

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/07/2026	
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF BILOXI				STREET ADDRESS, CITY, STATE, ZIP CODE 2279 ATKINSON ROAD , BILOXI, Mississippi, 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
M0000	<p>Initial Comments</p> <p>The State Agency (SA) conducted six (6) Complaint Investigations (CI MS# 3131810, CI MS# 3154285, CI MS# 3153835, CI MS# 3175172, CI MS# 3205449, and CI MS# 3711506) at the facility from 10/05/26 through 10/07/26. During the survey, the SA determined the facility was not in compliance with the requirements for the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements, for CI MS# 3711506, which was investigated for other resident safety and M 610 was cited at an Immediate Jeopardy (IJ) level. CI MS# 3131810, CI MS# 3154285, CI MS# 3153835, CI MS# 3175172, and CI MS# 3205449 which were investigated for Neglect, Quality of Care, accidents, Resident Rights, and Nursing Services with no deficiencies cited.</p> <p>The facility failed to provide adequate supervision for Resident #1, who was identified as an elopement risk. On 9/30/26, Resident #1 exited the facility unnoticed through an open window. The resident was last observed at approximately 10:40 AM and was discovered missing at 11:00 AM. At 11:07 AM, Resident #1 was located approximately 0.2 miles from the facility, walking with two unknown adults along a heavily traveled two-lane roadway. The resident was returned to the facility at 11:22 AM.</p> <p>The facility's failure to provide adequate supervision to prevent the elopement of Resident #1 placed Resident #1 and other residents at risk for wandering and elopement in a situation that was likely to cause serious injury, harm, impairment, or death.</p> <p>The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 9/30/26 and existed at Rule 45.21.8 Accidents - M640 Level IV.</p> <p>The SA notified the facility's Administrator of the IJ and SQC on 10/05/26 at 4:00 PM.</p> <p>Based on the facility's implementation of corrective actions on 10/02/26, the SA determined the IJ and SQC to be Past Non-Compliance (PNC), and the IJ was removed as of 10/03/26, prior to the SA's entrance on 10/05/26.</p>			M0000			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0000	Continued from page 1 The facility held a license for 180 beds, with a census of 144.	M0000					
M0640	<p>45.21.8 Accidents</p> <p>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.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record reviews, and facility policy review, the facility failed to provide adequate supervision to prevent a resident from leaving the facility unnoticed and unsupervised for 1 (one) of 21 residents who were identified as being at risk for elopement and wandering, Resident #1.</p> <p>The facility failed to provide adequate supervision for Resident #1, who was identified as an elopement risk. On 9/30/26, Resident #1 exited the facility unnoticed through an open window. The resident was last observed at approximately 10:40 AM and was discovered missing at 11:00 AM. At 11:07 AM, Resident #1 was located approximately 0.2 miles from the facility, walking with two unknown adults along a heavily traveled two-lane roadway. The resident was returned to the facility at 11:22 AM.</p> <p>The facility's failure to provide adequate supervision to prevent the elopement of Resident #1 placed Resident #1 and other residents at risk for wandering and elopement in a situation that was likely to cause serious injury, harm, impairment, or death.</p> <p>The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 3/24/26 and existed at Rule 45.21.8 Accidents - M640 Level IV</p> <p>The SA notified the facility's Administrator of the IJ and SQC on 10/05/26 at 4:00 PM and provided the Administrator with the IJ template.</p> <p>Based on the facility's implementation of corrective actions on 10/02/26, the SA determined the IJ and SQC to be Past Non-Compliance (PNC), and the IJ was removed as of 10/03/26, prior to the SA's entrance on 10/05/26.</p> <p>Findings include:</p>	M0640	"Past Noncompliance - no plan of correction required"				

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M0640	<p>Continued from page 2</p> <p>Review of the facility's policy, "Safety and Supervision of Residents," reviewed 8/2023, revealed, "...Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities..."</p> <p>Review of the facility's policy, "Emergency Procedure-Missing Resident," reviewed 3/2023, revealed, "...Resident elopement resulting in a missing resident is considered a facility emergency..."</p> <p>Record review of the "Resident Incident Timeline" revealed that on 9/30/26 at approximately 11:00 AM, the Life Connection Aide discovered Resident #1 was missing from her room, and the resident's window was open with the window screen missing. The last reported time Resident #1 was observed inside the facility was at 10:40 AM. The facility initiated Code W (missing resident) at 11:02 AM, and staff conducted a search inside and outside the facility. At 11:07 AM, Resident #1 was located by Certified Nursing Assistant (CNA) #3 approximately 0.2 miles from the facility, walking with two unidentified adults while carrying a suitcase and water pitcher. Resident #1 had exited the facility through her bedroom window without staff knowledge or supervision. The outside temperature was approximately 85°F with clear skies. Resident #1 initially resisted returning to the facility and required assistance from the Administrator and Director of Nursing (DON) to return safely. The DON completed an assessment, with no injuries identified. The Nurse Practitioner (NP) was notified, and Resident #1 was transferred to the local emergency department for evaluation. Resident #1 was diagnosed and treated for a urinary tract infection (UTI) and returned to the facility. Upon return, Resident #1 was placed on one-to-one supervision pending transfer to a behavioral health unit. Following the incident, the facility initiated corrective actions, including staff in-services on abuse, neglect, reporting, and elopement; an emergency Quality Assurance and Performance Improvement (QAPI) meeting; facility-wide resident accountability and elopement risk assessments; care plan reviews and updates for residents identified at risk for elopement; updated resident identification photographs; elopement drills on all shifts; and installation of window alarms on all windows in the unit.</p> <p>On 10/5/26 at 10:28 AM, the State Agency (SA) observed Resident #1's room and the window identified as the point of exit during the elopement.</p>			M0640			

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M0640	<p>Continued from page 3</p> <p>The window opened laterally from the side and had a window screen in place. The SA observed the window opened approximately six (6) inches. The SA was informed that prior to the elopement, the window could be opened approximately eight (8) inches. A window alarm was present and sounded when the window was opened; the alarm stopped when the window was closed. The SA walked the route Resident #1 reportedly traveled after exiting the facility. The route extended behind the facility through the employee parking area, along the side of the facility, and toward a heavily traveled two-lane public roadway. The area behind and beside the facility consisted primarily of paved surfaces, grassy areas, and uneven ground. Portions of the grass were maintained, while other portions were taller. Residential homes were located across the two-lane roadway, with a sidewalk on the opposite side. During the SA's observation, with ten (10) vehicles passing by within ten minutes traveling in both directions on the roadway. The route provided unrestricted access from the facility grounds to the public roadway, where Resident #1 was reportedly located approximately 0.2 miles from the facility at a stop sign near the intersection of two roadways.</p> <p>Record review of Weather Underground (weatherunderground.com) revealed that on 9/30/26, the recorded temperature in for the area at 10:55 AM was 87 degrees with no precipitation.</p> <p>Record review of the "Admission Record" revealed the facility admitted Resident #1 on 8/14/26 with diagnoses including Metabolic Encephalopathy and Dementia.</p> <p>Record review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/21/26, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score that was not completed because the resident was rarely or never understood.</p> <p>Record review of the "Elopement Evaluation" dated 8/14/26 revealed Resident #1 was identified as being at risk for elopement.</p> <p>Record review of the "Progress Note" dated 9/30/26 at 11:01 AM revealed the Director of Nursing (DON) was notified by the nurse that Resident #1 was missing from her room, and the resident's window was open with the screen pushed out. The facility initiated Code W (missing resident), conducted a head count of all residents, and initiated a search for Resident #1 by staff both inside and outside the facility. At 11:07 AM, Resident #1 was located with</p>	M0640					

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M0640	<p>Continued from page 4</p> <p>two unidentified individuals, sitting under a tree on her suitcase and drinking water. The Nurse Practitioner (NP) was notified and ordered Resident #1 to be transferred to the local emergency department for evaluation. A body audit was completed, with no redness, bruising, or open areas identified. At 11:48 AM, Resident #1 was transferred to the local emergency department.</p> <p>On 10/5/26 at 1:18 PM, during an interview with Licensed Practical Nurse (LPN) #1, she reported that on 9/30/26 at approximately 10:00 AM, she completed the required hourly visual check of Resident #1 and documented the check with her signature. LPN #1 confirmed Resident #1 routinely kept her room door closed. The LPN reported that at approximately 10:36 AM, Resident #1 opened her room door, looked into the hallway, and asked when she could go outside to smoke. The LPN informed Resident #1 that the next scheduled smoking time was 11:00 AM, approximately 24 minutes later.</p> <p>On 10/5/26 at 1:30 PM, during an interview with CNA #2, she reported that on 9/30/26 at approximately 11:00 AM, she went to Resident #1's room to escort the resident to her scheduled smoking break. The CNA observed Resident #1's room door was closed. Upon entering the room, the CNA discovered Resident #1 was not present. The CNA observed the resident's window was partially open, the window screen had been removed, and the resident's suitcase was no longer in the room. The CNA immediately notified LPN #1, who notified the DON, and the facility initiated Code W (missing resident). The CNA confirmed she last observed Resident #1 at approximately 10:30 AM on 9/30/26, when she informed the resident that her scheduled smoking break would occur in approximately 30 minutes. The CNA reported the only change in Resident #1's usual behavior she had observed was that the resident had been looking out her closed door more frequently.</p> <p>On 10/5/26 at 1:50 PM, during an interview with the Life Connection Aide, she reported that on 9/30/26 at approximately 11:00 AM, she went to Resident #1's room to escort the resident to her scheduled smoking break. Upon entering the room, she discovered Resident #1 was missing and observed the window open with the window screen removed. She reported that staff initiated a search for Resident #1 both inside and outside the facility.</p> <p>On 10/5/26 at 2:00 PM, during an interview with CNA #1, she reported that on 9/30/26 at approximately 10:30 AM, Resident #1 was observed</p>			M0640			

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M0640	<p>Continued from page 5</p> <p>in the dining room obtaining a snack before returning to her room and closing the door. The CNA confirmed that Resident #1 routinely closed her room door and that this behavior was not unusual. The CNA reported the only change she observed in Resident #1's behavior on 9/30/26 was that the resident repeatedly asked about the scheduled time for her smoking break.</p> <p>On 10/5/26 at 2:45 PM, during an interview with the DON, she confirmed Resident #1 was identified as an elopement risk on 8/14/26 and required hourly visual checks due to wandering and elopement risk. The DON reported that on 9/30/26 at approximately 11:00 AM, she was notified that Resident #1 was missing from her room and that the resident's window was open with the screen removed. The DON confirmed that Code W was initiated and staff immediately began searching inside and outside the facility. Resident #1 was located at approximately 11:07 AM, approximately 0.2 miles from the facility, without staff supervision. She stated the resident was appropriately dressed in a tee shirt, shorts, and was wearing tennis shoes. The DON confirmed that Resident #1 had exited the facility through her bedroom window without staff knowledge. She reported that Resident #1 was assessed upon return, with no injuries identified, and was transferred to the local emergency department for evaluation as ordered by the Nurse Practitioner (NP). The DON confirmed that following the incident, Resident #1 was placed on one-to-one supervision pending transfer to a behavioral health unit. The DON reported that the facility implemented immediate corrective actions, including installation of window alarms, restrictions on window openings, staff education on elopement procedures, reassessment of residents for elopement risk, care plan reviews, and elopement drills on all shifts.</p> <p>On 10/5/26 at 3:00 PM, during an interview with the Administrator, she confirmed that Resident #1 was identified as an elopement risk prior to the incident on 9/30/26 and required hourly visual checks. The Administrator reported that on 9/30/26 at approximately 11:00 AM, staff discovered Resident #1 was missing from her room, with the window open and the screen removed. She confirmed that Code W was initiated and staff immediately began searching inside and outside the facility. Resident #1 was located at approximately 11:07 AM, approximately 0.2 miles from the facility, without staff supervision. The Administrator confirmed that Resident #1 exited the facility through her bedroom window without staff knowledge and that the window could open approximately eight (8) inches at the time</p>			M0640			

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M0640	<p>Continued from page 6 of the incident. She reported that she and the DON assisted Resident #1 back to the facility, where she was assessed and subsequently transferred to the local emergency department for evaluation. The Administrator confirmed that following the incident, the facility conducted an emergency Quality Assurance and Performance Improvement (QAPI) meeting, completed facility-wide elopement risk assessments and care plan audits, provided mandatory staff education on elopement procedures, and initiated elopement drills on all shifts. She further confirmed that the facility restricted the unit windows to openings of approximately six (6) inches and installed window alarms on 10/1/26. The Administrator reported that staff received education on the operation of the window alarms and that ongoing audits were implemented to ensure the alarms remained functional. The Administrator confirmed that the facility expected staff to provide supervision and implement individualized interventions to prevent residents identified as elopement risks from leaving the facility without staff knowledge.</p> <p>Corrective Action Plan:</p> <p>On 9/30/2026 at 11:00 AM, the Life Connection Aide (LCA) identified that Resident #1 was not in her room and observed that the resident's window was open and the screen was removed. Code W was initiated, and Resident #1 was located at 11:07 AM by facility Certified Nursing Assistant #2 (CNA #2) approximately .2 miles from the facility.</p> <p>On 9/30/2026 at 10:30 AM, Resident #1 received hydration (water) and snacks from the Life Connection Aide.</p> <p>On 9/30/2026 at 10:30 AM, Resident #1 asked staff for cigarettes. Staff informed Resident #1 that her scheduled smoke break would occur in approximately 30 minutes.</p> <p>On 9/30/2026 at 10:40 AM, Certified Nursing Assistant #1 observed Resident #1 standing in the doorway of her room.</p> <p>On 9/30/2026 at 11:00 AM, the Life Connection Aide approached Resident #1's room to retrieve her for her scheduled smoke break. The Life Connection Aide observed that Resident #1 was not in her room and that the resident's window was open and the</p>			M0640			

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M0640	<p>Continued from page 7 screen was removed. The LCA immediately notified nursing staff that Resident #1 could not be located.</p> <p>On 9/30/2026 at 11:01 AM, the Licensed Practical Nurse (LPN) assigned to the unit notified the Director of Nursing that Resident #1 was not located on the unit.</p> <p>On 9/30/2026 at 11:02 AM, the facility initiated Code W through the facility's phone intercom system and verbal notification to staff. The facility initiated its elopement/missing resident protocols. Staff were directed to search the exterior perimeters of the facility while other staff conducted an internal search. The facility also started a head count to account for all residents.</p> <p>On 9/30/2026 at 11:07 AM, CNA #3 notified the Licensed Social Worker (LSW) that Resident #1 was located approximately 0.2 miles from the facility. Resident #1 was observed carrying a suitcase and water pitcher and walking with two unknown adults. Resident #1 was dressed appropriately for the weather. The temperature was approximately 85 degrees with clear skies. CNA #3 approached Resident #1, who became combative and aggressive, then sat down on her suitcase to drink some water.</p> <p>On 9/30/2026 at 11:22 AM, the Administrator and DON returned Resident #1 safely to the building. The Nurse Practitioner (NP) was notified and requested that Resident #1 be sent to the local emergency department.</p> <p>On 9/30/2026 at 11:24 AM, the DON completed an assessment of Resident #1 that revealed no apparent injuries. The resident's skin was intact, with no marks or injuries identified.</p> <p>On 9/30/2026 at 11:44 AM, facility staff completed the facility-wide head count and compared the results to the daily census. All residents were accounted for.</p> <p>On 9/30/2026 at 11:48 AM, the Administrator notified the SA of Resident #1's elopement.</p> <p>On 9/30/2026 at 11:48 AM, Resident #1 was sent to</p>			M0640			

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M0640	<p>Continued from page 8 the local emergency department for a full medical evaluation.</p> <p>On 9/30/2026 at 11:52 AM, the Maintenance Supervisor inspected the resident-accessible windows for proper functioning and potential means of exiting. The windows were found to function properly. Resident #1's window was able to open eight inches.</p> <p>On 9/30/2026 at 2:00 PM, the facility conducted an emergency Quality Assurance Performance Improvement (QAPI) meeting regarding Resident #1's elopement. Attendees included the Medical Director, Nurse Practitioner, Administrator, Director of Nursing, Infection Preventionist, Maintenance Supervisor, MDS, Certified Dietary Manager, Licensed Social Worker, Admission Nurse, Environmental Supervisor, Medical Records, and Director of Rehab. Based on the facility's investigation and staff interviews, the facility determined that Resident #1 exited the facility through the window in her room.</p> <p>On 9/30/2026 at 2:15 PM, the DON and Assistant Director of Nursing (ADON) initiated mandatory staff education regarding the facility's Elopement/Missing Resident and Abuse/Neglect Protocols. All staff were required to complete their education before returning to work.</p> <p>On 9/30/2026 at 5:54 PM, Resident #1 returned to the facility from the Emergency Room. The emergency department's discharge documentation identified that Resident #1 had a urinary tract infection, with skin intact.</p> <p>On 9/30/2026 at 5:54 PM, Resident #1 was placed on continuous one-on-one supervision by the Administrator and LSW while awaiting transport to Behavioral Health.</p> <p>On 9/30/2026 at 6:12 PM, the Administrator and LSW assisted Resident #1 with transportation to Behavioral Health for further behavioral health evaluation and treatment related to aggression and combativeness.</p> <p>On 10/2/2026 at 9:30 AM, the facility conducted a follow-up QAPI meeting to review Resident #1's</p>			M0640			

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M0640	<p>Continued from page 9 elopement, the facility's investigation, corrective actions, staff education, environmental interventions, audits, and ongoing monitoring. The facility determined that the corrective actions necessary to remove the Immediate Jeopardy had been implemented and completed on 10/02/2026. Attendees included the Administrator, DON, Infection Preventionist, Medical Director, Licensed Social Worker, Environmental Supervisor, Medical Records, Minimum Data Set Coordinators, Director of Rehab, Life Connection Coordinator, Admission Nurse, and Certified Dietary Manager.</p> <p>QAPI Minutes</p> <ul style="list-style-type: none"> · On 9/30/26, the QAPI committee reviewed Resident #1's elopement, the facility's response to the incident, corrective actions implemented, and the facility's Elopement/Missing Resident policy. The committee reviewed the policy and determined that no revisions were necessary. · On 9/30/2026, the ADON and Minimum Data Set Coordinators (MDS) completed a 100% audit of current residents' elopement risk assessments to ensure residents at risk for elopement were appropriately identified. · On 9/30/2026, the facility completed a 100% audit of care plans for residents identified as being at risk for elopement to ensure individualized interventions were in place, including visual monitoring and identification/alert armbands, as applicable. · On 9/30/2026, the LSW completed a 100% audit of the facility's wandering residents to ensure photographs and identifying information for residents at risk for elopement were current. · On 9/30/2026, the facility initiated mandatory education for all facility staff regarding the Elopement/Missing Resident policy and procedures. Staff were required to complete the education before returning to work. · On 9/30/2026, the facility restricted all resident-accessible windows on the Serenity Unit to prevent the windows from opening more than six inches to reduce the potential for resident egress through the windows. · Effective 9/30/26, the DON and ADON initiated elopement drills on all shifts. Elopement drills will continue on all shifts for four weeks, starting 9/30/2026 through 10/28/2026, and every two 			M0640			

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(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
M0640	<p>Continued from page 10 months starting 10/29/2026.</p> <ul style="list-style-type: none"> · On 10/1/2026, the facility installed window alarms on residents' room windows on the Serenity Unit. The Administrator and/or Maintenance Supervisor will audit the window alarms five days a week beginning 10/1/2026 through 10/28/2026 and every two weeks thereafter beginning 10/29/2026 to ensure the alarms remain in place and function properly. Any identified concerns will be addressed immediately. <p>QAPI Follow-Up Minutes</p> <ul style="list-style-type: none"> · The facility provided education to staff working in the affected area regarding the purpose and proper use of the window alarms and the requirement for staff to respond immediately to the location when an alarm sounds. A staff member will be instructed to complete a full head count of the unit. · Upon Resident #1's return to the facility, Resident #1 will be placed on continuous one-on-one supervision for 72 hours. The facility will reassess Resident #1 to determine whether continued enhanced supervision or additional interventions are necessary. · The facility will encourage residents identified as being at risk for elopement to participate in individualized and meaningful activities and will monitor the residents according to their assessed needs and care-planned interventions. · The facility completed an audit of staff education to verify staff received education regarding the Elopement/Missing Resident and Abuse/Neglect protocols. · The Administrator, DON, and Maintenance Supervisor will review all audits within the established monitoring time frames. The Administrator and Maintenance Supervisor will audit the window alarms five days per week for four weeks and every two weeks thereafter. The Maintenance Supervisor will inspect resident-accessible windows weekly to ensure the six-inch opening restriction remains in place and the windows continue to function as intended. Any identified concerns will be corrected immediately. · The facility revised its elopement response protocol to require a designated staff member from each unit to exit through the nearest designated exit and immediately search the exterior perimeter of the building when an elopement/missing resident alert 			M0640			

Mississippi State Department of Health

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M0640	<p>Continued from page 11 is initiated. Facility staff were educated regarding the revised elopement response procedure.</p> <p>· Review of the facility's policies, "Accidents and Incidents" and "Emergency Procedure-Missing Resident," revealed no changes were made.</p> <p>The facility alleges all actions were completed to remove the IJ on 10/2/2026, and the Immediate Jeopardy was removed on 10/03/2026, prior to the State Agency's entrance on 10/5/2026.</p> <p>Validation:</p> <p>The SA validated the removal plan through observations, interviews, and record reviews on 10/7/26, and the immediacy was removed on 10/3/26 prior to exit.</p>			M0640			