the device, but nothing had been done.A record review of the admission Record revealed the facility admitted Resident #59 on 11/15/24 with diagnoses including Chronic Obstructive Pulmonary Disease.A record review of Resident #59's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.A record review of the Monthly Grievance/Concern Log for May 2025 revealed a grievance was recorded on 5/29/25 for Resident #59 indicating tablet broken accidentally. The Resolution section stated, unable to repair, unable to confirm staff responsibility, and indicated the complainant was notified on 6/2/25.A record review of an Order Summary, dated 8/18/25, revealed the facility ordered a replacement tablet scheduled to arrive on 8/22/25, almost three (3) months after the grievance was filed.On 8/20/25 at 11:51 AM, during an interview, the Licensed Social Worker (LSW) stated Resident #59's smart tablet had been accidentally broken by a staff member. She reported the facility attempted to have it repaired locally but was told it would be too costly and would be easier to replace. She explained she did not interview other staff members because the resident was cognitively intact and had provided the information. On 8/20/25 at 12:06 PM, during an interview, the Administrator stated she was aware of the broken tablet and confirmed it would be cheaper to replace rather than repair. She explained she was waiting for the facility's petty cash card to be loaded before ordering the device. She reported that a new tablet was ordered on 8/18/25 but she had not yet notified the resident. She confirmed the replacement was delayed for nearly three (3) months after the grievance was originally filed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review, staff interview, and facility policy review, the facility failed to ensure physician orders were followed for obtaining a Hemoglobin (Hbg) A1C (a blood test that measures average blood glucose levels over the past 2-3 months) as ordered for one (1) of six (6) residents reviewed for unnecessary medications. Resident #12.Findings include:A review of the facility's policy Physician's Orders dated 4/13/21 revealed, . Physician's orders are carried out unless the nurse or other licensed personnel believe the order to be inaccurate .A record review of the admission Record revealed the facility admitted Resident #12 on 4/25/18 with diagnoses including Diabetes Mellitus.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/1/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) Summary Score of 13, which indicated she was cognitively intact. A record review of the Order Summary Report with active orders as of 8/21/25 revealed Resident #12 had a Physician's Order, dated 10/23/24 for a (Hgb)A1C every six (6) months - April and October.A record review of lab results, dated 10/3/25, revealed HgbA1C results were obtained.A record review of lab results, dated 3/5/25, revealed there was no HgbA1C lab results.On 8/21/25 at 8:00 AM, during an interview with the Director of Nursing (DON), she explained Resident #12 should have had all labs completed per physician orders on 3/5/25 and if the other labs were drawn in March, the HgbA1C test should have been included. She reported that the labs were drawn in March instead of April due to the facility changing laboratory companies.On 8/21/25 at 10:08 AM, during an interview with Registered Nurse (RN) #1, she stated Resident #12's HgbA1C was not obtained in April as ordered. She explained the other labs were drawn in March and all the labs are typically obtained together. She contacted the lab and was told the HbgA1C that was drawn in March could not be processed because the blood was clotted, and the test was never repeated. She further explained that the facility changed laboratory companies in April 2025, and the new lab had better reporting and electronic access.On 8/21/25 at 3:15 PM, during an interview with the DON, she confirmed the HgbA1C was not done as ordered with the other labs and had not been followed up on. She stated RN #1 was responsible for monitoring labs and she expected all labs to be completed as ordered. She reported the physician would be notified and an HgbA1C level would be drawn at this time.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to ensure residents received proper hygiene care for residents dependent on staff and failed to ensure the proper storage of food during an annual recertification survey on 04/04/2024 and was cited again for the same deficiencies during the current recertification survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for two (2) of eight (8) deficiencies cited. F677 and F812.Findings Include:A review of the facility's policy, Quality Assessment and Performance Improvement (undated), revealed . The facility will implement and maintain a Quality Assessment and Performance Improvement program. Overview: The Quality Assurance and Performance Improvement (QAPI) committee will implement a process that is ongoing, multi-level, and facility wide . The primary purpose of the committee is to identify and analyze actual or potential quality issues, develop and implement appropriate plans to improve performance, to address identified quality issues, and monitor the effectiveness of implemented changes. The committee will make any needed revisions to performance improvement plans .Record review of the Provider History Report revealed the facility received a citation for F677- ADL Care provided for Dependent Residents and F812- Food Procurement, Store/ Prepare/ Service-Sanitary. Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 04/04/2024, revealed the facility received a citation for F677, . Based on observation, interviews, record review, and the facility policy review, the facility failed to provide Activities of Daily Living (ADL) care . for residents who require assistance for two (2) of three (3) residents . and for F812, . Based on observation, staff interview, and facility policy review, the facility failed to store food in accordance with professional standards .During the current recertification survey, the facility failed to provide adequate ADL care to ensure a resident was kept clean after episodes of incontinence, as evidenced by staff requiring multiple wipes to remove dark residue from the groin area during incontinent care for one (1) of 29 sampled residents and failed to ensure food items were properly stored, dated, and labeled in the dry goods room, freezer, and cooler for one (1) of two (2) kitchen observations.On 8/21/25 at 4:00 PM, during an interview with the Administrator, she explained that the facility discusses areas of high concern in QAPI meetings and works in good faith to correct problems. She stated that during these meetings, each department head presents issues from their area, and the team determines whether to initiate a Performance Improvement Project (PIP) or provide in-service education to staff. The Administrator acknowledged that staff turnover is ongoing, with new personnel recently hired in activities and social services. She was aware that repeated concerns from the previous survey had resurfaced. Following the last survey, the facility implemented additional in-services on providing ADL care and reinforcing nurses' responsibilities to ensure CNAs completed their tasks and documentation before the end of their shifts. The dietary manager provided in-service education to dietary staff on food storage and handling, while the registered dietitian conducted audits and routine checks on food storage and labeling. She explained that audits related to the plan of correction for prior deficiencies were conducted for three (3) months and reviewed in QAPI meetings; however, once the three (3) months ended, the issues were not revisited because the facility believed they were resolved.