STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORT VALLEY HEALTH AND REHAB	**604 BLUEBIRD BOULEVARD FORT VALLEY, GA 31030**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of the facility policy titled, 'Handling, Transport, and Storage of Laundry, the facility failed to prevent possible cross contamination during meal delivery service in one resident's room (room [ROOM NUMBER]); and during the transport of residents clothes/linens on two of three halls (200 and 300 hall). Findings include: 1. An observation of meal delivery for lunch began on 7/28/2020 at 12:45 p.m. on the 200 hall. Certified Nursing Assistant (CNA) AA was observed getting a black serving tray off the top of the hot cart and delivered a meal to room [ROOM NUMBER]. While in room [ROOM NUMBER] the black tray was sat on the sink counter while CNA AA assisted the resident in the room with moving items off the overbed table. After leaving room [ROOM NUMBER] the black tray was sat on top of the clean trays on the hot cart. CNA AA and CNA BB were observed using hand sanitizer. Once their hands were sanitized CNA BB picked up the black tray that CNA AA had used and delivered a meal to another resident in room [ROOM NUMBER]. There were no other concerns observed related to cross contamination during meal delivery. 2. An observation on 7/28/2020 at 12:52 p.m. revealed Laundry Aide CC on 200 hall delivering linens in a metal cart that was not covered. A second observation on 7/28/2020 at 1:14 p.m. revealed Laundry Aide CC delivering linens in an uncovered cart to the 300 hall linen cart. During a third observation on 7/28/2020 at 2:04 p.m. revealed Laundry Aide CC coming from outside to the 300 hall with residents' clothing in the cart uncovered. During the interview with Laundry Aide CC it was confirmed that there were resident's items in the cart. Laundry Aide CC further confirmed that the items in the cart were not covered. 3. During an observation on 7/28/2020 at 2:27 p.m. CNA AA was observed getting towels off the linen cart on 200 hall when four wash clothes fell to floor. CNA AA was then observed picking the towels up and throwing them back into the lower shelf of the clean linen cart. An interview was conducted on 7/28/2020 at 2:19 p.m. with CNA BB who reported that residents' plates are taken off the hot cart and placed onto a black tray for delivery to the resident's room. The black tray is sat on the bedside table and the meal items are removed from the tray. Lastly, she reported the black tray is removed from the room and a new black tray should be used before servicing another resident. During an interview on 7/28/2020 at 2:35 p.m. with the Housekeeping/Laundry Supervisor it was confirmed that linens and clothing should be transported on cart with a sheet covering the cart. During an interview with CNA AA on 7/28/2020 at 3 p.m. it was acknowledged that the black tray used during lunch should be new on each delivery. CNA reported that when towels fall to the floor, they should be placed in the dirty laundry container and acknowledged that she did not do so when towels fell on the floor earlier today on 200 hall. During an interview with the Director of Nursing (DON) on 7/28/2020 at 3:29 p.m. it was reported that a new black tray should be used for each resident receiving a meal during meal delivery. It was further reported that any items that fall to the floor should go to dirty laundry. An interview was conducted on 7/28/2020 at 3:43 p.m. with the Housekeeping/Laundry Supervisor related to training of staff related to delivery of linens and resident clothing. It was reported that the last training for laundry transport was in March 2020 prior to Laundry Aide CC or himself beginning work. Laundry Aide CC had not received the training related to the covering of items during transport, but he has now in serviced Laundry Aide CC. Review of the facility policy titled Handling, Transport, and Storage of Laundry updated July 22. 2020 revealed the following: Transport of Laundry - Clean linens must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport, and unloading (using a cover or lid during transport to prevent cross contamination). On 7/28/2020, the facility had no COVID-19 positive residents.

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.