STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515152	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTGOMERY GENERAL ELDERLY CARE	**501 ADAMS STREET MONTGOMERY, WV 25136**

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 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 and staff interview, the facility failed to ensure staff provided / offered hand hygiene to five (5) of five (5) residents prior to meal service during a COVID - 19 focused survey. Resident identifiers: #56, #37, #19, #18, and #46. Facility census: 57. Finding included: a) Noon meal At 12:35 PM on 06/22/20, observation of the noon meal service on Hallway - A, found two nursing assistants (NA's #1 and #2) passing trays to resident's eating in their rooms. Observation of Room - A 16, found NA #1 served a tray to Resident #56 while NA #2 served a tray to Resident #37. Observation of Room A -15 found NA #2 served a tray to Resident #19 while NA #1 served a tray to Resident # 18. NA #1 served a tray to Resident #46 in room A - 12. NA #1 and NA #2 were silent when asked if hand sanitizing was provided to the residents prior to meal delivery. At 12:45 PM on 06/22/20, Licensed Practical Nurse (LPN) #3, (the nurse on A - Hall), said she would expect hand hygiene to be provided prior to meal service. The facility has hand wipes available for sanitizing if residents are unable to wash their own hands. At 1:00 PM on 06/22/20, the facility administrator verified staff should provide hand hygiene prior to meal service. .

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

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.