STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER Billdora Senior Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, record review and facility policy review the facility failed to provide sufficient pain medication prior to wound care for a resident who moaned and yelled out during wound care for one (1) of two (2) wound care observations. Resident #1Findings Include:Policy review of facility's policy Pain Management dated 2025 revealed the facility should provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental and psychosocial well-being. Behavioral signs and symptoms they may suggest the presence of pain include but are not limited to facial expressions grimacing, groaning.On 04/08/2026 at 9:02 AM, during an observation of wound care being provided by Registered Nurse (RN) # 1/Treatment Nurse and was assisted by RN #2/Infection Preventionist (IP) nurse, RN #1 informed the State Agency (SA) that Resident # 1 moans out during wound care. She stated they gave her Tylenol thirty minutes prior to starting wound care. Resident #1 was turned on her side, and the soiled dressing was removed. RN #1 began to clean the wound with normal saline and Resident #1 yelled out it hurts. Resident #1 displayed facial grimaces, moaning and yelling out during the entire wound care process. RN #2 tried to console the resident by rubbing her hand and talking to her. RN#1 cleaned the wound several times, discarding gauze after each wipe. Resident #1 continued moaning and hollering out with every wipe applied to the wound. The SA asked again what time the nurse administered pain medication. RN #1 replied over 30 minutes ago and continued with the care. Each time RN #1 wiped the wound the resident moaned and yelled with facial grimaces. Record review of Resident #1's Weights and Vitals Summary dated 4/08/26 indicated a pain level of (4) and the resident was given Tylenol at 8:52 AM and wound care began at 9:02 AM.On 04/08/26 at 10:13 AM, in an interview with RN #1 she stated Resident #1 is confused and cannot verbalize pain. She stated resident was recently hospitalized and returned to the facility Sunday. She stated she did wound care on Resident #1 on Monday and Tuesday. She stated wound had declined when she came back from the hospital. She stated Resident #1 always moans and hollers doing wound care. She stated she does not think cart nurses gave resident pain medication prior to wound care for the last three months. She stated she did not give her any pain medication prior to wound care these past three months. She stated when she initially started doing resident wound care three months ago, the resident would holler out and moan. She stated she would stop and ask resident if she was in pain and Resident #1 would respond no. She stated she did not have an order for pain medication. She stated she did not contact the physician for pain medication prior to providing wound care these past three months. She confirmed that resident was moaning and yelling out in pain and she did not get an order. She stated the physician wrote an order yesterday for routine Tylenol. She stated she should have called and got an order for pain on Monday. She stated Resident was hollering out Monday and Tuesday and she did call them to get an order. She stated she asks the resident if she is in pain. She stated Resident cannot rate pain on a scale. She stated from a nurse's perspective, a resident with a stage 3 wound would need pain medication prior to receiving wound care.On 04/08/26 at 10:51 AM, during an interview Licensed Practical Nurse (LPN)#1 stated he is Resident #1's nurse today. He stated he gave Resident #1 Tylenol around 8:50 AM. He stated Resident #1 cannot verbalize needs and wants. He stated from a nurse's point of view he would give resident pain medication before providing wound care for stage (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 0697 Level of Harm - Actual harm Residents Affected - Few	3 wound.On 04/08/26 at 10:59 AM, in an interview with RN #2/IP nurse confirmed Resident #1 was moaning and hollering out during wound care. She confirmed that a stage 3 wound or higher should have pain medications before wound care is provided every time.On 04/08/26 at 3:00 PM, during an interview the Director of Nursing (DON) confirmed she would have given pain medication due to resident interview or signs and symptoms of pain. She stated Resident #1 has declined and was admitted with a stage 3 sacrum wound. She stated based on Resident #1's assessment staff should give some type of pain medication. She stated if there was no order, the nurse should have contacted the physician for a pain medication order. She stated her expectations of nurses is to use their judgement and stop wound care treatment for pain/discomfort and then continue with wound care after treatment with pain medication.On 04/09/2026 at 9:15 AM, in an interview with Certified Nursing Assistant (CNA) #1 stated she has assisted RN #1/Treatment nurse with wound care for Resident #1. She stated Resident #1 will moan and yell out it hurts when the nurse provides wound care. She stated the nurse would stop for a few minutes and continue with wound care.On 04/09/2026 at 11:34 AM, in an interview the physician acknowledged that the wound looks bad, not healing and the wound is painful. She stated the wound is worsening and Resident #1 required more medication than Tylenol. She stated she sees the resident once a month and has seen the wound. She stated she cannot recall if she ordered any pain medication prior to the Tylenol. She stated she switched the pain medication on 4/9/26 so resident would not be in pain during wound care.On 04/09/2026 at 12:30 PM, in an interview with the DON she confirmed that the vital pain level assessments dating back to November 2025 - April 8,2026 revealed multiple dates in that time frame where the resident was documented as having experienced pain. She stated that it was documented and present and staff must not have done anything about it. She stated that the process for assigning a pain score 0-10 to the resident in this case requires the nurse to utilize a face tool such as Wong-Baker score where the nurse chooses a facial grimace severity indicating pain that corresponds with a numerical value (0-10) on the Medication Administration Record (MAR) since the resident was unable to verbalize a numeric value for pain.Record review of Resident #1 admission Record revealed an admission date of 11/26/25 with diagnoses that included pressure ulcer of sacral region stage 3. Record review of the Order Summary Report with active orders as of 4/8/26 revealed a physician order dated 4/7/26 for Stage 3 to sacrum: Cleanse with normal saline, pat dry, apply collagen pad and calcium alginate to wound bed. Apply betadine to peri wound skin. Cover with silicone border dressing qd (every day) and prn (as needed) for soilage every day shift related to Pressure Ulcer of Sacral Region Stage 3.A record review of the Order Summary Report dated November 2025 through April 8, 2026, revealed there was no pain medication ordered prior to 4/8/26.Record review of the Order Summary Report with active orders as of 4/8/26 revealed an order dated 4/8/26 for Acetaminophen Oral Tablet 500 mg (milligrams). Give 2 (two) tablets via (by way of) PEG (Percutaneous Endoscopic Gastrostomy) tube every 6 hours as needed for pain.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/24/26 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicates the interview was not completed or was unable to be completed. Section J revealed Resident #1 did not receive pain medication. Section M revealed Resident #1 had a Stage 3 pressure ulcer.A record review of the Electronic Medication Administration Record (EMAR) from November 26, 2025, to April 7, 2026, revealed no pain medications were given.Record review of the Pain Assessment dated 11/25/25 revealed Should Pain Assessment Interview be Conducted? The response was marked Yes.Record review of Resident #1's Pain Assessment dated 12/3/25, 2/16/26 and 2/24/26 revealed Should Pain Assessment Interview be Conducted? The response was marked No.Record review of Resident #1 Wound Weekly Observation Tool dated 3/31/26 revealed sacrum wound granulation tissue present beefy red. Length (L) 0.7 centimeters (cm), Width (W) 0.3 cm, Depth (D) 0.1 cm. No drainage.Record review of Resident #1 Wound Weekly Observation Tool dated 4/7/26 revealed sacrum wound granulation tissue present beefy red. L 3.8 cm, W 1.8cm, D 0.1 cm. Small amount of serosanguinous drainage.Record review of Resident #1's Weights and Vitals Summary dated 1/1/26 through 4/8/26 (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	revealed Resident #1 complained of pain on 01/12/26 at a pain level was a five (5), on 01/14/26 pain level was a four (4), on 01/16/26 pain level was a (5),on 03/10/26 pain level was a (5), on 03/14/26, pain level was a six (6), on 03/24/26 pain level was a three (3) with no documentation in the medical record pain medication was administered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, and facility policy review the facility failed to ensure staff followed proper hand hygiene and Enhanced Barrier Precautions (EBP) during wound care and peri care for one (1) of two (2) sampled residents reviewed for pressure ulcers. Resident #1. Findings Include:Record review of the facility policy Hand Hygiene Policy dated 2025 revealed, Policy: Staff involved direct contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors.Record review of the facility policy Enhanced Barrier Precautions undated, revealed Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.4. High-contact resident care activities include.d. Providing hygiene.f. Changing briefs or assisting with toileting.On 04/08/2026 at 9:02 AM, during an observation of wound care, provided by Registered Nurse (RN) 1/Treatment Nurse and assisted by RN #2/ Infection Preventionist (IP) nurse. RN #2 donned (put on) a gown but did not don gloves prior to touching the feeding pump. RN #2 did not perform hand hygiene prior to applying gloves. RN #1 removed gloves, left room to retrieve a bag off the cart. She returned to the room and donned gloves and did not perform hand hygiene prior to applying gloves. After cleaning the wound she stated, I forgot to bring hand sanitizer in the room. She removed gloves and went to the cart to get hand sanitizer. The cart was parked in front of the door. She returned to the room with hand sanitizer. She applied sanitizer to hands. She opened normal saline and poured it on the gauze from the bottle into the gauze. RN #2 nurse told RN #1l to stop, you messed up you need to pour the saline in a cup on the gauze. RN #1 stopped removed gloves and went to get a cup and placed gauze and a cup and statured the gauze. She did not sanitize hands after removing gloves. She returned to the room to perform hand hygiene, donned gloves and continued to clean the wound. RN #1 finished up wound care, and they stated we need to do perineal (peri) care. RN #1 removed gowns and gloves and exited room to gather supplies for peri care. RN #1 returned to the room and started to do peri care in the buttocks area. RN #1 did not apply for a gown prior to starting peri care.On 04/08/26 at 9:38 AM, in an interview with RN #1/Treatment nurse confirmed that she had to leave the room several times due to not having all supplies needed for care. She confirmed that she did not have a gown when she provided peri care. She stated she should have had a gown on prior to peri care. She confirmed that doing care she had forgotten to sanitize her hands a couple of times. She stated she placed the resident at higher risk for infection by not wearing a gown and washing hands every time during wound and peri care. She stated the resident has an open wound and could get infected.On 04/08/26 at 10:59 AM, during an interview with RN #2/IP nurse stated she did not realize RN #1 did not wash her hands a couple of times during wound care. She confirmed she did not wash her hands after placing pump on pause. She stated Resident #1 had a higher risk of infection from RN #1 not wearing a gown during peri care. She stated she did not realize RN #1 had taken the gown off to get peri care supplies. She stated that it is a contamination issue.On 04/08/26 at 3:00 PM, during an interview with the Director of Nursing (DON), confirmed that RN #2/IP should have washed her hands before applying gloves to assist with wound care. She stated RN#1 /Treatment Nurse should have worn a gown doing peri care. She stated the proper technique is to wash or sanitize hands before applying gloves. She stated RN #1/Treatment Nurse should have donned a gown for EBP during direct care. She stated that peri care is direct care. She stated she expects staff to wear gowns when providing care to residents who are on EBP. She stated she expects staff to follow protocol standards for infection control aspects of it. Record review of Resident #1 admission Record revealed an admission date of 11/26/25 with diagnoses that included pressure ulcer of sacral region stage 3. Record review of the Order Summary Report revealed an order for treatment to a Stage 3 to the sacrum: Cleanse with normal saline, pat dry, apply collagen pad and calcium alginate to wound bed. Apply betadine to peri wound skin. Cover with silicone border dressing every day and as needed for soilage, every day shift related to pressure ulcer of sacral region stage (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/24/26 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the interview was not completed or was unable to be completed. Section J revealed Resident #1 did not receive pain medication. Section M revealed a stage 3 pressure ulcer.