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 _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLDORA SENIOR CARE	314 ENOCHS ST TYLERTOWN, MS 39667

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 03/03/2025 through 03/06/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F576, F584, F623, and F695. The facility had a census of 56 and was licensed for 60 beds.	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent	F 576		4/6/25

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

Electronically Signed | 03/20/2025

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.

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F 576	Continued From page 1 with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on facility policy review, interviews, and record review, the facility failed to provide residents with mail on Saturdays for one (1) of (17) sampled residents, Resident #25. Findings included: A record review of the facility policy "Communications Within and External to the Facility" revised in August 2024, revealed, "The facility will protect and facilitate the resident's right to communicate with individuals and entities within and external to the facility. The facility will ensure the resident has the ability to ...receive mail, letters, packages, and other materials delivered to the facility ..." On 03/04/2025 at 10:10 AM, during a resident council meeting, members stated that residents in the facility does not receive mail on weekends. On 03/04/2025 at 10:20 AM, during an interview, the facility Administrator stated that the Activities	F 576	F576 1. Charge Nurse was assigned on 3/5/2025 to collect the mail from the front desk mailbox on Saturday. The Charge Nurse will sort the mail by resident names and deliver directly to resident's room. The Charge Nurse will record mail delivery using the Weekend Mail Delivery Log. 2. All Residents receiving mail on Saturday have the potential to be impacted by this deficient practice. 3. Charge Nurse was in serviced by Administrator on 3/5/25 on Saturday mail delivery. All Staff in serviced on weekend mail delivery on 3/14/25 by the Staff Development Nurse. 4. Weekend Mail Delivery Log will be monitored by Administrator on Mondays	

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F 576	Continued From page 2 Director distributes mail during the weekdays. The Administrator further stated that the front desk receptionist, nurses, or Certified Nurse Aides (CNAs) distribute mail on weekends when it is received at the front desk. The Administrator suggested that Resident #25 be interviewed, as she consistently receives mail. On 03/04/2025 at 10:27 AM, during an interview, Resident #25 stated that she never receives mail on weekends. She stated that even if mail arrives on the weekend, it is stored in the front office, and the Activities Director delivers it to her on Mondays. Resident #25 stated that no CNA or nurse has ever brought her mail on weekends. On 03/04/2025 at 10:22 AM, during an interview, the front desk receptionist stated that she does not work on weekends. She stated that nurses and CNAs usually retrieve the mail and distribute it on weekends. On 03/04/2025 at 10:30 AM, during an interview, Licensed Practical Nurse (LPN)# 1 stated that she was unaware of who retrieves the mail on Saturdays and distributes it to residents. LPN #1 stated that she had never delivered mail on weekends and had never seen any residents receive mail on Saturdays. On 03/04/2025 at 10:35 AM, during an interview, CNA #1 stated that she did not know what happens with mail on weekends. She stated that she had never been instructed to retrieve mail from the front office or distribute it to residents on weekends. On 03/04/2025 at 10:47 AM, during an interview, the facility's Social Services Director stated that	F 576	beginning on 3/10/2025 for four weeks, then monthly for three months, then quarterly for six months to ensure compliance. The Results of these audits will be reviewed by the Quality Assurance Performance Improvement Committee on 3/27/25 and then monthly for twelve months and changes will be made as needed to ensure compliance. Residents will be encouraged to report any concerns regarding mail delivery to the charge nurse or through the resident council.	

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F 576	Continued From page 3	F 576		

the Activities Director distributes residents' mail Monday through Friday but was unsure who distributed mail on weekends.

On 03/04/2025 at 10:53 AM, during an interview, Activities Staff #1 stated that she distributes residents' mail Monday through Friday. She stated that the charge nurse is responsible for distributing mail on weekends when she is not there. However, she stated that when she arrives on Mondays, packages are often waiting in the office to be distributed.

On 03/04/2025 at 11:01 AM, during an interview, Registered Nurse (RN)# 1 stated that she had never distributed mail on weekends. She further stated that, to her knowledge, if mail is delivered to the facility on the weekend, it is stored in the front office until it is distributed on Monday.

On 03/04/2025 at 11:05 AM, during an interview, the Director of Nursing (DON) stated that Activities Staff #1 distributes the mail during the week. When asked who delivers mail on weekends, the DON stated that she assumed it would be distributed by social services or activities staff. The DON confirmed that nurses and CNAs do not retrieve or distribute mail on weekends.

A record review of Resident #25's "Admission Record" revealed an admission date of 05/10/2017 with a diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side.

A record review of Resident #25's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/2024 revealed a Brief Interview

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F 576	Continued From page 4 for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 576		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information	F 585		4/6/25

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of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a

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F 585	Continued From page 6 summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review the facility failed to provide prompt resolution of a grievance related to a resident's missing property for one (1) of (17) sampled residents. Resident #22. Findings included: A review of the facility's policy titled "Missing Property," dated 4/17, revealed "It is the policy of the facility to safeguard resident' property (to the extent possible) to assure there is no misappropriation...." On 03/03/25 at 12:24 PM, in an interview, Resident #22 stated that a Saints jersey was missing from her closet. She was unsure when it went missing. She reported that Social Services (SS) initially told her they would order a	F 585	F 585 1.Administrator ordered a Saints Jersey on 3/4/2025 for resident #22. 2.Residents who reported missing property have the potential to be affected by this deficient practice. 3.Regional Administrator in serviced Administrator and the Grievance Official, Social Services Director on 3/4/2025 on the facility policy and procedure on Missing Property. On 3/18/2025 Staff Development Nurse in serviced all staff on the Missing Property policy and the location of Missing Property Forms. 4.Beginning on 3/10/2025 Administrator	

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F 585	Continued From page 7	F 585		

replacement jersey but later informed her in January 2025 that they would need to reorder it. She further stated that SS told her they would check on the status of the jersey but never followed up with her.

On 03/04/25 at 1:10 PM, in an interview, SS stated that she typically completes a grievance when residents report missing items. She confirmed that Resident #22 had reported her missing jersey late in 2024, during football season. She stated she completed a grievance but acknowledged that there was no record of the grievance in the grievance book. She further stated that she discussed the issue with the Nursing Home Administrator (NHA) and that the plan was to replace the jersey. The last time she spoke with NHA about the issue was at the end of 2024.

On 03/04/25 at 1:22 PM, in an interview, NHA stated she planned to contact the resident's family to verify that Resident #22 owned a Saints jersey. She stated the resident never reported the missing jersey to her directly, but that SS had informed her about it. She confirmed she had not yet contacted the family for verification but planned to order a replacement jersey in size 2XL (extra large). However, she acknowledged that she had not verified Resident #22's size before placing the order.

On 03/04/25 at 2:03 PM, in a phone interview, Resident #22's Resident Representative (RR) stated she was informed by both the resident and SS about the missing jersey. She stated the incident occurred late last year and assumed the facility had already replaced it. She confirmed that SS had contacted her and that she verified the

and Social Services Director will review all Missing Property Forms weekly times four weeks, then monthly for three months, reviewed by the Quality Assurance Performance Improvement Team on 3/27/2025 and then monthly for twelve months and changes will be made as needed to ensure compliance.

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F 585	Continued From page 8 jersey was missing. She also confirmed that the jersey was not at the resident's home. On 03/06/25, in a follow-up phone interview, the RR stated that a 2XL jersey would not fit Resident #22. She expressed concern that the facility did not contact her to confirm the appropriate size before ordering the replacement. A record review of Resident #22's inventory sheet, dated 11/25/24, documented the presence of one Saints jersey with #9 and "Brees" on it. A record review of Resident #22's Admission Record revealed an admission date of 07/15/21 with diagnoses including Major Depressive Disorder. A record review of Resident #22's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		3/28/25

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accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which

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receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as

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F 623	Continued From page 11 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notification of the reason for a resident's hospital discharge to the resident and/or Resident Representative (RR) for one (1) of (1) residents reviewed for hospitalization (Resident #18). Findings include: A record review of the "Admission Record" revealed the facility admitted Resident #18 on 6/10/24, with diagnoses including Acute Respiratory Failure with Hypoxia and Acute Systolic Congestive Heart Failure. A record review of the transfer/discharge letter dated 1/9/25 revealed the Resident was discharged to the hospital on 1/8/25, however, the letter did not provide a reason for the transfer/discharge. On 03/04/25 at 1:07 PM, in an interview with the Social Service Director, she confirmed it was her role to mail hospital transfer/discharge letters to the family. She stated she was not aware that the letter was required to include the reason for the transfer/discharge and confirmed with the State Agency (SA) that the letter sent to the RR for Resident #18 did not include this information. On 03/04/25 at 1:22 PM, in an interview the Administrator, stated she was not aware of any regulation requiring the facility to include the written reason for the transfer/discharge in the	F 623	1. Representative of Resident #18 was mailed notification of transfer to hospital in writing by the Social Services Director on 1/9/2025 with reason stating an immediate transfer or discharge is required by the resident□s urgent medical needs. Resident Representative was notified via phone by Nursing of resident□s condition and specific medical needs at time of transfer with understanding voiced. A revision of the Notice of Resident Transfer or Discharge was made on 03/7/25 to provide additional space for inclusion of the specific urgent medical need requiring transfer to hospital. 2. The facility has determined that all residents who have been transferred or discharged have the potential to be affected. 3. A revision of the Notice of Resident Transfer or Discharge was made 3/7/25 to provide additional space for inclusion of the specific urgent medical need requiring transfer to hospital. An in-service education program was conducted by the Corporate Nurse Consultant with the Social Services Director on 3/10/25 addressing circumstances regarding required notices for residents upon transfer and discharge from the facility and inclusion of the specific urgent	

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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
F 623	Continued From page 12 letters sent to the Responsible Party. She stated she believed that doing so would be a violation of the Health Insurance Portability and Accountability Act (HIPAA).	F 623	medical need. 4. An audit of all residents who have been transferred or discharged from the facility will be done weekly x 4 weeks beginning 3/10/25 by the Medical Records Nurse to ensure the Resident and/or Resident Representative was notified in writing of the transfer/discharge and the reason for the transfer/discharge. Monitoring will continue monthly x 3 months to ensure compliance. Results of audit findings will be reviewed and monitored at the Quality Assurance/Performance Improvement meeting on 3/27/25 and monthly for four months. Changes will be made as needed until such time consistent substantial compliance has been met.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure a resident requiring oxygen therapy had an "Oxygen in Use" sign placed on the resident's door as specified in the facility policy for one (1)	F 695	1. Oxygen in use sign placed on door of resident #107 on 3/3/25 by Licensed Practical Nurse #1. 2. All residents receiving oxygen has the	3/28/25

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 _____	03/06/2025

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F 695	Continued From page 13 of four (4) days of survey observations. (Resident #107). Findings Include: A record review of the facility's "Oxygen Concentrator" policy, revised April 2017, revealed Policy: To administer oxygen for the treatment of certain diseases or conditions. Policy Explanation and Compliance Guidelines: 1. Care of the Resident... h. Place an oxygen warning sign on the resident's door..." On 03/03/25 at 11:30 AM, an observation of Resident #107 in her room, up in a wheelchair, revealed that oxygen was flowing at 3 milliliters per hour. However, there was no "Oxygen in Use" signage on the door. On 03/03/25 at 11:32 AM, during an interview, Licensed Practical Nurse (LPN)#1 confirmed that there was no oxygen signage on the door. She stated that an "Oxygen in Use" sign should have been placed on the door upon admission on 2/17/25 to alert staff and visitors not to enter with flammable materials. On 03/05/25 at 11:45 AM, during an interview, the Director of Nursing (DON) confirmed that oxygen signage should have been placed on the door. She stated that the purpose of the signage is to alert staff and visitors that oxygen is in use to prevent fire hazards. A record review of Resident #107's "Admission Record" revealed an admission date of 2/17/25 with diagnoses including Dysphagia and Shortness of Breath.	F 695	potential to be affected. 3. Record review of all residents, as well as room checks of all residents were completed by Quality Assurance Nurse and Director of Nursing Services on 3/3/25 to identify residents with oxygen. Doors of all residents receiving oxygen was checked on 3/3/25 by Quality Assurance Nurse and Director of Nursing Services to ensure oxygen in use signs were in place. Staff Development Nurse initiated education to all nursing staff on 3/6/25 addressing the significance of alerting staff and visitors when oxygen is in use to prevent fire hazard as oxygen has the potential to be flammable. 4. Quality Assurance Nurse and/or Director of Nursing Services will monitor all residents receiving oxygen for presence of "Oxygen in Use" sign on door beginning on 3/4/25 five times a week for three weeks, then monthly for three months. Results of monitoring will be reported to the Quality Assurance Performance Improvement Committee on 3/27/25 then monthly for three months. Changes will be made as needed and determined by the committee to ensure and sustain substantial compliance.	

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F 695	Continued From page 14 A record review of Resident #107's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/24/25 revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview.	F 695		