

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115708	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Church Home Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2470 Hwy 41 N 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and a review of the facility's policy titled Abuse Investigation and Reporting, the facility failed to report to the State Survey Agency (SA) a fall with major injury as required within two hours and in a timely manner for one of 46 sampled residents (R) (R9.) Findings Include: Review of the policy titled Abuse Investigation and Reporting, revised July 2017, section Reporting, documented 2. Alleged violations of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. TWO (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty- four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. Review of the Electronic Medical Record (EMR) revealed resident R9 was admitted to the facility on [DATE] with diagnoses including, but not limited to, Alzheimer's disease with late onset, unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified intracapsular fracture of left femur, subsequent encounter for closed fracture with routine healing and repeated falls. Review of R9's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00, which indicates R9 has severe cognitive impairment. Section GG, functional status, revealed R9 has no impairments with upper and lower body extremities but benefits from the use of wheelchair. With self-care, R9 is dependent in all areas with the exception of eating, requiring setup/clean up assistance. Mobility R9 requires partial moderate assistance in all areas attempted. Review of the Care Area Assessment (CAA) on the significant change, MDS documented no significant change. MDS was completed. Review of R9's care plan dated 7/29/2025 indicated a problem of an alteration in musculoskeletal status r/t fracture of the left hip. Interventions included, but not limited to, anticipate and meet needs, be sure call light is within reach, and respond promptly to all requests for assistance. A review of the Facility Incident Report Form submitted to the state on 7/27/2025, revealed type of incident: NH (Nursing Home) Only: witnessed fall with major injury with no alleged abuse. Date and time of incident: 7/26/2025 at 5:30 pm. Details of incident: On 7/26/2025 at approximately 5:30 pm, resident returned via wheelchair from the dining room and was sitting at the lobby area watching tv (television), in front of nurses desk. Resident was observed to rise from her wheelchair and immediately fall to the floor. Resident fell on left side. Staff immediately assessed resident and contacted Medical Director (MD) and family. Injury: Yes. Left femur per hospital. Interview on 7/31/2025 at 3:02 pm with Registered Nurse Supervisor (RN) SS revealed that he did not witness R9's fall. However, when he was called into the common area outside of his office, he saw R9 lying on her left side on the floor. RN SS stated he got on the ground to make sure she was not bleeding and completed checks (around 5:00 pm or 6:00 pm). RN SS then revealed that he instructed two staff members to return R9 to bed after assisting R9 off the ground. RN SS revealed that he called the MD, who ordered x-rays for R9, and she was given pain medication. RN SS stated that the primary nurse received a call from the mobile x-rays [NAME], stating they would not be available on [7/26/2025] but would be available at the facility on [7/27/2025]. RN SS revealed that on 7/27/2025, he called the MD around 2:00 pm to request that R9 be sent to the Emergency Department (ER) for evaluation, to which the MD agreed. R9 left the facility around 2:40 pm on 7/27/2025 for the local ER. Interview on 7/31/2025 at 5:54 pm with the Administrator; she stated that if this is a reportable incident, it should have been reported within 2 hours.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, staff and resident interviews, record review, and review of the facility's policies titled Hand Hygiene and Handling Clean Linen, the facility failed to ensure proper infection control practices were followed during observations of dining and clean laundry pass. This deficient practice had the potential to increase the risk of the spread of infections due to cross-contamination. The facility census was 74. Findings include:</p> <p>Review of the facility policy titled "Hand Hygiene," dated 5/1/2025, revealed the "Policy" section stated, "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff." The "Policy Explanation and Compliance Guidelines" section included, "1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice." Review of the facility policy title, Handling Clean Linen, dated 5/1/2025, revealed the "Policy Explanation and Compliance Guidelines" section included, " &hellip; 6. Carry clean linen with clean hands away from your body. &hellip;";</p> <p>1. Observations on 7/31/2025 from 11:58 am to 12:12 pm, of dining in the dining room, revealed that Dietary Aide OO was passing meal trays to multiple residents without performing hand hygiene between the tray passes. Further observation revealed that Dietary Aide OO opened a trash can with her hand and served drinks to residents without performing hand hygiene between tasks. In an interview on 7/31/2025 at 12:20 pm, Dietary Aide OO stated that she did not know that she should perform hand hygiene between resident tray passes or after touching dirty objects until this date. In an interview on 7/31/2025 at 12:55 pm, the Dietary Manager revealed that he expected dietary aides to perform hand hygiene between each resident tray pass.</p> <p>2. Observations on 7/31/2025 at 2:35 pm revealed that Housekeeper HH entered and exited multiple resident rooms while delivering clean clothing and placing items inside the residents' closets without performing hand hygiene between resident rooms. Observations on 7/31/2025 at 2:36 pm revealed that Housekeeper II entered and exited multiple resident rooms while delivering clean clothing and placing items inside the residents' closets without performing hand hygiene at any point between resident rooms. In an interview on 7/31/2025 at 2:47 pm, Housekeeper HH confirmed that she did not perform hand hygiene after entering and exiting each resident's room, and stated should have. In an interview on 7/31/2025 at 2:50 pm, Housekeeper II confirmed that he did not perform hand hygiene after entering and exiting each resident's room, and stated he was uncertain as to when he should be performing hand hygiene. In an interview on 7/31/2025 at 3:16 pm, the Director of Nursing (DON) revealed the expectation was for all staff to perform hand hygiene before and after entering each resident's room, including housekeeping staff.</p>		