STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. BUILDING _____ B. WING _____	**09/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREEN HILLS CENTER FOR REHABILITATION AND HEALING	**3939 HILLSBORO CIRCLE NASHVILLE, TN 37215**

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.** Based on facility policy review, observation and interview the facility failed to maintain a clean and sanitary biohazard room for 1 of 2 biohazard rooms observed. The findings include: Review of the facility policy Department (Environmental Services)-Laundry and Linen revised 1/2014 revealed .Place any linen saturated with blood or body fluids into a leak-resistant bag before placing it into the hamper . Observation on 9/29/2020 at 9:48 AM in the biohazard room on the 2nd floor revealed a yellow linen biohazard bag of linen unsecured on the floor of the room. Observation and interview on 9/29/2020 at 9:52 AM with the Administrator in the biohazard room on the 2nd floor confirmed the linen biohazard bag of linen was on the floor not secured. During an interview on 9/29/2020 at 11:30 AM with the Director of Environmental Services confirmed the facility had special barrels to store isolation bags of linen and they were to be stored in the soiled side of the laundry room and not the biohazard room. During an interview on 9/29/2020 at 4:50 PM with the Administrator confirmed the staff made a mistake in storing the isolation linen bag in the biohazard room.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on medical record review and interview the facility failed to document the COVID-19 test results in 31 of 59 resident medical records. The findings include: Review of the COVID 19 testing log for residents dated 9/22/2020 revealed 31 residents were tested for COVID 19. Continued review revealed on 9/23/2020 the tests were negative for 31 residents. Review of the medical record revealed no documentation of a COVID 19 test and its results for 31 residents in the resident personal medical record for the test date of 9/22/2020. During an interview with Licensed Practical Nurse (LPN) #1 on 9/29/2020 at 3:15 PM revealed the administration tested the residents for COVID 19 and were responsible for documenting the results in the residents medical record. During an interview with LPN #2 on 9/29/2020 at 3:17 PM revealed LPN #2 did not administer COVID 19 tests to the residents nor document the results in their medical records. Continued interview stated, the DON (Director of Nursing) handles it. During an interview with LPN #3 on 9/29/2020 at 3:18 PM revealed LPN #3 did not administer COVID 19 tests to the residents at the facility and the administration made her aware of the residents test results. During an interview with the DON on 9/29/2020 at 4:09 PM revealed the nursing department was responsible for administering the COVID 19 tests to the residents. Continued interview confirmed I am responsible for documenting the test results in the residents records and I forgot to document them because I was excited about the negative test results.

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.