

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Spring Meadows Nursing, A Villa Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 Clarion Ave Holland, OH 43528	

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)
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445</p> <p>Based on observation, medical record review, staff interviews, interviews with the Local Health Department (LHD), review of hospital medical records, review of water sample testing reports, review of chlorine level logs, review of the facility's water management plan and review of the facility's water treatment program, the facility failed to implement immediate action to protect residents from Legionella (bacteria that causes a severe form of pneumonia with exposure generally from droplets of water) when a water sample test detected Legionella on the 300 Hall on 06/03/24. This resulted in Immediate Jeopardy and serious life-threatening harm and the potential for additional negative health outcomes and/or death when one resident (#01), who resided on the 100 Hall, developed respiratory symptoms and experienced a change in condition on 06/13/24. On 06/14/24, Resident #01 was sent to the hospital for further evaluation and subsequently was admitted to the intensive care unit (ICU) with diagnoses including sepsis with acute renal failure and septic shock due to an unspecified organism and later tested positive for Legionella pneumonia (also known as Legionnaires' disease). Resident #01 remained hospitalized in the ICU with high flow oxygen and intravenous (IV) antibiotic therapy. The facility was notified by the hospital on 06/16/24 of Resident #01's positive Legionella pneumonia result. Following the notification to the facility that Resident #01 had tested positive for Legionella pneumonia, the facility did not notify the local health department (LHD) or implement any immediate actions to protect the remaining 86 residents of the facility, placing them at potential risk for Legionella bacteria exposure. The facility census was 87.</p> <p>On 06/18/24 at 12:03 P.M., the Administrator and the Director of Nursing (DON) were notified Immediate Jeopardy began on 06/16/24 when the facility was notified by the hospital Resident #01 tested positive for Legionella pneumonia. Review of the facility water test samples revealed on 06/03/24, a water sample from the 300 Hall tested positive for Legionella pneumophila, serogroup one. At that time, the facility stopped use of the water on the 300 Hall but implemented no additional interventions for other areas of the facility. Review of Resident #01's medical record revealed the resident resided on the 100 Hall. Further review revealed on 06/13/24, Resident #01 developed respiratory symptoms, which included a wet cough. Resident #01's condition continued to decline, to include congestion and confusion. On 06/14/24, a chest x-ray was completed, which indicated a nonspecific left perihilar density that could be pneumonia. Resident #01 was transferred to the hospital for further evaluation and subsequently admitted to the ICU and was diagnosed with Legionella pneumonia. Resident #01 remained in the ICU on high flow oxygen and antibiotic therapy.</p> <p>The Immediate Jeopardy was removed on 06/18/24 when the facility implemented the following corrective actions:</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 366042	If continuation sheet Page 1 of 7

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/10/24, an additional 10 water samples were taken for legionella testing. Results for the 10 samples were received on 06/19/24 and each tested negative for Legionella bacteria.</p> <p>Beginning on 06/17/24, Maintenance Services Director (MSD) #301 will audit the recirculating pipe one time daily for two months to ensure appropriate temperatures are maintained.</p> <p>On 06/17/24 at 10:00 A.M., MSD #301 set the facility's circulating pump to continuous run.</p> <p>On 06/18/24 at 10:00 A.M., MSD #301 installed filtered shower heads on all showers.</p> <p>Beginning on 06/18/24, the DON will audit staff call-offs three times weekly for four weeks for signs and symptoms related to Legionella illness.</p> <p>On 06/18/24 at 12:00 P.M., Regional Director of Operations (RDO) #320 and Regional Director of Plant Operations (RDPO) #325 reviewed the facility's water management policy and updated it to meet the Centers for Disease Control (CDC) and the Ohio Department of Health's (ODH) recommendations.</p> <p>On 06/18/24 at 1:00 P.M., the Administrator re-educated MSD #301 and Maintenance Assistant (MA) #330 on flushing the whole water system utilizing the flushing documentation log and testing and documenting chlorine levels daily to ensure adequate sanitization to kill Legionella and to validate electronic measuring systems.</p> <p>On 06/18/24 at 1:00 P.M., Dietary Manger (DM) #306 inventoried the in-house bottled water and confirmed a sufficient supply was available to meet resident needs.</p> <p>On 06/18/24, Food Service Provider (FSP) #500 delivered bagged, bulk ice. Deliveries will continue two times weekly (Mondays and Thursdays) and as needed until the facility's water is deemed safe by the LHD.</p> <p>On 06/18/24 at 2:30 P.M., MSD #301 installed a medical grade ice machine filter (protects against Legionella) on the facility's ice machine. On 06/20/24 at 11:00 A.M., the refrigeration contractor serviced the medical grade ice machine filter for use.</p> <p>On 06/18/24 at 4:00 P.M., ADON #300 began all staff education on the facility's Legionnaires Guidelines, to include no use of facility faucets, bed pan washers, ice machine, kitchen faucets/sprayers or any other water source; nebulizer, CPAP, Bi-Pap and respiratory equipment to be rinsed with sterile water; proper use of alcohol-based hand sanitizer for residents and staff and utilizing bottled water for hand washing if hands are visibly soiled; and use of bottled water for drinking, brushing teeth and cleaning. Any staff, including agency staff, unable to be reached will receive the education from ADON #300 or designee prior to their next scheduled shift.</p> <p>On 06/18/24 at 5:15 P.M., MSD #301 covered all faucets, ice machine and all other water supply sources to ensure no resident or staff use.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/18/24 at 5:30 P.M., an Ad Hoc Quality Assurance Performance Improvement (QAPI) committee meeting was held to review the facility's Legionella Policy and Procedures and the steps taken to remediate the immediacy of the concern. In attendance were the Administrator, the DON, Assistant Director of Nursing (ADON) #300, MSD #301, Certified Nurse Practitioner (CNP) #350, Registered Nurse Supervisor (RNS) #302, Housekeeping Supervisor (HS) #303, Social Worker (SW) #305, DM #306, RNS #310, Registered Dietitian (RD) #312, Physical Therapy Director (PTD) #313, Licensed Practical Nurse (LPN) #315, and Admissions Director (AD) #316. A root cause analysis was initiated to determine gaps in monitoring the Water Management System to prevent Legionella outbreaks and implement corrective actions in conjunction with the local health department (LHD).</p> <p>On 06/18/24 at 6:00 P.M., the DON completed a respiratory assessment on all residents with no new respiratory concerns identified.</p> <p>Beginning on 06/18/24, the DON or designee will complete respiratory monitoring on all residents each shift until the results of the final water samples, taken on 06/25/24, are received and the facility water is deemed safe by the LHD.</p> <p>On 06/18/24 at 6:00 P.M., Corporate Medical Director (CMD) #650 audited all residents sent to the hospital in the past 30 days for potential Legionella related illness. No areas of concern related to Legionella illness were identified.</p> <p>Beginning on 06/18/24, MSD #301 will audit water chlorine levels, water temperatures and flushing of dead legs two times weekly for two months. Any concerns will immediately be reported to the Administrator and follow up with the QAPI committee to determine appropriate interventions.</p> <p>Beginning on 06/18/24, the Administrator or designee will complete audits of three random staff three times weekly for four weeks then one time monthly for two months to ensure compliance with the Legionella education provided.</p> <p>Interviews on 06/20/24 from 10:25 A.M. through 10:30 A.M. with State tested Nurse Aide (STNA) #400, STNA #401, STNA #402, LPN #403, LPN #404 and LPN #405 verified education was provided regarding Legionella and protective measures to limit the transmission of Legionella bacteria.</p> <p>Observations on 06/20/24 from 10:25 A.M. through 10:40 A.M. confirmed the facility had bottled water and bagged ice available for residents. Additionally, all water faucets were covered with plastic to prevent resident and staff use.</p> <p>Review of two (#2 and #57) additional open resident records, reviewed for respiratory illness, revealed no concerns.</p> <p>The QAPI Committee will meet monthly to review audit results to ensure on-going compliance. An Ad Hoc QAPI will be held to address any immediate audit findings.</p> <p>Although the Immediate Jeopardy was removed on 06/18/24, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Findings include:</p> <p>Review of the medical record for Resident #01 revealed an admitted [DATE]. Diagnoses included multiple sclerosis with paraplegia and bilateral lower extremity wasting and contracture, peripheral vascular disease, chronic kidney disease, hypertension and paroxysmal atrial fibrillation.</p> <p>Review of the quarterly Minimum data Set (MDS) assessment dated [DATE] revealed Resident #01 was cognitively intact, independent with eating and oral care and dependent for toilet use, showers, and personal care. Resident #01 was frequently incontinent of bowel and bladder, had functional impairments to both lower extremities and utilized a manual wheelchair for mobility. Resident #01 was dependent on staff for mobility and transfers.</p> <p>Review of a progress note, dated 06/13/24 at 8:58 A.M., revealed Resident #01 had a wet cough with coarse breathing and dark urine. The physician was notified, and an order was received for Mucinex twice a day for seven days. Additional review of a progress note dated 06/13/24 at 2:10 P.M. revealed Resident #01 had an oxygen saturation on room air of 94%. Further review of the progress notes revealed on 06/13/24 at 10:26 P.M., Resident #01 continued with a nonproductive cough, with hoarse voice sounds and congestion. Resident #01 had difficulty feeding himself at mealtime and required staff assistance. On 06/14/24 at 7:13 A.M., Resident #01 was observed in bed with pale skin, was disoriented and confused and continued with a cough. On 06/14/24 at 2:45 P.M., Resident #01 had a chest x-ray completed. The results were called into the facility at 2:55 P.M. and revealed a nonspecific left perihilar density that could be pneumonia. Resident #01 was subsequently transferred via emergency medical services (EMS) to the hospital for further evaluation.</p> <p>Review of the Hospital Emergency Department (ED) notes, dated 06/14/24 at 3:51 P.M., revealed Resident #01 had not been feeling well for two days and report from the extended care facility showed lungs were collapsed and the intestines were pushing up into them, which is sepsis criteria. Temperature upon arrival was 103.1 degrees Fahrenheit (F), hypotensive at 101/58 with a pulse rate of 109 beats per minute, oxygen saturation of 92% on 4 liters of oxygen, and breath sounds were decreased with rhonchi (coarse, loud sounds caused by constricted larger airways) present in both the left middle and upper lobe. Resident #01 was treated for septic shock and responded well to intravenous fluids.</p> <p>Additional review of hospital documents dated 06/14/24 revealed a chest x-ray was completed while Resident #01 was in the ED. It showed left upper lobe consolidation suggesting pneumonia, and elevated right hemidiaphragm (muscle that separates the chest cavity from the abdomen and serves as the main muscle for respiration) raising the possibility for diaphragmatic paralysis. Resident #01 had a computed tomography (CT) which revealed a large left upper lobe consolidation concerning for pneumonia, elevated right hemidiaphragm which was new on comparison to previous radiographs completed on 04/23/24. Review of a CT of the abdomen and pelvis revealed concerns for pneumonia marked by elevation of the right hemidiaphragm, likely from diaphragmatic paralysis and phrenic nerve (controls the diaphragm) palsy. Lastly, review of the laboratory testing completed on 06/14/24 revealed a complete blood count (CBC) was obtained with results showing an elevated white blood count (WBC) of 12.9 (normal is 4.0-11.0) and platelets 135 (normal is 150-450). A urinalysis collected on 06/14/24 at 8:40 P.M. was positive for a large amount of leukocyte esterase (normal is negative) and hemoglobin (normal is absent or negative) with urine culture positive for the Legionella antigen. Resident #01 was admitted to the ICU with diagnoses including Legionella pneumonia, sepsis with acute renal failure and septic shock with a plan for 10 to 14 days of IV antibiotics and oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of a hospital pulmonary consult progress note dated 06/16/24 revealed Resident #01 experienced worsening respiratory failure and required additional oxygen with high flow oxygen and DuoNeb (breathing) treatments every six hours. The progress summary revealed Resident #01 had left upper lobe Legionella pneumonia and positive Legionella urinary antigen was reported to the local health department. The note indicated the facility must be notified as well.</p> <p>Review of a repeat chest x-ray, completed in the hospital on 06/16/24 due to respiratory distress, difficulty breathing, and shortness of breath revealed an increasing right pleural effusion (build-up of fluid around the lungs) and right lobe atelectasis (collapse of the lung/part of the lung) with stable left midlung consolidation.</p> <p>Review of a nursing progress note dated 06/16/24 at 5:17 P.M. revealed the facility checked with the hospital on Resident #01's condition. Resident #01 remained hospitalized and had been diagnosed with Legionella in the urine.</p> <p>Review of the facility's weekly water chlorine level testing from 05/12/24 through 06/07/24 revealed on 05/24/24 the low range result was 0.16 and the high range result was 0.3 (the normal chlorine control range is between 0.5 and 4.0). On 06/05/24 a low range test result was 0.46, which was below the 0.5 minimum reading required.</p> <p>Review of the facility water testing samples, taken 05/23/24 with results on 06/03/24, revealed a water sample collected on the 300 Hall had a positive result for L. pneumophila, serogroup 1 at a concentration of 130 colony-forming unit/milliliter (CFU/mL). Further review revealed uncontrolled levels of Legionella bacteria were greater than or equal to 10 CFU/mL in potable (drinkable) water. Additionally, L. pneumophila serogroup 1 was highly associated with Legionnaires' disease. Lastly, the document indicated at 130 CFU/mL, a high action level was required, which included adjusting biocide (disinfectants such as chlorine) treatments immediately or disinfect/clean within 30 days, review program and retest.</p> <p>Observations on 06/17/24 from 7:25 A.M. until 8:50 A.M. revealed staff providing bottles of water to residents. Residents were denied ice when requested.</p> <p>Interview on 06/17/24 at 8:20 A.M. with LPN #306 revealed Legionella was detected in the facility's water. LPN #306 reported a resident had been admitted to the hospital and tested positive for Legionella. Upon arriving to the facility on [DATE] for her morning shift, LPN #306 was told not to use the facility water and was provided bottled water for medication administration.</p> <p>Interview on 06/17/24 at 9:20 A.M. with the DON revealed the facility had conducted water testing and a sample from the 300 Hall came back positive for Legionella on 06/03/24. The DON stated the positive water sample result was questionable but respiratory assessments for all residents on the 300 Hall were initiated on each shift. However, Resident #01, who resided on the 100 Hall, exhibited respiratory symptoms on 06/13/24 and was subsequently sent to the hospital for evaluation on 06/14/24. The DON stated Resident #01 tested positive for Legionella and remained in the hospital. The DON verified the facility became aware of Resident #01 testing positive for Legionella on 06/16/24 but residents and staff were not instructed until the morning of 06/17/24 at approximately 6:00 A.M. to not use the facility water. Additionally, the DON confirmed the facility did not notify the LHD of Resident #01's positive Legionella result on 06/16/24.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 06/17/24 at 12:19 P.M. with MSD #301 revealed routine annual water testing was completed on 05/23/24 with a water sample sent from rooms [ROOM NUMBERS]. On 06/03/24, testing results were received and revealed Legionella was detected in the water sample sent from room [ROOM NUMBER]. MSD #301 stated a meeting with the Administrator, the DON and corporate representatives occurred on 06/04/24 to discuss an action plan. The plan included changing the water faucet and the water lines in room [ROOM NUMBER] and for staff to stop using the shower room on the 300 Hall. MSD #301 verified the low chlorine test results on 05/24/24 and 06/05/24 and further verified no interventions had been implemented for the low chlorine levels on those dates. MDS #301 stated he did not recognize the chlorine levels as low. MSD #301 confirmed the filter on the facility's ice machine did not protect against Legionella and had been in use until the morning of 06/17/24.</p> <p>Interview on 06/18/24 at 11:55 A.M. with Local Health Department Epidemiologist (LHDE) #900 revealed the facility did not notify them, as required, of Resident #01 testing positive for Legionella. On 06/17/24, LHDE #900 stated they received notification from the hospital where Resident #01 was being treated. While the facility became aware on 06/16/24 (Sunday), the LHD had an after-hours phone number for facilities to call to report Legionellosis associated illness. LHDE #900 verified the first contact with the facility related to Resident #01 testing positive for Legionella was on 06/17/24 at approximately 9:00 A.M., when they reached out to the facility.</p> <p>Interview on 06/20/24 at 10:00 A.M. with LHDE #910 confirmed she became aware on 06/17/24 of Resident #01 testing positive for Legionella, when she received the notification from the hospital. LHDE #910 stated she reached out to the facility to begin their investigation and verified the facility did not notify the LHD as required. LHDE #910 stated the investigation revealed Resident #01 never left his room and had not left the facility since October 2023, therefore, the Legionella exposure had to of come from the facility. While the facility had one Legionella positive water sample on the 300 Hall, they had not been able to determine how Resident #01 contracted Legionella. LHDE #910 confirmed Legionella was not spread from person to person and transmission was through inhalation of contaminated, aerosolized water. LHDE #910 stated they were able to determine Resident #01 used no aerosol machines, such as breathing treatments, and the only known potential source was the facility's water supply. Additionally, LHDE #910 verified the facility did not begin implementing any interventions to protect the additional residents of the facility until the morning of 06/17/24. LHDE #910 confirmed they were currently working with the facility on their water mitigation plan and no additional cases of Legionella had been identified.</p> <p>Review of the facility's plan for water management titled Water Management Plan, dated 01/02/24, revealed procedures for minimizing the risk of Legionnaires' disease within the building water system. In the event of a known or suspected case of Legionellosis associated illness within the facility, directives issued by national authorities and regional and local health authorities should be followed, including where and when additional testing should be performed and procedures for emergency disinfection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the undated facility policy titled Water Management Program, revealed the facility will conduct an annual review of the water system. All cases of Legionella shall be reported to the local/state health officials, followed by an investigation including: a review of the microbiology and medical records; actively identifying all new and recent residents with healthcare-associated pneumonia and testing them for Legionella using both a blood culture of lower respiratory secretions and an urinary antigen; evaluating potential environment exposures; performing an environmental assessment; decontaminate environmental sources; work with local and/or state health department staff to determine how long heightened disease surveillance and environmental sampling should continue.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154915.</p>