STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27537

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/9/22 through 5/12/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DR1W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/9/22 through 5/12/22. Event ID# DR1W11. The following intake was investigated NC00178808. 4 of the 4 complaint allegations were not substantiated.	F 000		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		6/3/22

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

Electronically Signed | 06/03/2022

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F 690	Continued From page 1 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to secure indwelling urinary catheter tubing to prevent tugging or pulling for 2 sampled residents out of 2 residents who used catheters in the nursing home. (Resident #45, Resident #96) The findings included: 1. Resident #96 was admitted to the facility on 10/9/20 with diagnoses that included stage IV pressure ulcer to sacrum and urinary retention. A review of a physician's order dated 5/19/21 revealed an order for urinary catheter to straight drain for urinary retention. A review of Resident #96's most recent Minimum Data Set (MDS) dated 3/15/22 revealed that she had severe cognitive impairment and was coded as having an indwelling urinary catheter. An observation of Resident #96's urinary catheter was conducted on 5/11/22 at 10:31 AM with the Wound Treatment Nurse. There was no	F 690	**This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** F690 1. The corrective action taken for residents #96 and #45 was that nurse #1 went to the Central Supply closet and retrieved a leg strap for each resident. The leg strap was applied as the securement device for their indwelling urinary catheter tubing. 2. The process we used to identify any other residents having the potential to be affected by the alleged deficient practice was that Nurse #1 reviewed all residents in house to determine if any other residents had an indwelling catheter.	

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F 690	Continued From page 2 securement device for the urinary catheter. An interview was conducted with the Wound Nurse on 5/11/22 at 10:35 AM. The Wound Nurse stated that residents with a catheter should have a leg band to secure the catheter. 2. Resident #45 was admitted to the facility on 4/27/22 with diagnoses that included diabetes mellitus and hypertension. A review of Resident #45's most recent Minimum Data Set (MDS) dated 5/3/22 revealed no indwelling urinary catheter. Resident #45 was coded as occasionally incontinent of urine. A review of the physician's order dated 5/10/22 revealed an order for straight catheter, leave in place if urinary residual is greater than 150 ml (milliliters). A review of a health status note dated 5/10/22 revealed that an 18 French 10 ml balloon indwelling urinary catheter was inserted without difficulty and a urine specimen was collected for culture and sensitivity testing. Resident #45 had 800 ml of residual urine and the urinary indwelling catheter was left in place. An observation was conducted of Resident #45 on 5/11/22 at 10:56 AM with Nurse #1 present. Resident #45 had an indwelling urinary catheter but no securement device. An interview was conducted with Nurse #1 and Nurse #2 on 5/11/22 at 10:40 AM. Nurse #1 stated that residents with an indwelling urinary catheter should have a leg band to secure the device and keep it from pulling on the neck of the	F 690	Each resident identified with an indwelling catheter was assessed and, if needed, had a leg strap applied. 3. The measures we have taken to ensure future compliance with this alleged deficiency are: A.) The nursing staff has been re-educated on the requirement that any resident with an indwelling catheter must have a securement device, leg strap, applied to the catheter tubing to help prevent tugging or pulling. B.) For each resident with an indwelling urinary catheter, we have added an order in the eMAR to check the securement device each shift. C) When a new admission or a readmission is admitted to the facility, the admitting nurse will evaluate the resident to determine if they have an indwelling urinary catheter. If so, a securement device will be applied to their catheter tubing. 4. As of the date of this POC, Senior Citizen□s Home has one (1) resident with an indwelling catheter. For 30 days after survey exit, the Director of Nursing (DON), or her designee, will monitor on a weekly basis any resident that has an indwelling catheter to ensure they have a securement device in place. After that, the DON or her designee will monitor any resident with an indwelling catheter on a monthly basis to ensure compliance with this requirement. The results of the monitoring will be reviewed at our monthly Quality Assurance Meeting. If there are any issues identified, additional training and extended monitoring will be implemented. As well, a summary of the results for the quarter, will be reviewed	

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F 690	Continued From page 3 bladder. Nurse #1 further stated it was the nurse's responsibility to make sure residents with a catheter had a securement device. Nurse #2 stated that the catheter securement devices were kept in the storage room and were available to the nurses. An interview was conducted with the Director of Nursing (DON) on 5/11/22 at 2:40 PM. The DON stated that she expected that residents with an indwelling urinary catheter would have a securement device in place to prevent trauma to the bladder.	F 690	during our Quarterly, Quality Assurance Performance Improvement, QAPI, meeting. The Administrator will be responsible for ensuring that this Plan of Correction, POC, is followed and completed. Inservice Information for Foley Catheter Care: Per Policy, all foley catheters must have a leg strap or be taped to the leg. A securement device will prevent discomfort with movement and micro-abrasions to the urethra. It also prevents pulling of the catheter and delodgement. Please assess your residents who have urinary catheters to make sure that they have a securement device. An order will be added for each resident with a foley catheter to be checked to ensure the securement device is in place q shift.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		6/3/22

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F 806	Continued From page 4 by: Based on observations, record review, resident and staff interviews the facility failed to honor food preferences for 1 of 1 resident reviewed for food preferences (Resident #37). The findings included: Resident #37 was admitted to the facility on 3/24/20. Review of the annual Minimum Data Set (MDS) assessment dated 3/1/22 revealed Resident #37 was cognitively intact, had no weight changes, and was independent with eating. Review of Resident #37's food preferences dated 5/7/22 revealed Resident #37 had classified corn as a dislike. The physician orders for Resident #37 were reviewed. An order on 6/4/21 for no added salt and regular consistency diet with a special request by Resident #37 to not receive corn, oatmeal, grits, and okra at meals. During an observation on 5/9/22 at 12:45 PM, Resident #37 had corn on her lunch meal tray. The meal ticket stated capri vegetable blend. During an interview with Resident #37 on 5/9/22 at 1:09 PM, she revealed her food preferences included not to receive corn at meals, but she had received it today at lunch. She stated she often did not receive what the menu stated on her meal tray. Resident #37 indicated she had complained to dietary staff in the past, but there had been a lot of turn over in the kitchen.	F 806	F806 1 The corrective action taken for resident #37 was for the Dietary Manager (DM) to meet with the resident to verify that her list of likes and dislikes was correct. The DM then met with the cooks to re-educate them about verifying that any menu item substitutions are not on resident #37□s dislike list. 2 For residents who have the potential for the alleged deficient practice to affect them, the DM met with each resident, that was capable of doing so, to verify their list of dislikes is accurate and up to date. 3 The systemic changes we are making to address the alleged deficient practice is that the DM has developed a resident roster that lists by resident their dislikes. This document is now posted adjacent to the serving line for the dietary staff to reference as needed. This roster will be updated upon admission as new residents move in to our facility. The DM will update this listing on a monthly basis for in-house residents for three months from the survey exit. After that, the listing will be updated on a quarterly basis into the future. 4 The Regional Manager (RM) or the Registered Dietitian (RD) will monitor for compliance with this POC at least twice per month for the first three months. The RM or RD will then monitor at least quarterly for compliance going into the future. Any issues identified will be addressed immediately. The results of this monitoring will be brought to the Quarterly Quality Assurance Performance	

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F 806	Continued From page 5 During a follow-up interview with Resident #37 on 5/11/22 at 9:45 AM, she revealed corn was a dislike for her because it caused digestive discomfort and she had acid reflux. An interview was conducted with the Dietary Manager (DM) on 5/10/22 at 1:35 PM. She revealed Resident #37 received corn yesterday at lunch meal because corn was a substitute for capri vegetables, and the computer program used by the kitchen did not identify substitutes only set menu items. She stated she just started working at the facility 1 week ago and was reviewing food preferences with residents. The DM confirmed Resident #37 disliked corn. During an interview with the Registered Dietitian (RD) on 5/10/22 at 1:46 PM, he revealed he had been the RD at the facility since February 2022. He stated he expected the DM to input all resident preferences into the computer program used by the kitchen, so that residents did not receive dislike items. The RD indicated there was no way for dietary staff to accommodate Resident #37's food preferences due to a substitute used at lunch meal on 5/9/22. He stated he planned to discuss with the DM to notify him when substitutions were made with the menu to ensure it met the needs of all residents and that food preferences were honored as well. The Administrator was interviewed on 5/10/22 at 3:23 PM, and he revealed Resident #37's preferences should have been honored. He stated he completely agreed with the RD's statements, and they planned to evaluate the process for meal substitutions to determine how they can ensure it would not impact resident preferences.	F 806	Improvement Committee meeting to be evaluated for continued compliance.	

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain kitchen equipment clean, in good repair and in a sanitary manner to prevent cross contamination by failing to remove excessive ice and food debris from 2 of 4 freezers, failed to make repairs to a damaged freezer, failed to clean 1 of 2 ovens, 3 of 3 HVAC filters, 1 of 1 can openers, and clean 1 of 1 nourishment room refrigerators. The findings included: During the initial kitchen tour on 5/09/22 at 11:17 AM 4 of 4 freezers were observed. Freezer #4 (chest freezer) The left side of the lid frame was missing, and the insulation was visible. Freezer	F 812	F812 1 The corrective action implemented was to re-glue the corner piece on the lid of freezer #4 and the dietary staff defrosted the freezer and the interior was cleaned where some food had spilled in the bottom of the freezer. Freezer #3 was also defrosted and the interior was cleaned from where some food had spilled in the bottom of the freezer. The oven top that was observed with a film of golden grease on the top and inside the oven door has been cleaned. The HVAC filters have been removed and cleaned. The tabletop can opener has been disassembled and cleaned. The	6/3/22

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F 812	Continued From page 7 #4 was observed with 2-3 inches of ice buildup on the interior. The bottom of the freezer had loose corn, carrots, and peas in 1 inch of ice. Freezer #3 was observed with ice buildup and frozen food debris in the bottom of the freezer. 1 of 2 ovens were observed with a film of golden grease on the top and inside the oven door. A second observation of the kitchen was conducted on 5/10/22 at 11:34 AM. Six trays of stacked drinks were observed held on the sink side ready to be served. Three HVAC intake filters located directly above the trays of stacked drinks were observed covered with a film of black dust. The tabletop can opener was observed with dark sticky substance on the side of the can opener housing. On 5/11/22 at 9:13 AM a kitchen observation was conducted with the certified dietary manager. Freezer #4 (chest freezer) the left side of the lid frame was missing, and the insulation was visible. Freezer #4 was observed with 2-3 inches of ice buildup on the interior. The bottom of the freezer had loose corn, carrots, and peas in 1 inch of ice. Freezer #3 was observed with ice buildup and frozen food debris in the bottom of the freezer. 1 of 2 ovens were observed with a film of golden grease on the top and inside the oven door. Three HVAC intake filters located directly above the sink side apron were observed covered with a film of black dust. The tabletop can opener was observed with dark sticky substance on the side of the can opener housing. An observation of the nourishment room was conducted on 5/11/22 at 9:25 AM. The refrigerator was noted with a thin white liquid on each shelf and the refrigerator door had dried food particles.	F 812	nourishment room refrigerator has had everything in it removed, the shelves and door cleaned and restocked appropriately. 2 The Dietary Manager (DM) had been transferred to our facility approximately one week before our annual survey began. She has developed a Weekly Cleaning Assignments sheet that details who is responsible for cleaning various items and areas in the kitchen. Each item listed on the CMS 2567 is covered on the cleaning schedule. 3 The DM will be responsible for ensuring the staff is cleaning their assigned areas at least weekly or sooner if needed. The Regional Manager or the Registered Dietitian will monitor for compliance at least two times per month. The Administrator will conduct monthly inspections to ensure the dietary staff is maintaining a clean department.	

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F 812	Continued From page 8 During an interview on 5/11/22 at 9:22 AM the certified dietary manager (CDM) revealed she had been in her position less than one week and would maypost the new cleaning schedules. She indicated the freezers should be free of ice and the areas would be cleaned. The CDM revealed she was not sure who was responsible to clean the nourishment refrigerator and would find out. During an interview on 5/11/22 at 10:24 AM the Director of Nursing (DON) stated the kitchen area should be cleaned and have no ice buildup or spilled food in any of the freezers. She indicated she was not aware that Freezer #4 lid frame was missing. The DON indicated housekeeping was responsible for wiping the nourishment room counters daily and nursing staff were to wipe out the refrigerator every other day. The DON stated she would have staff clean the refrigerator. In an interview on 5/11/22 at 11:42 AM the maintenance man stated he had glued the freezer lid part on before, but it continued to be knocked off. He indicated management was aware and he was told to glue the freezer lid part back on. During a phone interview on 5/11/22 at 12:13 PM the administrator revealed their CDM was new and was working on cleaning the kitchen. The administrator revealed the maintenance man had the freezer part and would glue it back in place. He indicated he would have the kitchen staff clean the freezers, oven, can opener and HVAC vents.	F 812		
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	F 880		6/16/22

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F 880	Continued From page 9	F 880		

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 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

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F 880	Continued From page 10 (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 Administrator interview, the facility failed to implement a Legionella prevention program. This deficient practice had the potential to affect all 44 residents. Findings included: Review of the Emergency Preparedness and Infection Control Programs revealed the facility did not have a policy, procedures, or program for Legionella prevention. During an interview with the Administrator on	F 880	F880 1 The corrective action taken by the facility was to create an Infection Control Policy and Procedure (P&P) for Legionnaires Disease (LD). This P&P was developed to establish and maintain an LD infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of LD. 2 Because this alleged deficient practice had the potential to affect each resident in our facility, the LD P&P is	

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F 880	Continued From page 11 5/11/22 at 9:05 AM, he revealed there had not been a Legionella Prevention Program in place. He stated his expectation was to have one implemented immediately with a policy and procedures to be created that will include a facility assessment, water management program and testing protocols. The Administrator indicated a testing kit had been purchased and was due to arrive next week.	F 880	designed to envelop the entire building. 3 There are a number of measures that have been reviewed, shared and instituted to create our LD prevention program. Initially we performed a Root Cause Analysis (RCA) to determine why our facility did not have a P&P for LD. The results of the analysis may be viewed on the attached RCA sheet. We consulted with other professionals in the nursing home industry to determine how they developed their P&P as well as how they utilized their program. We realized that we did not have a Water Management Program (WMP); therefore, we fashioned our WMP after the Center for Disease Control□s seven key elements of a WMP. We found a company that sells Legionella Water System Test Kits. We purchased a kit and tested our water. The test was negative for Legionella bacteria (see information included). The training for our staff has been done by our Infection Preventionist and the Administrator within the facility as well as by our Director of Operations from the Governing Body (she is a nurse by background). A long-established relationship exists between the City of Henderson□s Water Department staff and a few of our key department managers. We have an open line of communication between the department and our Maintenance Director (employed for 14 years) and Central Supply Clerk (employed 22 years). These veteran department managers along with the original and current owner of our facility for the past 53 years, provides us with a working relationship with the city	

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	345316	A. BUILDING _____ B. WING _____	C 05/12/2022

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water department that is very sound. We began the training of our staff on May 24th with the department managers then extended it to all other staff on May 25th and 26th. Additional training for other staff members will be completed on June 15th with our annual Emergency Preparedness training.

4 The Maintenance Director will be responsible for performing inspections on the water system and mixing valves at least on an annual basis. He will coordinate his efforts with the City of Henderson□s water department as well as with the facility Infection Preventionist. Annual training for staff will be conducted as part of our annual training for Emergency Preparedness and Infection Control. The Administrator or their designee will be responsible for presenting the findings of the inspections to the Quarterly Quality Assurance Performance Improvement Committee at the quarterly meeting following the annual inspections.

Infection Control Policy and Procedure:
Legionnaires Disease
Senior Citizen□s Home, Inc.
May 24, 2022

Policy:
Senior Citizen□s Home promotes proactive steps to establish healthy, infection-free environments for their residents, staff and visitors. Residents who might contract Legionnaires Disease potentially may have been exposed to inadequately managed building water

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The procedures we incorporate will assure that the facility implements and maintains an Infection Prevention and Control Program designed to prevent, recognize and control, to the extent possible, the onset and spread of infections within the facility. The program will include:

" Perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection.

" Prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions.

" Use records of infection incidents to improve its infection control processes and outcomes by taking corrective actions, as indicated.

" Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination.

" Properly store, handle, process and transport linens to minimize contamination.

" The facility□s water management program is to coordinate any water issues with the City of Henderson□s Water Department to share our/their concerns or findings with the city water system that may create issues for the facility.

If a single case or multiple cases of Legionnaires disease is/are detected:

1 Report to the State Department of Health and to the local health department.

2 Recommendations for control will

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vary depending on the types of residents the facility services, whether the case is a probable or definite healthcare facility associated case and certain elements of the physical plant. The recommendations will cover:

-- Retrospective and prospective surveillance to identify additional cases.

-- Obtaining urinary antigen for Legionella for cases identified on retrospective surveillance.

-- Assessment of physical plant, potable water systems, construction activities and current water treatment and maintenance

-- Environmental culturing

-- Molecular analysis of patient and environmental isolates.

-- tap water restrictions for immune compromised populations

-- Notification to patients and family members if a water restriction is indicated, including the rationale for the restriction.

If a case of Legionnaires disease is definitively linked to the facility, the testing protocol will be to disinfect/treat our water system as quickly as possible. Long-term control measures are complex and must be individualized. Expert advice will be sought when developing long-term control measures. Consultants must assess corrosion, scaling biofilm, pH, temperature profile and other physical parameters that may negatively affect treatments. Other possibilities may include replacing or disinfecting shower heads, installing mixing or anti-scald

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F 880	Continued From page 16	F 880	valves to allow higher temperatures in all or part of the system, removing shock absorbers, replacing rubber washers with synthetic washers, removing aerators, periodically flushing to improve treatment in distal outlets or modifying the hot water re-circulation system to list some of the many modifications/options that may be used. This list is not all inclusive but would be a good start. Should additional resources be needed, we will always be able to reach out to the Centers for Disease Control (CDC) or the American Society of Health, Refrigerating and Air-Conditioning Engineers, Inc. The results of any investigation for Legionnaires Disease will be included in our Infection Control Committee Meeting. The findings from this committee are reviewed during our Quarterly Quality Assurance Performance Improvement Committee Meetings to determine if additional measures should be taken. AGENDA FOR STAFF MEETING MAY 25 and 26, 2022 7:15AM, 10:30AM and 2:30PM !!!!!THANK YOU FOR A GREAT SURVEY!!!!! I. Resident care and use of incontinence products II. Turning and Repositioning/Incontinence care III. Facility Noise Levels	

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IV. Foley Catheter Care

V. Resident Falls

VI. Infection Control

VII. Communication Between Departments

VIII. Documentation Clues

IX. Legionella P&P

X. Admissions and Readmissions

XI. Review of Inservice Book

SCH Water Management Program

The Water Management Program for our facility is made up of seven key elements. They are as follows:

1 We have formed a water management program team. This team consists of the Maintenance Director, Infection Preventionist, Administrator and The Director of Operations for SCH, Inc. The team will be responsible for driving the water management program in our facility.

2 Describe the building water systems using text and flow diagrams. Our building is fed by the City of Henderson□s Water Department. We have city water and sewer services. This is important because this gives us an extra layer of protection using city water verses well

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water and septic. The city water department must operate their system based on sound water management policies with strict supervision of the use of chemicals (chlorine) and routine flushing of the main water lines. This gives us a much cleaner, sanitary water supply than if we were to be on a well system.

3 Identify areas that Legionella could grow and spread. We do not have a pool, spa or other areas where we hold water in the facility. Our sprinkler system is a dry system so water is not sitting stagnant in the pipes providing a possible growth area for Legionella. We utilize the instant hot water heaters instead of large boilers with holding tanks. This reduces the chance of bacteria growing in the hot water lines. As well the hot water lines have circulating pumps to keep the water moving in the system.

4 Decide where control measures should be applied and how to monitor them. Control measures would be applied at the mixing valves for the hot water. This is our most vulnerable location due to the mixing valves being constantly forced to combine hot and cold water in order to maintain safe water temperatures for the residents. We will monitor these units at least monthly to ensure proper temperature control and to visually inspect them for possible build up or corrosion on the valves.

5 The way we will intervene when control limits are not met will be to bring in a qualified plumber to consult and or correct any issues that are identified.

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F 880	Continued From page 19	F 880	6 We will verify that the program is running as designed and is effective by maintaining open communications with the city water department. This will allow us to validate that the main water lines are being flushed routinely, that there have no outbreaks of LD in the city or county and to monitor the water quality for our facility. 7 The last area of our water management program is that we will document our efforts to maintain a safe and infection free water supply for our residents. We will maintain an open line of communication with the city water department to keep us informed of any issues in our area, our city or our county. Root Cause Analysis for Failure to Develop Legionella Disease P & P 1 Identify the event to be investigated: Why was there no P&P on LD developed for this facility? 2 Team members to be included in this investigation: Director of Operations, Administrator and Director of Nursing. 3 Describe what happened: ¿ on June 2, 2017 CMS created a requirement for all nursing homes to have a P&P for LD. ¿ The Administrator of record at that time failed to develop the P&P for LD. ¿ On July 6, 2018, CMS repeated their mandate that nursing homes must have a P&P for LD. ¿ The Administrator of record for 2017 was the same in 2018. The Administrator failed to implement or	

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develop a P&P for LD.

4. Identify the contributing factors:

- The facility was having difficulty transitioning with ensuring Care Plans were personalized for each resident.
- Several members of the management team had personality conflicts that caused the Administrator to be less attentive to additions or changes in some regulations.
- There have been 6 different administrators since this requirement went into effect.

5. Identify the root causes:

- A lack of communication and follow through
- A failure by the Administrator to keep abreast of all policy or regulatory changes in the industry.
- The governing body placed too much trust in the Administrator□s ability to keep the facility in compliance with all regulatory requirements

6. Design and implement changes to eliminate the root causes:

- The current Administrator will maintain close communication with the Director of Operations on any regulatory changes issued by CMS
- The Administrator will review the weekly UPDATE Newsletter from the North Carolina Health Care Facilities Association to monitor for any changes in the regulations.
- The Director of Operations will share any new changes in the regulations she finds with the Administrator to ensure future compliance with P&P

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F 880	Continued From page 21	F 880	development or other regulatory requirements 7. Measure the success of changes: - This RCA will be used to help the facility succeed in the future with our compliance of creating and instituting new P&P□s as recommended or required by CMS or other governmental agencies that relate to the operation of a nursing facility. We believe we understand what happened and why it happened. We all care about making sure we do not repeat the errors from the past.	