STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365466	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Heath	717 South 30th Street Heath, OH 43056

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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on record review, interview, and facility policy review, the facility failed to implement a comprehensive and effective water management program to identify areas in facility at risk for Legionella growth. This affected one resident (#122), who contracted Legionella while residing in the facility and had the potential to affect all 120 residents residing in the facility. The facility census was 120. Findings Include: Record review revealed Resident #122 was admitted to the facility on [DATE] with diagnoses including quadriplegia, dependence on respirator, chronic bronchitis, moderate protein calorie malnutrition, acute embolism and thrombosis, acute respiratory failure with hypoxia, edema, dysphagia, hypertension, pleural effusion, anemia, anxiety disorder, insomnia, sepsis, urinary tract infection, pneumonia, acute kidney failure, major depressive disorder, neuromuscular dysfunction of bladder, bradycardia, Raynauds' syndrome, post traumatic stress disorder (PTSD), osteoarthritis, and other psychoactive substance abuse. Review of the Minimum Data Set (MDS) assessment, dated 06/04/24 revealed the resident was cognitively intact. Review of Resident #122's progress note dated 08/11/24 revealed the resident was less reactive and more lethargic (a change in condition for the resident). The facility nurse practitioner was called and orders were obtained to transfer the resident to the hospital. Review of Resident #122's hospital laboratory results, dated 08/11/24 revealed the resident had been hospitalized three weeks ago at which time testing for L. pneumophilia Serogroup 1 antigen test was negative for Legionella pneumophilia. However, a repeat laboratory test, obtained on 08/11/24 revealed the resident tested positive for Legionella at this time. Interview with Licensed Practical Nurse (LPN) #101 on 08/13/24 at 1:55 P.M. revealed the facility had always had running water, but were told yesterday (08/12/24) they had to implement emergency water protocol and not to use the tap water because of a positive Legionella case. (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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(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 - Many	Interview with the Administrator and Director of Nursing (DON) on 08/13/24 at 2:30 P.M. revealed they were aware of the hospital testing results for Resident #122, who was admitted to the hospital on 08/11/24 due to lethargy and change of condition and subsequently diagnosed with Legionella. The Administrator and DON revealed as soon as they were made aware of the positive result (08/12/24) they implemented the facility emergency water management protocol. This included not using water from any faucet in the facility. Interview with the Administrator and Maintenance Director #107 on 08/13/24 at 3:30 P.M. revealed the facility had not completed a Legionella risk assessment prior to Resident #122 testing positive for Legionella. The facility had not completed a risk assessment to determine potential areas in the facility where Legionella may grow or be present. They reported the facility did have measures in place to prevent Legionella such as checking water temperatures, PH/Chlorine testing and visual inspections of the water outlets and felt these measures had been sufficient. The Administrator and Maintenance Director #107 indicated a (contracted) water management company would be in the facility on 08/15/24 and 08/16/24 to complete a Legionella assessment of the facility to determine if there were places Legionella could grow, and to obtain water sample(s) to be tested for Legionella. Water testing results would take seven to ten days. Review of facility Water Management Program, dated 02/01/24, revealed water management programs identify hazardous conditions and take steps to minimize growth and spread of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program was a multi-step process that required continuous review. Seven key activities were routinely performed in a Legionella water management program: Establish a water management program team. Describe the building water systems using flow diagrams and a written description. Identify areas where Legionella could grow and spread. Decide where control measures should be applied and how to monitor them. Establish ways to intervene when control limits were not met. Make sure the program was running as designed (verification) and was effective (validation). And document and communicate all the activities. The general principles of an effective water management program included maintaining water temperatures outside of the ideal range for Legionella growth, preventing water stagnation, ensuring adequate disinfection, and maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella growth. The facility would implement measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems with a water management program that was based on nationally accepted standards and would include an assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread, and measures to prevent the growth of opportunistic waterborne pathogens and how to monitor them. The assessment would include a description of the building water systems using text and flow diagrams for identification. Control measures may include visible inspections, use of disinfectant, and temperature. Monitoring such controls include testing protocol for control measures, acceptable ranges, and documenting the residents of testing. Water cultures for Legionella or other opportunistic waterborne pathogens were not required as part of routine program validation, although there may be instances when it was needed. Interventions would be implemented when control limits were not met. The facility would contact the local/state public health authority if there was a case of healthcare associated Legionellosis or an outbreak of an opportunistic waterborne pathogen causing disease. The facility would follow public health authority recommendations which may include, but were not limited to, remediating the pathogen reservoir and adjusting control measures as necessary. This deficiency represents non-compliance investigated under Complaint Number OH00156760.