STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265866	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steelville Senior Living	311 N Spring Street Steelville, MO 65565

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 - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33477 45564 Based on observation, interview and record review, the facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD- a serious type of pneumonia (lung infection) caused by Legionella bacteria). On 02/20/24, one resident (Resident #1) tested positive for Legionella. Failure to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems has the potential for the failure of staff to identify and mitigate the presence of waterborne pathogens, which places all residents of the facility at risk of exposure which could lead to illness. The facility census was 48 with a capacity of 72. The administrator was notified on 03/08/24 at 3:30 P.M., of an Immediate Jeopardy (IJ) which began on 02/20/24. The IJ was removed on 03/08/24 as confirmed by the surveyor's onsite verification. 1. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17; showed: -The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; (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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the Centers for Disease Control and Prevention (CDC) and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit; -Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities: -Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; -Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Observations on 03/01/24 during the facility tour which began at 9:45 A.M., showed signs posted at the entrance of the facility to notify facility occupants not to use the facility water due to a detected presence of Legionella. Observations showed the water turned off to resident accessible water fixtures, except for two water fountains located in the rear common area. Review of the facility's water management program records, updated 03/01/23, showed the records contained documentation of a water management team, a description of the facility's water distribution systems, identified risk areas and control measures for the identified areas, identified systems for monitoring control limits and effectiveness, and a contingency plan for when control measures were not effective. Review showed the facility staff documented the identified areas of concern and the control measures for the identified areas which included: -All incoming main lines due to external hazards such as construction or main breaks. Staff documented the control measure as visual inspection of water and city water test reports; -Sinks and showers due to disinfectant risk and stagnation. Staff documented the control measure as disinfectant levels; -Cooling tower and chiller due to stagnation risk, temperature and conditions for bacteria. Staff documented the control measure as Visual, Disinfectant, Temperature; -Ice Machine due to temperature and conditions for bacteria. Staff documented the control measures as Visual; (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Garden Water Fountain due to temperature and conditions for bacteria. Staff documented the control measures as Visual, Disinfectant; -Hot water heaters and boilers due to temperature. Staff documented the control measures as Temperature; -Laundry Facilities due to stagnation and temperature. Staff documented the control measure as Temperature; -Closed loop heating system due to conditions for bacteria and temperature. Staff documented the control measure as Temperature, Disinfectant. Review of the water management program records showed the staff documented the system for monitoring control limits and effectiveness as weekly inspections documented via the facility's computer based preventative maintenance portal (TELS) and bi-monthly inspections by an outside water specialist company, as well as any corrective actions. Review of the facility water management program records showed they did not contain documentation of specified testing protocols, staff responsible for the testing, and acceptable ranges for the control measures identified by the staff for the areas at risk. Review of the CDC's Routine Legionella Testing: A multifactorial approach to performance indicator interpretation (a document which describes various levels of Legionella growth and types of Legionella associated with LD) dated 02/03/21, showed the detection of 1.0 to 9.9 colony forming unit per milliliter (CFU/ml) (the measurement unit for Legionella growth) indicated poorly controlled growth of Legionella in the potable water system. Review of the facility's water inspection and testing records dated, January 2023 through January 2024, showed the records contained documentation of results for Legionella testing of facility water samples conducted by an outside contracted laboratory, dated 01/27/23, 10/20/23 and 01/22/24. Review of the testing record dated 01/27/23, showed the laboratory documented the Legionella detection results as less than 1 CFU/ml (controlled) in six facility water samples. Review of the testing record dated 10/20/23, showed the laboratory documented the Legionella detection results as 1 CFU/ml (poorly controlled growth) in one of six facility water samples and 2 CFU/ml (poorly controlled growth) in one of the five remaining water samples. Review the testing record dated 01/22/24, showed the laboratory documented the Legionella detection results as 4 CFU/ml (poorly controlled growth) in one of six facility water samples and 5 CFU/ml (poorly controlled growth) in one of the five remaining water samples. Review of the facility's water management team quarterly meeting minutes, dated 09/28/23 through 12/29/23, showed the staff did not document any corrective actions taken to the identified growth of Legionella in the facility's water system identified by the laboratory results dated [DATE]. Review of the quarterly meeting minutes dated 12/29/23 showed the staff documented no new concerns. Review showed the records did not contain documentation of another water management team meeting between the dates of 12/30/23 and 03/01/24. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Department of Health and Senior Services (DHSS) Bureau of Environmental Health Services' (BEHS) Sanitation Observation Report dated 02/27/24, showed BEHS staff conducted an environmental Legionella assessment and collected 28 environmental Legionella samples for testing at the facility as a result of a reported case of Legionella in an individual who had an associated stay at the facility. Review showed the report contained documentation the facility staff provided a copy of an established water management plan which appeared to be missing portions of the plan. The Observation Report showed the facility conducted Legionella monitoring water sampling and Legionella detection sample results were reported in October 2023 and January 2024. Review showed BEHS staff recommended the facility immediately vacate residents from room [ROOM NUMBER] as a result of the reported case of Legionella. BEHS staff also recommended the facility to engage the services of a water management company to update the facility's water management plan as the submitted copies appeared to be missing portions of the plan, which included monitoring of chlorine residuals throughout the facility due to the use of in-line chlorination systems and written procedures to direct facility actions when a Legionella detection sample is reported. Review of the facility's Legionella Laboratory Results Reports, dated 03/06/24, showed BEHS staff collected 28 samples from the facility on 02/27/24 and submitted the samples to the state public health laboratory for analysis. The reports showed all of the samples were analyzed by the laboratory on 02/28/24 and the results were released on 03/06/24. The reports showed Legionella detected in 20 of the 28 samples collected from the facility, which included the cold and hot water from the sink in Resident #1's room. During an interview on 03/01/24 at 12:00 P.M., the administrator said he/she did not have any additional documentation for the water management program related to specified testing protocols, staff responsible for the testing, and acceptable ranges for the control measures identified by the staff for the areas at risk. Review of Resident #1's facility medical record showed an admitted [DATE]. Review of the resident's nursing notes, dated 02/18/2024 at 2:15 A.M., showed the resident discharged to the hospital due to shortness of breath and lethargy (sleepiness or deep unresponsiveness). Review of the resident's social services notes, dated 02/20/24 at 2:02 P.M., showed the resident's daughter reported resident will probably expire at the hospital due to health decline. Review of the resident's hospital records, with an admitted [DATE], showed the resident was admitted to the hospital for shortness of breath and tested negative for influenza and Covid on 02/18/24. Review showed the results of a urine specimen, collected on 02/19/24, reported as positive for Legionella on 02/20/24. Review showed the resident passed away on 02/21/24 with a primary cause of death indicated as heart failure and secondary cause of death indicated as pneumonia. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 03/01/24 at 12:00 P.M. the administrator said Resident #1 had a decline in health between 02/17/24 and 02/18/24. The administrator said the resident complained of rib pain and then he/she developed a fever, had a decrease in his/her oxygen saturation level to 88 percent on room air, had little response to physical stimuli and staff noted wheezing in the resident's lungs, so they sent the resident to the hospital on 02/18/24. The administrator said the resident's family member notified the facility on 02/20/24, the resident would likely pass away due to a decline in his/her condition and they were notified the resident passed away on 02/21/24. The administrator said the local health department called and said Resident #1 had tested positive for LD. The administrator said the facility has an outside company test the water for Legionella and after being notified about the resident, he/she reviewed the water management records and found they did not have the results for the samples that were sent for testing in January 2024. The administrator said it usually takes a month to get the testing results from the company, but due to a recent facility domain change, which caused issues with them getting emails, they did not get the results until he/she called them after he/she spoke to the health department. The administrator said when they got the results from the October 2023 testing back from the lab, the company directed the facility to flush their water lines due trace amounts of Legionella detected. The administrator said he/she had a verbal conversation with the company representative and he/she did not have documentation to show their recommended corrective actions. The administrator said they flushed the water lines as directed, but he/she did not have documentation to show their corrective actions. The administrator said the facility had a city water line break in January 2024. The administrator said they contacted the city to fix the break and did not do any increased monitoring, testing or treatment of facility water since it was just a water line and not a water main. The administrator said the facility also has a chlorination system attached to the facility water supply. The administrator said when the facility's contracted water system service provider came to the facility on [DATE], they found one of the three chlorinator pumps was not working appropriately. The administrator said he/she did not know the acceptable ranges for the levels of chlorine in the water, the facility staff only checked the function of the chlorination pumps and staff had not tested for the amount of chlorine in the water prior to this incident. The administrator the facility corporation and the facility's outside water management company are responsible for the development of the facility's water management program. He/She said the current program was developed by the outside water management company. The administrator said he/she did not know the water management program needed parameters for the control measures put in place, he/she did not know what the parameters for the control measures were and he/she did not know the facility's water management plan did not contain all required information. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 03/01/24 at 2:40 P.M., the maintenance director said he/she forgot about the two fountains in the rear common area. The maintenance director said the facility's water system service provider installed the water chlorination pumps after the facility tested positive for Legionella in 2021. The maintenance director said prior to this incident, he/she did not know what the acceptable levels of chlorine in the water were and facility staff had not tested the chlorine levels. The maintenance director said when they were installed, the service provider told him/her to just check the function of the pumps, which he/she does every Monday, and as long as they were working they would supply the correct amount of chlorine so he/she did not need to test the chlorine levels. The maintenance director said he/she also routinely tests the hot water to maintain the temperatures between 95 and 120 degrees Fahrenheit and he/she flushes the water heater tanks. The maintenance director said the facility has a company that comes in 12 times a year to monitor the closed loop system and cooling tower for the water system, but they do not monitor for the presence of Legionella. The maintenance director said he/she sends off water samples to another company to test for Legionella twice a year and the results of those tests are sent to the administrator about a month later. The maintenance director said the facility's water management team meets quarterly to discuss any issues and possible solutions which includes a review of the water testing records. The maintenance director said he/she flushed the water systems around October to November 2023 as directed and he/she had not seen the January 2024 water sample test results prior to this incident due to an issue with the email system. The maintenance director said, since the administrator is emailed the testing results, the administrator should notify him/her of any abnormal results so they can make corrections as needed. The maintenance director said he/she did not know the facility's water management plan did not contain all required information. During an interview on 03/07/2024 at 2:54 P.M., the maintenance director said he/she did not find out about the positive water samples in October and January until the BEHS staff showed up a couple of weeks ago. The maintenance director said the facility went through an e-mail change and they did not receive the October and January reports until after they got the e-mail issue fixed. He/She said the reports went to the administrator. The maintenance director said during the December water management team meeting, the lack of October results was not addressed. The maintenance director said the last time he/she checked chlorine levels was right after Christmas and the levels were okay, so he/she stopped checking and did not tell anyone. The maintenance director said he/she did not know acceptable ranges for chlorine levels. The maintenance director said he/she was never told to check chlorine levels as a part of chlorine injector maintenance. The maintenance director said he/she would make sure the chlorinator pumps were still pumping by performing visual inspection from outside chlorinator unit. Inspections consisted of looking for leaks and making sure pumps were pumping. The maintenance director said he/she never received training on the units. The maintenance director said in January there was a facility water main line break, which feeds resident showers and sinks. The maintenance director said he/she did not take any actions because he/she did not consider the water line break a hazard because it was on the city side of the shutoff valve. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level L. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At the time of exit, the severity of the deficiency was lowered to the F level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO000232462