STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345546	A. BUILDING _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEWOOD HEALTH CENTER	8710 CYPRESS CLUB DRIVE RALEIGH, NC 27615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 02/07/23 through 02/10/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# V9OC11.	E 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		3/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/02/2023

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.

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F 880	Continued From page 1 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a documented water management plan that included an assessment	F 880	Infection Control and Prevention Water Management Plan	

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F 880	Continued From page 2 to identify were Legionella and other waterborne pathogens could grow and spread and what control measures were in place. This had the potential to affect all residents in the facility. Findings included: A review of the infection prevention and control program policy dated October 2018 revealed no documented water management plan. During an interview with the Maintenance Director on 2/10/23 at 11:44 am it was revealed the facility did not have a plan in place to assess and or monitor for Legionella and other opportunistic waterborne pathogens. He stated he checked the water temperatures and was not aware of the regulation to have a water mangagment plan in place. An interview was conducted on 2/10/23 at 11:54 am with the Administrator and he indicated he was not aware there was not a plan in place for a water management plan. An interview was conducted with the Invention Preventionist on 2/10/23 at 12:28 pm and she indicated they had not had any case of a resident with legionellosis.	F 880	Water Management Plan policy and procedure reviewed and revised. Please see attached. Updated plan includes diagrams of community water sources and areas of monitoring as control measures. Water Management Plan created by Administrator, Infection Preventionist, Executive Director, and Plant Operations. Physical plant was reviewed for water entrance and exit through the community, including areas of stagnation which may lead to increased risk of Legionella exposure. Based on physical assessment, the following monitoring systems have been put in place: temperature checks weekly at various locations throughout facility identified in flow chart, water quality testing monthly and when temperature controls are not within range, and Legionella testing when water quality testing are not within control range. All testing and controls will be audited for compliance 1x/week x4 weeks and 1x/month ongoing. Control measures will be monitored in monthly QAPI meetings. Staff have been educated on signs and symptoms of Legionella and proper procedure for responding to pneumonia cases within 48 hours. Plan of Correction Addendum In order to meet the requirements of the Directed Plan of Correction for F-880 Water Management Plan to protect against Legionella, the following corrective	

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F 880	Continued From page 3	F 880	actions and implementations have taken place to ensure compliance. 1. Complete RCA for Water Management Plan 2. Develop Water Management Team 3. Develop Water Management Plan including Legionella 4. Implement education on water management plan & control factors to maintenance team 5. Implement education on signs and symptoms of legionella to nursing staff Audits will be conducted as defined in original POC to assure compliance. Water Management Plan will be reported to QAPI monthly x3 months and intermittently to ensure compliance is met. Compliance Date is 03/17/2023 NHA is responsible for compliance.	