STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255243	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Billdora Senior Care	314 Enochs St Tylertown, MS 39667

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, the facility failed to ensure adequate supervision was provided to prevent an elopement from the facility for one (1) of four (4) sampled residents reviewed. Resident #1The facility's failure to provide adequate supervision resulted in Resident #1 leaving the facility unnoticed and unsupervised on 1/20/26. This placed Resident #1 and all other residents who are at risk for wandering in a situation that is likely to cause serious injury, serious harm, serious impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 1/20/26 when Resident #1 eloped from the facility. The facility Administrator was notified of the IJ on 1/28/26 at 6:00 PM and was presented with the IJ template. The facility provided an acceptable removal plan on 1/29/26, in which they alleged all corrective actions to remove the IJ were completed on 1/20/26.The SA validated the Corrective Action Plan on 1/29/26 and based on the implementation of the corrective actions completed by the facility on 1/20/26 the SA determined the IJ and SQC to be past non-compliance (PNC) and the IJ was removed on 1/21/26 prior to the SA's entrance on 1/28/26.Findings Include:Record review of the facility policy titled, Elopements and Wandering Residents dated 2025 revealed This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents.Policy Explanation and Compliance Guidelines.1. The facility is equipped with door locks/alarms to help avoid elopements.3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks.4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering.c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.d. Adequate supervision will be provided to help prevent accidents or elopements.Review of the admission Record for Resident #1 revealed the facility admitted the resident on 1/19/26 with diagnoses that included dementia and delusional disorder and hallucinations.Record review of the admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 1/26/26 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Section E indicated Resident #1 had a history of wandering. Section GG indicated Resident #1 was able to walk independently for one hundred fifty (150) feet.Record review of the admission History and Physical for Resident #1 dated 11/24/25 revealed History of Present Illness.history of dementia with agitation and psychosis.being seen in his home and meets homebound criteria due to difficulty leaving home without assistance.Aggressive behaviors and irritability have been noted, particularly in relation to attempts to cross the street. Agitation occurs when unable to perform desired activities, such as going across the (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	road.Safety issues discussed with daughters. Recommend getting a second lock on all doors where you need a key to exit doors to avoid patient wandering and leaving the house.Dementia.with psychotic disturbance.Record review of the admission physician orders for Resident #1 dated 1/19/26 revealed the resident had order for monitoring Wandering & elopement X (for) 14 days.Record review of the Order Summary Report dated 1/28/26 for Resident #1 revealed an active order with start date 1/19/26 for Monitor Behavior every shift for.anxious/Restless.Pacing; Other. Record review of the Progress Notes for Resident #1 dated 1/20/26 11:57 AM revealed Licensed Practical Nurse (LPN) #1 documented, At approximately 10:35-10:40 AM resident was visually observed sitting on side by this nurse. At approximately 11:30-11:40 AM staff were getting lunch ready for resident and noted that he was not in his room. Staff attempted to search in facility for resident but were unable to locate and floor nurse notified the DON (Director of Nursing). At 11:52 Code [NAME] was called overhead. Building was searched and outside areas. At 11:55 AM resident was located. At 11:57 AM resident returned to facility.On 1/29/26 at 3:39 PM, during a telephone interview the Resident Representative of Resident #1 stated that she was notified by LPN #1 on the morning of 1/20/26 that Resident #1 had exited the facility unaccompanied and unsupervised and had been located by staff and returned to the facility.On 1/28/26 at 11:15 AM, during an interview, the Administrator stated that on 1/20/26 she was notified by the DON at approximately 11:42 AM she was notified by announcement of Code [NAME] via the overhead speaker and that all staff responded appropriately according to the facility missing resident procedure. She stated that the resident was located by the Maintenance Technician 0.5 miles (half mile) from the facility and returned him to the facility. She stated that following the incident she was able to review security camera footage and observed the Dietary Aide assisting Resident #1 with the front door and Resident #1 exited the front door. She stated that she notified all appropriate agencies according to state and federal requirements and completed an investigation which revealed that the Dietary Aide confirmed that she had observed Resident #1 at the front door at approximately 11:45 AM, did not know who he was, and disengaged the lock on the front door by entering the numeric code into the wall-mounted keypad next to the front door for Resident #1 to exit unaccompanied and unsupervised. She confirmed that the facility had procedures in place that included monitoring for wandering and elopement for newly admitted residents, and staff-confidential numeric codes required to open all exit doors, which were monitored routinely by the maintenance staff. She confirmed that the facility had no two-part (resident worn monitor and corresponding door monitor) safe wandering system. On 1/28/26 at 12:00 PM, observation and interview revealed Resident #1 was resting on his bed in his room with staff present for one-on-one supervision. The resident was alert and oriented to self and able to communicate well verbally but unable to explain the 1/20/26 elopement.On 1/28/26 at 12:10 PM, during an interview, Registered Nurse (RN) #1 stated she was the assigned Unit Manager for Resident #1 on 1/20/26. She confirmed she received in-service training related to missing resident and elopements and participated in elopement drills since the 1/20/26 incident. She confirmed that she, LPN #1, the DON and the residents' primary physician had assessed and evaluated the resident upon return to the facility with no injury noted and one-on-one supervision was initiated and continued for Resident #1, as well as use of an elopement risk band placed on the resident's left wrist. She stated the weather on 1/20/26 had been clear, cool and fair and that the resident had been wearing black jeans, a plaid button-up shirt, black socks and slip-on athletic-casual loafers with a rigid sole.On 1/28/26 at 12:15 PM, during an interview LPN #1 stated that he was familiar with Resident #1 and his care and that he had been on duty and responsible for the care of Resident #1 on 1/20/26 dayshift (6:00 AM through 6:00 PM). LPN #1 explained that the resident was admitted by the facility on 1/19/26 and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	weather condition was fair.Immediacy Removal Plan:Incident10:40 A.M. On 01/20/26, newly admitted resident #1 was observed by Licensed Practical Nurse (LPN) #1 sitting on the side of his bed in his room.11:40 A.M. Certified Nursing Assistant (C.N.A.) #1 was unable to locate resident #1.Immediate Action taken on 1/20/202611:40 AM CNA #1 notified LPN #2 that she could not locate the resident.11:41 AM LPN #1 notified Director of Nursing that the resident was missing.11:41 AM Code [NAME] initiated by Director of Nursing11:42 AM Administrator notified immediately by Code Adam11:43 AM Physician notified by Administrator11:43 AM Resident representative notified LPN #211: 45 AM LPN #1 head count to ensure all other residents were accounted for11:45 AM All staff began an search of the facility.11:48 AM Dietary Aide reported to Dietary Manager who reported to LPN #1 she may have mistakenly allowed the resident to exit the building.11:49 AM Search expanded outside the facility with Maintenance staff assigned to search by vehicle11:55 AM Maintenance Technician located the resident sitting outside a local business 0.5 mile from facility. Resident stated that he was on his way to the high school to a basketball game.11:57 AM Resident returned safely to the facility by Maintenance Technician.11:58 AM Physician assessed and evaluated Resident #1 with no injury noted.11:58 A.M. LPN #1 performed a full body audit with no injury.11:59 AM Pain Assessment performed by Registered Nurse (RN) #1 with no pain verbalized.12:00 Noon Resident#1 placed on 1:1 monitoring upon return.12:01 PM Resident #1 reassessed for wander and elopement risk by RN #1 scoring moderate risk for elopement12:05 PM Care plan updated by Minimum Data Set (MDS) coordinator to include one-on-one (1:1) monitoring12:15 PM Maintenance Supervisor assured all doors where functioning properly12:15 PM Director of Nurses and MDS Coordinator and Quality Assurance Nurse performed audit on 43 residents to identify risk for wandering and elopement. Four other residents continue to be at risk for wandering and elopement1:00 PM Administrator called the Mississippi State Department of Health Hotline to report the event and reported on Attorney General Medicaid Fraud Site.1:15 PM Wonder and Elopement Binder was reviewed by Director of Nursing and Quality Assurance RN for updated risk assessment and current photo for five residents1:15 PM Updated Colored Signage signaling to check with nursing before allowing anyone out the door was completed by Staff Development Nurse.1:15 PM Dietary Aide suspended pending investigation and then terminated by AdministratorQuality Assurance Committee:Quality Assurance Performance Improvement (QAPI) conducted an emergency meeting on 1/20/2026 at 1:00 PMA Quality Assurance Performance Improvement (QAPI) Committee was held on 1/20/2026 at 1:00 PM with the following staff in attendance: Administrator, Business Office Manager, Infection Preventionist, Social Services Director, MDS Coordinator, Maintenance/Housekeeping Director, Medical Director, Certified Occupational Therapist, Director of Nursing, Activity Director, Dietary Manager, and Staff DevelopmentRoot Cause Analysis: The Dietary Aide tapped in the code to the door and allowed the resident to walk out the door without following resident-identification protocols.EducationStaff Development Nurse and Director of Nursing started on 1/20/2026 and ending on 1/21/2026. educating all staff on Elopement and Wandering Residents Policy, Code [NAME] Policy, Identifying Residents at Risk for Elopement, Resident Identification Protocols, Conducted Elopement Drills on each shift. All staff educated on the above in services prior to beginning their shift.MonitoringBeginning 1/22/26 the Staff Development Coordinator and DON will monitor the competency of education regarding wandering and wandering risk and safety awareness of staff using knowledge testing of three staff members five days weekly for two weeks, then two staff members three days weekly for two weeks, then one staff member weekly for one month, then one staff member monthly for three months.Beginning 1/22/26 the Social Services Director will monitor the Elopement Binder to ensure each resident assessed as at risk for elopement has a current photograph and up to date risk assessment in the binder daily, five times weekly.Beginning 1/22/26 the Social (continued on next page)

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