STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policy titled, Safe, Clean, Comfortable, Homelike Environment F584, the facility failed to maintain a safe, clean, comfortable, homelike environment for nine out of 28 rooms (Rooms 202, 204, 206, 208, 210, 302, 303, 304, and 306). This deficient practice had the potential to compromise the hygiene and safety of the residents' environment, increasing the risk of infection and negatively impacting the health and well-being of residents.Findings include:Review of the facility's policy titled, Safe, Clean, Comfortable, Homelike Environment F584 dated 10/2025 under the Policy Statement revealed, F584 Residents have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.1. Observation on 12/19/2025 at 9:05 am in the shared bathroom for room [ROOM NUMBER] and room [ROOM NUMBER] revealed areas of the wall had missing paint, and the cove base was in disrepair.Observation on 12/19/2025 at 2:00 pm in the shared bathroom for rooms [ROOM NUMBERS] revealed areas of the wall with missing paint and the cove base in disrepair.2. Observation on 12/19/2025 at 9:18 am in room [ROOM NUMBER] revealed, the cove base was in disrepair.Observation on 12/19/2025 at 1:38 pm in room [ROOM NUMBER] revealed the cove base was in disrepair.3. Observation on 12/19/2025 at 9:22 am in room [ROOM NUMBER] revealed a hole in the wall near the bathroom door.Observation on 12/19/2025 at 1:50 pm in room [ROOM NUMBER] revealed a hole in the wall near the bathroom door.4. Observation on 12/19/2025 at 9:13 am in room [ROOM NUMBER] revealed areas of the wall had missing paint behind the headboards for both A and B beds.5. Observation on 12/19/2025 at 1:55 pm in room [ROOM NUMBER] revealed areas of the wall had missing paint behind the headboards for both A and B beds.6. Observation on 12/19/2025 at 10:30 am in room [ROOM NUMBER] revealed that the overbed light string was short, there was missing paint on the wall at the top of the bed, and the privacy curtain did not pull completely around the bed.7. Observation on 12/19/2025 at 10:59 am in room [ROOM NUMBER] revealed missing paint on the wall at the top of the bed, and a missing baseboard around the sink.8. Observation on 12/19/2025 at 11:05 am in the shared bathroom for 206 and 210, there was a loose baseboard behind the toilet.9. Observation on 12/19/2025 at 12:00 pm in room [ROOM NUMBER] revealed a missing baseboard by the sink and a hole in the wall. Observational rounding and interviews on 12/21/2025 from 11:28 am to 12:00 pm with the Administrator and Maintenance Director confirmed the following concerns:In room [ROOM NUMBER], the missing cove base by the sink and a hole in the wall.In room [ROOM NUMBER], the short string for the overbed light, and the missing paint on the wall at the head of the bed.In the shared bathroom for 206 and 210, a loose baseboard behind the toilet.In room [ROOM NUMBER], the missing paint from the wall at the head of the bed, the missing cove base around the sink, and behind the toilet.In room [ROOM NUMBER], the hole in the wall near the bathroom door.In room [ROOM NUMBER], the cove base in disrepair.In room [ROOM NUMBER]-304 shared bathroom, the areas of the walls with missing paint and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the cove base in disrepair.In room [ROOM NUMBER], the missing paint behind the headboards for both A and B beds.An interview with the Maintenance Director confirmed the findings and revealed that he was unaware of them. He revealed that he conducted environmental rounds daily. He stated that he reviewed the electronic maintenance work orders system daily and prioritized work orders by severity and if the room was available for repairs. He confirmed that none of the identified areas were in the electronic maintenance work orders system, nor had they been reported. He further revealed that he was in the process of identifying if the beds needed bed stops (used to prevent chipping paint from the wall). He stated that he would be working on getting these items repaired.An interview with the Administrator revealed that his expectation was for staff to complete a work order in the electronic maintenance work orders system and notify the Maintenance Director so he could follow up on the needed repairs based on the order received and the urgency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled Baseline Care Plan, the facility failed to develop a baseline care plan for one of 33 sampled residents (R) (R55). This deficient practice had the potential to place R55 at risk of unmet care needs. Findings include:Review of the facility's policy titled Baseline Care Plan revealed the Policy section stated, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.Review of the clinical record revealed R55 was admitted to the facility on [DATE] with diagnoses of, but not limited to, traumatic subarachnoid hemorrhage with loss of consciousness. Review of the clinical record revealed no baseline care plan.During an interview on 12/20/2025 at 9:39 am, the Minimum Data Set (MDS) Coordinator stated that because R55 was a respite resident, a baseline care plan was not completed. She further stated that a baseline care plan should be completed on all residents upon entry to the facility. During an interview on 12/20/2025 at 10:43 am, the Director of Nursing (DON) stated that she did not initiate a baseline care plan for R55. The DON further stated it was her expectation for all new residents to have a baseline care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled Oxygen Administration, the facility failed to implement the plan of care for one of 33 sampled residents (R) (R19). In addition, the facility failed to develop a comprehensive person-centered care plan for two of 33 sampled residents (R16 and R29). This deficient practice had the potential to place R33, R16, and R29 at increased risk of unmet needs and a diminished quality of life. Findings include: Review of the facility's policy titled Oxygen Administration dated 10/2024 under Preparation revealed . 2. Review the resident's care plan to assess for any special needs of the resident. 1. Review of the Electronic Health Record (EHR) for R19 revealed diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD). Review of the care plan for R19 revealed a focus area of [Name] on Oxygen Therapy r/t (related to) Shortness of breath. Interventions/Tasks included, but were not limited to, Administer oxygen as ordered. Date Initiated 8/18/2024. Observation on 12/19/2025 at 9:30 am revealed R19 was receiving O2 at 3 LPM via NC from an oxygen concentrator. Observation on 12/19/2025 at 1:44 pm revealed R19 was receiving O2 at 2.5 LPM via NC from an oxygen concentrator. Observation and interview on 12/19/2025 at 3:35 pm with the Director of Nursing (DON) confirmed R19 was receiving O2 at 2.5 LPM via NC from an oxygen concentrator. The DON reviewed R19's physician orders and confirmed the orders for oxygen to be administered at 2 LPM via NC. In an interview on 12/20/2025 at 2:00 pm, the Clinical Reimbursement Coordinator (CRC) revealed that she was responsible for developing care plans and that her expectation was for nurses to follow the plan of care. 2. Review of the admission Record for R16 revealed diagnoses including, but not limited to, dementia in other diseases classified elsewhere without behavioral disturbance, hoarding disorder, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment for R16, dated 10/3/2025, revealed section I (Active Diagnoses) documented diagnoses including, but not limited to, depression. Section N (Medications) documented that the resident received an antidepressant during the look-back period. Review of the Medication Administration Record (MAR) for R16, dated 12/1/2025 through 12/31/2025, revealed an order dated 8/7/2025 for mirtazapine (an antidepressant medication) 15 milligrams (mg), one tablet by mouth at bedtime for weight loss. Review of the care plan for R16 revealed no focus area or interventions for the use of the antidepressant medication. 3. Review of the admission Record for R29 revealed diagnoses including, but not limited to, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	schizophrenia. Review of the Annual MDS assessment for R29, dated 9/10/2025, revealed section I (Active Diagnoses) documented diagnoses including, but not limited to, schizophrenia. Section N (Medications) documented that the resident received an antipsychotic during the look-back period. Review of the Medication Administration Record (MAR) for R29, dated 12/1/2025 through 12/31/2025, revealed an order dated 2/20/2025 for Seroquel (an antipsychotic medication) 25 mg, one tablet by mouth at bedtime, related to schizophrenia. Review of the care plan for R16 revealed no focus area or interventions for the use of the antipsychotic medication. In an interview on 12/20/2025 at 9:30 am, the MDS Coordinator confirmed R16 and R29 did not have active care plans that addressed the residents' psychotropic drug use. In an interview on 12/20/2025 at 10:45 am, the DON confirmed that R16 and R29 did not have a psychotropic care plan in place and stated that a care plan should have been initiated to address the residents' current health status. Further interview also revealed that it is her expectation that residents' care is planned correctly to meet their care needs. Cross Reference F695

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, staff interviews, record review and review of the facility's policy titled, Oxygen Administration, the facility failed to administer oxygen (O2) as ordered and clean the outside of the oxygen concentrator for one resident (R) (R19) and failed to ensure there was a physician's order for O2 prior to administering O2 to one resident (R57) out of five sampled residents receiving oxygen therapy. These deficient practices had the potential to place R19 and R57 at increased risk of respiratory complications. Findings include:Review of the facility's policy titled Oxygen Administration, dated 10/2024, under Preparation revealed, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Under Steps in the Procedure, revealed, . 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.1. Review of the Electronic Health Record (EHR) for R19 revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD). Review of the physician orders for R19 revealed an order for O2 at 2 liters per minute (LPM) via (by way of) nasal canula (NC) dated 9/10/2025.Review of the Quarterly Minimum Data Set (MDS) assessment for R19, dated 9/20/2025, revealed Section O (Special Treatments, Procedures, and Programs) documented the resident received oxygen therapy while a resident.Observation on 12/19/2025 at 9:30 am revealed R19 was receiving O2 at 3 LPM via NC from an oxygen concentrator that was covered with dust and debris.Observation on 12/19/2025 at 1:44 pm revealed, R19 was receiving O2 at 2.5 LPM via NC from an oxygen concentrator that was covered with dust and debris.Observation and interview on 12/19/2025 at 3:35 pm with the Director of Nursing (DON) confirmed R19 was receiving O2 at 2.5 LPM via NC from an oxygen concentrator that was covered with dust and debris. She revealed that it was her expectation for the Charge Nurse to make sure oxygen concentrators are cleaned and for the oxygen to be on the correct setting as ordered. The DON reviewed R19's physician orders and confirmed the orders for oxygen to be administered at 2 LPM via NC.Observation and interview on 12/19/2025 at 3:45 pm with Licensed Practical Nurse (LPN) EE revealed she was responsible for making sure R19 oxygen was on the correct setting. LPN EE confirmed that the oxygen setting was on 2.5 LPM via NC and that the oxygen concentrator was covered with dust and debris. LPN EE revealed that it was the nurses and Certified Medication Aides responsibility to make sure that the oxygen concentrator was clean.2. Review of the EHR for R57 revealed diagnoses including, but not limited to, COPD, acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, and chronic respiratory failure with hypoxia.Review of the admission MDS assessment for R57, dated 12/22/2025, revealed a status of In Progress due to a recent admission and was within the window for data entry before the completion date.Review of the physician orders for R57 revealed no order for O2 therapy. Observation on 12/19/2025 at 9:18 am revealed R57 receiving O2 at 4 LPM via NC from an O2 concentrator.Observation on 12/19/2025 at 1:50 pm revealed R57 receiving O2 at 4 LPM via NC from an O2 concentrator.Observation and interview on 12/19/2025 at 3:38 pm with the DON confirmed R57 was receiving O2 at 4 LPM via NC from an oxygen concentrator. The DON reviewed R57's physician orders and confirmed there were no orders for oxygen administration. The DON stated that her expectation was for the admission nurse to reconcile all medication orders and to transcribe them in the system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, staff interviews, and facility document review, the facility failed to ensure puree recipes were followed to ensure the correct nutritional value was provided for 10 of 10 residents who received a puree meal. This deficient practice had the potential to place the residents receiving pureed meals at increased risk of weight loss and medical complications. Findings include:Review of the menu for 12/20/2025 revealed the lunch meal included country-fried steak with onion gravy, roasted potatoes, California medley vegetables, dinner roll, brownie crinkle cookie, margarine, and beverage of choice. Review of the recipes for pureed food for the lunch menu for 12/20/2025 revealed:1. Suggested scoop size for pureed country-fried steak was scoop #8.2. Suggested scoop size for pureed California medley was scoop #20.3. Suggested scoop size for mashed potatoes was scoop #10.Review of the menu for 12/21/2025 revealed the breakfast meal included orange juice, hot oatmeal, scrambled eggs, bacon, cinnamon roll, coffee, and milk. Review of the recipe for pureed cinnamon roll included:3. Combine milk and commercial thickener and gradually add rolls while processing.5. Chill to 41 degrees Fahrenheit (F) or below.Hold for service at 41 degrees F or lower. Observation and interview on 12/20/2025 at 11:56 am in the kitchen with the Assistant Dietary Manager, while serving lunch, revealed that a yellow-handled scoop was used to serve the pureed mashed potatoes, pureed meat, and pureed mixed vegetables. When questioned about the serving size of the yellow scoop, the Assistant Dietary Manager stated that it was 1.58 ounces (oz).During an interview and observation on 12/20/2025 at 12:45 pm with the Regional Dietitian (RD), she stated that the yellow scoop being used for the pureed mashed potatoes, mixed vegetables, and meat was too small. She stated that the #10 scoop should have been used for the mashed potatoes and the #20 scoop for the mixed vegetables. She confirmed the portion sizes on the pureed food trays were too small and stated that dietary staff should follow the recipes to determine portion sizes. Observation on 12/21/2025 at 7:08 am revealed that during the pureeing of cinnamon rolls, Cook/Dietary Aide BB put an undisclosed amount of water in the blender to thin the puree. She reported that she added 3 tablespoons of water. The mixture was then placed on the steam table. Review of the recipe said to use milk and cool the mixture to 41 degrees before serving. During an interview with the Certified Dietary Manager (CDM) on 12/21/2025 at 11:07 am, it was reported that more scoops will have to be ordered to ensure that they have the correct scoops for serving all food items, and he could not explain why the kitchen staff were not using the correct scoop sizes when serving lunch on the previous day. The CDM reported that he has not provided education about scoop sizes. It was further reported that the aides are responsible for ensuring that resident trays are correct based on their dietary orders on the tickets. CDM further confirmed that water should not have been used when pureeing the cinnamon rolls and that the recipe should be followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of the facility policy titled Refrigerators and Freezers F812, the facility failed to ensure food items were labeled, dated, and not beyond their expiration date. In addition, the facility failed to ensure proper use of the three-compartment sink and to maintain sanitary conditions in the kitchen. These deficient practices had the potential to place 42 of 42 residents receiving an oral diet from the kitchen at increased risk of foodborne illness. Findings include:Review of the facility policy titled Refrigerators and Freezers F812, effective date 10/2025, revealed the following: . 6. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (date of delivery) will be marked on cases and on individual items removed from cases for storage. 8. The food shall be labeled and clearly marked to indicate the date or day by which the food shall be consumed or discarded. 12. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes.During the initial kitchen tour on 12/19/2025 at 8:30 am, with the Certified Dietary Manager (CDM), observations revealed: In the dry storage area there was a can of pineapples on the floor, a bag of stone ground yellow grits on the floor with an a 12/17/2024 date, an opened bag of brownie mix with a use by date of 11/21/2025, a box of dressing with a use by date of 12/13/2025, three cans of chicken that had a use by date of 11/19/2025, and black buildup on the floor under the shelves with paper and straws on the floor.In the walk-in cooler, there was a green bell pepper with gray substance on it, an open bag of cole slaw that did not have an open date or use-by date, and an undated box of whipped topping that was to remain frozen for up to nine months or used within 14 days once thawed.In the first reach in freezer, there were bags of pastries with no open date or use-by date, and pies with no use-by dateIn the second reach in the freezer, there were boxes of turkey sausage, bologna, and chicken that had received dates but no use-by date.There was a large, clear storage container with cereal in it that did not have an open date or use-by date.Interview with the CDM on 12/19/2025 confirmed the expired and undated items found during the initial kitchen tour.During a subsequent kitchen visit on 12/21/2025 at 7:08 am, observations revealed:Observation of the three-compartment sink at 7:12 am revealed a puree blender bowl not fully submerged in the sanitation sink of the three-compartment sink. The bowl was not fully submerged but removed from the solution at 7:22 am. During an interview on 12/21/2025 at 11:07 am, the CDM stated that the cooks should check for expired items and ensure everything was labeled. He reported that he goes behind them, so he is responsible for ensuring these things are done. Observations and an interview with the CDM on 12/21/2025 at 11:25 am in the kitchen revealed spider webs, stained ceiling tiles, and dust and bugs in the window seals. The CDM stated that deep cleaning consists of taking down vents and spraying inside, cleaning around the baseboards, but he was unsure about the window seals. The CDM further stated that the kitchen staff sweep and mop the dry storage area daily. However, the buildup on the floors, straws, and other items remained on the floor as confirmed by CDM. Review of the daily cleaning log for the kitchen showed no entries indicating the kitchen had been cleaned since 12/12/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115651	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure that staff followed infection-control practices for Transmission-Based Precautions (TBP) in one of one resident room (room [ROOM NUMBER]) on TBP from a sample size of 33 residents. This deficient practice had the potential to place the residents, staff, and visitors at increased risk of infectious illness due to cross-contamination. Findings include:Observation on 12/21/2025 at 11:41 am revealed Certified Nursing Assistant (CNA) DD entered room [ROOM NUMBER], with TBP signage and Personal Protective Equipment (PPE) on the door, without putting on PPE. Continued observation revealed that CNA DD exited the room without using hand hygiene. Observation on 12/21/2025 at 11:44 am revealed Housekeeper FF entered room [ROOM NUMBER], with TBP signage and PPE on the door, without putting on PPE. Continued observation revealed Housekeeper FF swept the floor in the resident room, and walked in and out of the room while emptying the dustpan. In an interview on 12/21/2025 at 11:42 am, CNA DD revealed she thought that she only needed to wear PPE when she was doing something to the resident, not just when going into the room. In an interview on 12/21/2025 at 11:44 am, Housekeeper FF confirmed the signage and PPE on the door of room [ROOM NUMBER]. She stated she forgot to put on PPE when entering the room. In an interview on 12/21/2025 at 11:53 am, the Infection Control Preventionist (ICP) stated staff were required to follow the instructional signage on the TBP room's doors, put on PPE before entering the room, and use hand hygiene upon exiting the room.In an interview on 12/21/2025 at 11:53 am, the Assistant Director of Nursing (ADON) stated staff should put on PPE when entering TBP rooms and further stated she would provide education to the staff. She stated that failing to follow the process could place other residents and staff at risk of contracting infectious diseases. In an interview on 12/21/2025 at 11:53 am, the Director of Nursing (DON) stated she expected staff to follow TBP guidelines to prevent the spread of infectious disease in the building. She further stated she expected staff to perform hand hygiene when entering and exiting resident rooms.