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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLDORA SENIOR CARE	**314 ENOCHS ST , TYLERTOWN, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #2722686) at the facility from 1/28/26 through 1/29/26. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated Complaint/Incident# 2722686 for Accidents/Elopement and cited F689 at Immediate Jeopardy (IJ) with Substandard Quality of Care (SQC), Past Noncompliance, when facility staff failed to provide adequate supervision for Resident #1 resulting in the elopement of the resident. The facility failed to prevent Resident #1, a newly admitted, cognitively impaired, vulnerable resident at risk of wandering and elopement from exiting the facility on 1/20/26 through the front door with no supervision. The facility staff opened the door for the resident to exit and leave unaccompanied and unsupervised. The resident was found by staff approximately eleven (11) minutes later, approximately 0.6 miles away from the facility. The facility failed to ensure Resident #1 was adequately supervised to ensure vulnerable residents did not exit the facility unsupervised. The 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. The IJ and SQC existed at: CFR 483.25(d)(2) Accidents/Hazards - F689 - Scope/Severity "J" The facility Administrator was notified of the IJ and SQC on 1/28/26 at 6:00 PM and was presented with the IJ Template. The facility provided an acceptable Corrective Action Plan on 1/29/26, in which they alleged all corrective actions to remove the IJ and SQC were completed on 1/20/26 prior to SA entrance on 1/28/26, and the IJ	F0000		

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 reverse for further 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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F0000	Continued from page 1 removed on 1/21/26. 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 and the IJ was removed on 1/21/26 prior to the SA's entrance on 1/28/26. The facility had a license for 60 beds, with a census of 45 residents.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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 #1 The 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	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = SQC-J	Continued from page 2 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 road…Safety issues discussed with daughters. Recommend	F0689		

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F0689 SS = SQC-J	Continued from page 3 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 Adam 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 Adam” 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	F0689		

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F0689 SS = SQC-J	Continued from page 4 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 during the morning of 1/20/26 had been observed walking in the hallway and in his room. He stated that he had personally observed the resident sitting on the side of his bed at approximately 10:35 AM, and the resident had later walked to the nurse's station. He explained that at approximately 11:40 AM, Certified Nurses' Aide (CNA) #1 had reported that she could not locate the resident to serve his lunch. LPN #1 said that following a quick (one to two minute) search, the Director of Nurses (DON) was notified that the resident was missing and the DON announced a "Code Adam" (missing resident) via the overhead speaker, which summoned all staff to the nurses station where they were told the identity of the missing resident and provided with instructions. He	F0689		

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F0689 SS = SQC-J	Continued from page 5 stated that the Maintenance Technician located the resident 0.5 miles from the facility sitting outside on the steps of a local business and returned Resident #1 to the facility. He said that Resident #1's primary physician was at the facility and evaluated the resident, with no injury or new orders noted and RN #1 assessed the resident, including a body/skin audit and noted no injury. He stated the weather on 1/20/26 had been clear, cool and fair and that the resident had been wearing black jeans, a black and gray plaid button-up shirt, black socks and slip-on athletic-casual loafers with a rigid sole. On 1/28/26 at 1:00 PM, during an interview, the Maintenance Technician revealed that he was on duty on 1/20/26 and at approximately 11:40 AM was notified by CNA #1 that she could not find Resident #1. He said he immediately began to look for the resident inside and after reporting to the nurses' station upon hearing the missing resident announcement via the overhead speaker got into his car and drove towards town and at approximately 11:55 AM saw the resident 0.5 miles from the facility sitting on the steps outside a local business. He stated he approached the resident who asked him for a ride and got into his car without incident and he notified facility staff that he had located the resident and was returning to the facility. The Maintenance Technician stated that when Resident #1 got into his car the resident's clothes and shoes were clean and dry. He stated that he brought him straight back to the facility and assisted him inside at approximately 11:57 AM. He confirmed he then assisted with checking exit doors to confirm doors and locks were functioning correctly. He confirmed that regardless of the route taken by Resident #1 on 1/20/26, he would have had to cross two of the busiest streets in town. He confirmed the weather on 1/20/26 had been clear, cool and fair and that the resident had been wearing clean, dry black jeans, button-up shirt, black socks and slip-on athletic-casual loafers with a rigid sole. On 1/28/26 at 1:40 PM, during an interview CNA #1 revealed she was on duty on dayshift (6:00 AM to 6:00 PM) 1/20/26. At approximately 11:40 AM she was serving lunch on "lower hall". She stated that she began to look for Resident #1, first in the dining room and then in therapy and then notified the nurses that Resident #1 may be missing. She stated that following a quick one-to-two-minute search to check, a "Code Adam" was announced over the overhead speaker and all staff reported to the nurses' station and were told the name of the missing resident and began to search for him inside and outside the facility. She stated that in a	F0689		

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F0689 SS = SQC-J	Continued from page 6 matter of minutes the code was cleared via overhead speaker. She stated that she obtained the resident's vital signs upon return and was assigned to one-on-one supervision of Resident #1 and confirmed that the resident remained on one-on-one supervision. On 1/29/26 at 3:24 PM, during a record review of the Personnel Action dated 1/20/26 and interview, the Dietary Aide confirmed that at approximately 11:40 AM on 1/20/26 she failed to check with nursing staff and input the numeric code into the wall-mounted keypad beside the front entrance and allowed Resident #1 to exit unaccompanied and unsupervised, which resulted in termination of her employment at the facility on 1/28/26. Record review of the local weather history according to WWW.Wunderground, copyright the Weather Channel, for the facility location for 11:53 AM, revealed the temperature was 56 degrees Fahrenheit, with zero precipitation, six to eight mile per hour winds and the weather condition was fair. Immediacy Removal Plan: Incident 10:40 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 1/20/2026 11:40 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 Adam initiated by Director of Nursing 11:42 AM Administrator notified immediately by Code Adam 11:43 AM Physician notified by Administrator 11:43 AM Resident representative notified LPN #2 11: 45 AM LPN #1 head count to ensure all other residents were accounted for	F0689		

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F0689 SS = SQC-J	Continued from page 7 11:45 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 vehicle 11:55 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 elopement 12:05 PM Care plan updated by Minimum Data Set (MDS) coordinator to include one-on-one (1:1) monitoring 12:15 PM Maintenance Supervisor assured all doors where functioning properly 12:15 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 elopement 1:00 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 residents	F0689		

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F0689 SS = SQC-J	Continued from page 8 1:15 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 Administrator Quality Assurance Committee: Quality Assurance Performance Improvement (QAPI) conducted an emergency meeting on 1/20/2026 at 1:00 PM A 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 Development Root 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. Education Staff 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 Adam 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. Monitoring Beginning 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	F0689		

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F0689 SS = SQC-J	Continued from page 9 daily, five times weekly. Beginning 1/22/26 the Social Services Director will monitor residents at risk of wandering and elopement for alert ban placement five times each week for one month, then once weekly for one week, then monthly for three months. Upon installation of Safe Wandering System, alert ban placement will be replaced by safe wandering system bracelet placement. Facility alleges all corrective action completed on 1/20/2026. The SA validated the Corrective Action Plan on 1/29/26 through observations, interviews, and record reviews and determined that the IJ was removed on 1/21/26, prior to SA entrance on 1/28/26 and was determined to be Past Noncompliance.	F0689		