STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A188	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOLIVAR MEDICAL CENTER LTC	901 E SUNFLOWER RD P O BOX 1380, CLEVELAND, Mississippi, 38732

(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 an annual re-certification survey at the facility from 7/28/25 through 7/31/25. During the survey, the SA determined that the facility was not in compliance with the Medicare and Medicaid regulations for participation and cited regulatory deficiencies F 641, F812 and F 851. Census at the time of survey was 28 and the facility is licensed for 35.	F0000		08/13/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F0641	F0641 Immediate Corrective Action 1. Minimum Data Set (MDS) Coordinator entered a modification request and submitted it to Centers for Medicare and Medicaid Services (CMS) for Resident #19. All residents' charts (total of 28) have been audited to ensure all Level II (two) Preadmission Screening and Resident Review (PASRR) have been coded correctly on Section A 1500. These actions were completed 07/30/25 by MDS Coordinator. Identifying and Protecting Other Residents 1. All residents have the potential to be affected by failing to code the Minimum Data Set (MDS) accurately for any resident diagnosed with a Mental Illness. On 07/30/25, the MDS Coordinator reviewed all current residents' charts in comparison with the MDS coding for Level I or Level II to ensure accuracy. Completed 07/30/25.	09/05/2025

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 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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F0641 SS = D	Continued from page 1 and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to code the Minimum Data Set (MDS) accurately for a resident with a Mental Illness for one (1) of the 22 sampled residents. Resident #19 Findings include: Review of the facility policy titled “Nursing Assessment and Interdisciplinary Care Plan,” with a revision date of 06/2023, revealed: "2. Long Term Care Facility will conduct a comprehensive, accurate, standardized reproducible assessment upon admission and at regular intervals to ensure that each resident meet his/her highest practicable level of physical, mental, and psycho-social functioning:..Physical and mental functional status..." Record review of Resident #19's Significant Change MDS with Assessment Reference Date (ARD) of May 16th, 2025, revealed Section A 1500, "Is the resident currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition? coded as "No". Record review of Resident #19's "Summary of Findings Report", from the PASRR Office, dated 2/13/24 under "Mental Health" revealed "the individual meets criteria for having a diagnosis of mental illness as defined by PASRR." During an interview with MDS Coordinator on 7/30/2025 at 2:00 PM, she verified that the Significant Change MDS with an ARD of May 16th, 2024, Resident #19 was coded incorrectly. She agreed that the MDS should be coded correctly to ensure that the resident is receiving the correct level of care. In an interview with the Director of Nursing (DON) on 7/30/25 at 3:07 PM, she agreed that it was her expectation that the MDS would be coded correctly. A record review of the "Admission Record" revealed Resident #19 was initially admitted by the facility on	F0641	Continued from page 1 Measures to Prevent Recurrence: 1. MDS Coordinator and Director of Nursing (DON) reviewed the Nursing Assessment and Interdisciplinary Care plan on08/01/25. 2. All residents were added to a PASRR (Preadmission Screening and Resident Review) audit form. The audit form is actively maintained by the Licensed Social Worker (LSW) and the MDS Coordinator and then forwarded to the Director monthly for tracking and trending. The audit form includes the following: -name of resident -admission date -date of most current PASRR -whether the resident is Level I or Level II -if there is a significant change -the date the PASRR Office Confirmation is received -the completion of the MDS Section A 1500 3. The admission of all new incoming residents has been revised to include the addition of the new resident being placed on the log. Monitoring for Sustained Compliance: 1. PASRR Audit will be conducted by the Licensed Social Worker and the Minimum Data Set Coordinator Monthly. The audit completion is provided to the Director for tracking and trending. The monitoring began on 08/11/25 and will continue for a minimum of 4 months or until 100% compliance has been met consistently for an entire quarter. The compliance goal rate is 100%. Numerator = total number of residents that are on the log/Denominator = total number of residents (including all new admits). 2. The results of this audit will be reported to the Quality Assessment and Assurance Committee quarterly. This audit begins on 08/11/25 and the first report to Quality Assessment and Assurance Committee will be on Thursday, 09/04/25.	

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F0641 SS = D	Continued from page 2 2/14/2024 with a diagnosis of Bipolar Disorder.	F0641	Continued from page 2 3. Effective 8/14/25, the PASRR levels are being reviewed during each resident's quarterly care plan meetings and with any significant change care plan meeting along with MDS for each Resident and updated as needed. Completion Dates: Corrective action will be fully implemented on 09/05/25.	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, and facility policy review the facility failed to ensure hair restraints were utilized during food preparation to prevent contamination for one (1) of two (2) kitchen tours. Findings include: Review of the facility policy "SANITATION AND INFECTION CONTROL" with a revision date of 1/2025, revealed that	F0812	F0812: Immediate Corrective Action: 1. The Dietary Manager provided in-person on-site training re: the Sanitation and Infection Control policy with staff as well as the importance of compliance. Visual audit to ensure all kitchen staff were wearing proper hair restraints (hair nets). Corrected on 07/31/25. Identifying and Protecting other Residents: 1. This deficient practice has the potential to affect all 28 residents. 2. As of 07/31/2025, there are no reports of concerns or complaints to Administrator or to Dietary Manager from this deficient practice-confirmed by Administrator on 08/12/2025. Measures to Prevent Recurrence: 1. In-service education began on 08/13/25 and was provided to all current kitchen staff members on policy regarding hair restraints. Policy will be provided to the staff along with directions from Dietary Manager. Copy of all signed education will be provided to the Administrator upon completion. 2. The new hire kitchen staff orientation revised to include the training. This will help ensure continued compliance and consistency with training. This takes effect with all new hires starting on 08/13/25 and going forward.	09/05/2025

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F0812 SS = F	Continued from page 3 "Team members will wear hair restraints regardless of the length of hair or beard at all times in the kitchen." On 7/30/2025 at 11:00 AM during the kitchen tour with the Dietary Manager (DM), an observation was made of Chef #1 preparing food in the kitchen without a hair net in place. Chef #1 was wearing a black baseball hat, and his hair was sticking out approximately 3-4 inches in length from under the hat. An interview with the DM on 7/30/25 at 11:15 AM revealed she was aware Chef #1 was required to wear a hair net and stated, " Yes, he should have a hair net on and I've told him he has to wear it." During an interview with the Administrator (ADM) on 7/31/2025 at 9:45 AM, she stated that she has had to talk with Chef #1 in the past regarding the hair net and their facility policy regarding food safety.	F0812	Continued from page 3 3. All trainings attended will be signed and dated by the staff member and Dietary Manager. A copy to be provided to the Administrator. 4. All staff will be fully educated on the policy no later than 08/22/25. Monitoring for Sustained Compliance: 1. Dietary Manager or appointed designee (Administrator or Dietitian) will perform random visual audits for compliance with hair restraints: a. Weekly for first three (3) months beginning 08/18/25. b. Monthly for three (3) months beginning December 2025 through February 2026 c. Quarterly beginning in March 2026 2. Dietary Manager will report results of audits and observations to Quality Assessment and Assurance Committee quarterly. Goal compliance rate of 100%. The first report to Quality Assessment and Assurance Committee will be on Thursday, 09/04/25. 3. Any non-compliance from an employee will be immediately escalated to Administration for re-education and/or disciplinary action. Completion Date: Corrective action will be fully implemented on 09/05/25.	
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and	F0851	F0851: Corrective Action Taken Immediately: 1. Currently, as of 07/31/25, the Administrator is manually entering all Payroll Based Journal (PBJ) submission information on each employee for each day worked.	09/05/2025

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F0851 SS = F	Continued from page 4 contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule.	F0851	Continued from page 4 Identifying and Protecting other Residents: 1. None of the residents have been affected by the inaccurate submission of staffing data. This was confirmed by the Administrator by auditing actual timecards and work schedules for all direct care staff during the time that was reported incorrectly. 2. Thorough review of schedules and timecards with employee punch in and out times by the Administrator and the Director of Nursing on 07/30/25. Measures to Prevent Recurrence: 1. Facility reviewed and will ensure compliance with the “Electronic Staffing Data Submission Payroll Based Journal” policy on 08/11/25. 2. The Administrator will manually enter employee staffing information upon completion of each bi-weekly payroll cycle. This began on 08/11/25. 3. Administrator will continue to work with corporate payroll processing department to create an automated report in the acceptable PBJ format to help remove human error. This began on 08/11/25 with bi-weekly pay period ending on 08/09/25. 4. The Director of Nursing and Administrator will compare each employee timecard information being submitted with the current schedule to ensure accuracy of information being reported. This began on 08/11/25 with bi-weekly pay period ending 08/09/25. 5. The Administrator will continue to review all PBJ reports for accuracy prior to the submission due date each quarter. This review began on 08/11/25. Monitoring for Sustained Compliance: 1. Bi-weekly monitoring by the Administrator and the Director of Nursing to compare timecard punches with the schedule. This monitoring began on 08/11/25 and will continue for 12 months. 2. Bi-weekly manual entry to Centers for Medicare & Medicaid Services (CMS) PBJ Submission system Quality	

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F0851 SS = F	Continued from page 5 The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of two (2) quarters reviewed. (2nd Quarter 2025) Findings include: Record review of the facility policy titled, "Electronic Staffing Data Submission Payroll-Based Journal" with a revision date of 6/30/25, revealed, "...Mandated to submit to CMS (Centers for Medicare and Medicaid Services) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate..." Record review of the "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 2 2025 (January 1 - March 31)" revealed "Excessively Low Weekend Staffing – Triggered = Submitted Weekend Staffing data is excessively low. No RN (Registered Nurse) Hours – Triggered = Four or More Days Within the Quarter with no RN Hours. Failed to have Licensed Nursing Coverage 24 Hours/Day – Triggered = Four or More Days Within the Quarter with <24 Hours/Day Licensed Nursing Coverage." During an interview on 7/30/2025 at 11:25 AM, the Administrator (ADM) stated that the facility had recently transitioned to a new payroll system. She explained that, unlike the previous system, the new system did not automatically transfer data from the time clock, which resulted in missing staffing data for the second quarter of 2025 PBJ submission. The ADM acknowledged that she failed to verify the accuracy of the data prior to its transfer and submission, which led to discrepancies and errors in the quarterly PBJ report.	F0851	Continued from page 5 Improvement and Evaluation System (QIES) of employee hour data by the Administrator or Director of Nursing. This manual entry began on 08/11/25. This process will continue until uploading payroll reports directly from payroll system becomes available from corporate office. 3. Monthly Audit for submission completion by the Administrator for a minimum of 4 months or until 100% compliance has been maintained for minimum of a quarter. The audit results will be reported to Quality Assessment and Assurance Committee quarterly and this first report will be given to Quality Assessment and Assurance Committee on Thursday, 09/04/25. Completion Date: Corrective action will be fully implemented on 09/05/25.	