

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 445501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2020
NAME OF PROVIDER OF SUPPLIER WEST HILLS HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 6801 MIDDLEBROOK PIKE KNOXVILLE, TN 37919	
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 facility policy review, observation, and interview the facility failed to maintain proper storage of biohazardous waste in 1 of 2 soiled utility rooms observed for infection control. The findings include: Review of the facility's Infectious Waste Management Plan (undated) showed .the proper handling of infectious waste will be used in the care of all residents as it is critical to the prevention of the spread of infection and disease .Wastes from Resident Care Areas: All waste contaminated with blood/body fluids shall be disposed of in the trash container . Observation of the soiled utility room located on LTC 1 was performed with the Administrator and Director of Nursing (DON) on 8/24/2020 at 5:20 PM. Findings revealed biohazard bags being stored in a single bin. The bin was filled to capacity and overflowing. Eight biohazard bags were observed on the floor beside the storage bin. During this observation the DON stated she recalled the waste being emptied by the Maintenance Department on Friday (8/21/2020). Interview with the Administrator on 8/24/2020 at 7:10 PM, confirmed the soiled utility room did not look the way it normally does .it is not the standard we want to achieve . In conclusion, the biohazard waste bin located in the soiled utility room on LTC 1 had not been emptied when it had reached maximum storage capacity. The waste was allowed to accumulate in excess and biohazard bags were being stored on the floor beside the bin.		

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.