Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969017	A. BUILDING: _____ B. WING _____	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERMARK AT TRINITY (THE)	1960 BLUE FOX WAY TRINITY, FL 34655

(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) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number: 2023002499) and a generator monitoring were conducted at Watermark of Trinity on . Deficiencies were identified at the time of survey.	A 000		
A 152 SS=J	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during	A 152		

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A 152	Continued From page 1 use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a safe living environment free from Legionnaires for one (Resident #1) of eleven residents sampled. Additionally, the facility failed to safeguard residents' well-being by failing to implement their control policies and procedures to mitigate the multiplication of which placed all 78 residents that resided at the facility at imminent risk for harm, health exacerbation, illness, or . Findings Included: A review of the facility's self-reported document dated for Resident #1, conducted on , revealed that Resident #1 was sent to the hospital on due to a with a injury. The facility was notified by the local health department on that Resident #1 was diagnosed with Legionnaires . Resident #1 , , on . The local health department assessed the facility's water systems, heating systems, and water tanks on . The facility's corrective actions within the self-reported documented included: -The facility's maintenance staff would continue to flush the water system for five minutes in each apartment which included toilets, faucets, and	A 152		

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A 152	Continued From page 2 shower heads every week until the cultures can provide a result. -The facility's [redacted] water softener and other equipment management company completed an environmental assessment on the water softener on [redacted] and found no concerns. -The local County's water service came to the facilitiy on [redacted] found no issues. -The local health department collected water samples on [redacted] from various places throughout the community to sent the samples for culture and the results should be completed within the next [redacted] weeks. A review of Resident #1's hospital visit report, conducted on [redacted], revealed that Resident #1 was evaluated in the emergency department and then admitted to the hospital on [redacted] related to a [redacted] with [redacted] injury. Resident #1 was transferred to the hospital's [redacted] on [redacted] for her continued decline from complications of [redacted], [redacted] and acute hypoxic [redacted], failure due to [redacted] and [redacted]. Resident #1 was also found to have [redacted] positive for [redacted]. On [redacted], Resident #1's prognosis was poor due to the worsening of [redacted] and was on high amounts of [redacted]. The hospital notified the local health department as to Resident #1's diagnosis of Legionnaires [redacted]. On [redacted], Resident #1 was transferred to hospice services and [redacted], on the same day. Resident #1's [redacted] certificate stated that the resident's diagnosis was [redacted], retention and [redacted], and the preliminary cause of [redacted] was [redacted], failure. A record review for Resident #1, conducted on [redacted], revealed that Resident #1 was admitted to the facility on [redacted] and	A 152		

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A 152	Continued From page 3 discharged on due to the resident's . According to Resident #1's health assessment form dated , the resident had diagnosis of , , and . Resident #1 ambulated with a walker and required supervision with eating, grooming, and toileting and assistance with bathing, and self-administration of medications. It was noted in Resident #1's record that she had a on and was sent to the hospital's emergency department. Resident #1 did not return to the facility due to her . There was no documentation in Resident #1's record of her positive diagnosis of Legionnaires . A review of and Legionnaires found at Legionnaires' - Symptoms and causes - Mayo Clinic, conducted on , revealed that Legionnaires was a severe form of , from due to an by the bacterium known as . Most people catch Legionnaires' by inhaling the from water or soil. Persons at greater risk and susceptible to Legionnaires are smokers and people with weakened systems. Untreated, Legionnaires can be fatal and urgent medical attention is usually recommended. Prompt treatment with usually cures Legionnaires' . During a phone interview with the local health department Biological Scientist III (Scientist), conducted on at 12:54pm, the Scientist stated that a source of the had not been identified and the positive case of Legionnaires was in the memory care unit. The Scientist stated that there were	A 152		

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A 152	Continued From page 4 sixteen specimens taken from various places in the facility. The Scientist stated that one of the sixteen specimens came [illegible] positive for [illegible] and was found in [illegible] which was in the assisted living unit of the facility. The Scientist stated that the local health department set forth recommendations at the time of the visit on [illegible] and once the specimen came [illegible] positive on [illegible], the recommendations then became requirements. The Scientist stated that the facility was contacted on [illegible], [illegible], and [illegible] by the local health department to determine if the requirements were implemented and the facility had indicated that the requirements were not implemented with each contact. The Scientist stated that the most recent request was made on [illegible]. The Scientist stated that the facility informed the local health department that they were conducting flushes of their water systems. The Scientist stated that the facility was informed by the local health department on multiple occasions that [illegible] flushing was not an adequate remediation of [illegible] and that more [illegible] measures were needed. The Scientist stated that persons entering the facility should be under droplet precautions such as a facemask for airborne transmission and gloves for water handling. During observations, conducted on [illegible] from 09:30am through 06:00pm revealed that there were no signs posted in the facility that the facility had a positive case of Legionnaires [illegible]. None of the staff, residents, or visitors were wearing facemasks or other droplet precaution measures. A review of the local health department's	A 152		

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A 152	Continued From page 5 [redacted] test results, conducted on [redacted], revealed that fourteen random samples were collected on [redacted] and the results were available on [redacted]. The areas tested included the hot water tank, the water main, and [redacted] (3 samples), 1114 (3 samples), 1117 (2 samples), 2234 (2 samples), and 3304 (2 samples). Thirteen of the fourteen samples were negative for [redacted]. However, the sample taken from [redacted]'s shower was positive for [redacted]. A review of the resident list, conducted on [redacted], revealed that there were 59 residents that resided in the assisted living unit and 19 residents in the memory care unit. [redacted] were vacant. Resident #1 resided in [redacted] prior to her [redacted]. Resident #3 and Resident #11 resided in [redacted]. Residents #3 and #11 moved into [redacted] on an unknown data after [redacted]. Resident #9 resided in [redacted]. Resident #10 resided in [redacted]. During an interview with the Campus Adminsitrator, conducted on [redacted] at 09:55am, the Campus Administrator stated that on [redacted], the facility collected one sample from the shower in [redacted] that was found positive by the local health department and that test came [redacted] negative with no [redacted] detected on [redacted]. The Campus Adminsitrator stated that the facility was performing a four-minute flush of all empty rooms to the showers, sinks, and toilets every Wednesday. The Campus Adminsitrator stated that the facility had replaced the shower [redacted] in [redacted] prior to their testing on [redacted]. The Campus Adminsistrator stated that a letter went out to all residents and family members on [redacted] informing the residents and family	A 152		

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A 152	Continued From page 6 members of the positive sample of and that the facility had a positive case of Legionnaires . The Campus Adminsitrator stated the shower was replaced and the facility's efforts to prevent the spread of the was by their flushing efforts. A record review for Resident #2, conducted on , revealed that Resident #2 was admitted on . Resident #2's health assessment dated noted that the resident had diagnosis of , Type II, and . Resident #2 was independent with activities of daily living but required assistance with medications. On , Resident #2 had , symptoms and . Resident #2 was sent to the hospital on the same day. There was no evidence found that the facility notified the local health department related to Resident #2's , symptoms. There was no evidence found that the facility notified the hospital that there was a positive sample of the and a positive case of Legionnaires at the assisted living facility. A review of the facility's control policy entitled "Assisted Living Control" revised on , conducted on noted on page one that the facility was to track, trend, and prevent or minimize the incidence of and implement procedures directed by the local health department. A review of an email dated from the local health department to the facility, conducted on , the email noted that the facility was found to have a single confirmed Legionellosis case in the memory care unit between and .	A 152		

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A 152	Continued From page 7 Legionairres [illegible] is caused by the [illegible] that exist naturally in the environment and can also be found in man-made water systems such as hot tubs, spas, cooling towers, hot water tanks, or large plumbing systems. The local health department's assessment indicated that conditions in the facility's plumbing could harbor and breed biofilms and [illegible]. The local health department made the following recommendations and requirements: We recommend you obtain professional consultation from a qualified water system expert for proper assessment and remediation of your water system. The remediation action plan must be reviewed by [the local health department] and results of follow-up monitoring must be provided to [the local health department]. We recommend post-remediation testing following a detailed plan that is submitted to [the local health department] along with results from each post-remediation sampling event. Post-remediation samples should be collected at least 48 hours after the water system or device has been restored to normal operating conditions through at least a six-month period post-remediation. We recommend a sampling approach described in [Health Care [illegible] Control Practices Advisory Committee - Centers for Control and Prevention], in which environment samples are collected for culture at two-week intervals for three months and if no [illegible] is detected in cultures during three months of monitoring at two-week intervals, continue to collect monthly for another three months. If [illegible] is detected in one or more cultures, you should: review and modify the water	A 152		

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A 152	Continued From page 8 management plan; perform additional remediation, if indicated; and implement a new six-month period for post-remediation follow-up sampling. We recommend that [the facility's] Memory Care Unit install 0.2-micron biological point-of-use filters on any showerheads or sink/tub faucets intended for use until remediation of your facility's plumbing has occurred or restrict the use of showers to reduce the risk to guests during this investigation until further notice. We recommend that [the facility's] Memory Care Unit notify incoming residents in writing about the ongoing investigation of Legionnaires' cases with association to this facility. This provides residents an opportunity to make an informed decision based on their personal assessment of risk. We recommend that notification of current residents also occur as soon as possible. Management should contact residents who visited the facility's memory care unit within the last four weeks (starting from to present) to notify them about the ongoing investigation of Legionnaires' cases associated with the facility's memory care unit. This provides recent visitors the opportunity to seek medical care appropriately should they become ill with symptoms of . If management is unable to do this, please let us know. For maintenance of the facility's plumbing system and to minimize growth of , domestic hot water should be stored at a minimum of 140°F and delivered at a minimum of 105°F to all points of delivery. Minimum temperatures of	A 152		

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A 152	Continued From page 9 122°F are required to prevent new growth of within hot water systems. It is also recommended your facility monitor hot water temperatures at locations from the hot water heaters. Annual inspections of the entire water system are advisable. These should include periodic draining, cleaning with a solution, and flushing of all water storage tanks to remove biofilm, scale, and sediment. The importance of maintaining complete documentation of the facility premise plumbing maintenance, water management efforts, and temperature logs cannot be overstated. Report all possible cases of Legionnaires' (staff or residents) immediately to [the local health department]. Develop a written water safety management plan for the prevention and control of . Provide [the local health department] with a copy of your facility water safety management plan. We recommend that any detachable shower hoses be hung to promote full drainage of water. We remain committed to assisting you in this process. In addition to the attached remediation and maintenance recommendation we have also attached some useful resources for you regarding developing and implementing a water safety management program for this facility and other similar establishments in your organization. Please feel free to contact us with any questions, concerns, or comments. The email to the facility noted the recommendation of 'maintenance after decontamination' and 'accepted remediation and	A 152		

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A 152	Continued From page 10 maintenance guidelines' which included: Domestic Hot Water Systems: Emergency Management and Best Practices Background Information: The following protocol for minimization of in Potable and Emergency Water Systems has been adapted from the ASHRAE Standard , Minimizing the Risk of Legionellosis Associated with Building Water Systems and is recommended in cases where Legionnaires' is known or suspected and may be associated with the potable water system ....these measures can be effective in fostering the safety of the potable water system. This is accomplished through the destruction of free-swimming , including , and indirectly by eliminating conditions that favor amplification (multiplication), i.e. the elimination of biofilms and and other protozoa that feed on biofilms and which serve as hosts. Where decontamination of hot water systems is necessary the following control measures should be taken - Chlorination: 1. should be added to achieve a free residual of at least 2mg/L throughout the system. 2.This may require chlorination of the water heater or tank to levels of 20 to 50mg/L. 3.The pH of the water should be maintained between 7.0 to 8.0. 4.Each outlet should be flushed until the odor of is detected. 5.The should remain in the system for a minimum of 2 hours (not to exceed 24 hrs) 6.Thoroughly flush the system. of water systems is not recommended due to frequent failure and rapid	A 152		

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A 152	Continued From page 11 recolonization of [illegible]. During a phone interview with the local health department Biological Scientist II (Scientist), conducted on [illegible] at 11:36am, the Scientist stated that she verbally spoke with the Campus Administrator via telephone and addressed the shift from the recommendation to requirements on [illegible], and [illegible]. At 02:54pm, the Scientist stated that on [illegible] and that there were several telephone and email communications between the local health department and the facility to determine remediation efforts for [illegible] and Legionnaires [illegible] since their visit to the facility on [illegible]. The Scientist stated that both herself and the Regional Epidemiologist verbally told the facility that the [illegible] flushing of pipes were not an adequate method of remediation of [illegible] and could cause a rapid regrowth of the [illegible]. The Scientist stated that both herself and the Regional Epidemiologist verbally told the facility that if any of the samples came [illegible] positive, the recommendations would then become requirements. The Scientist stated that the facility did not implement any of the recommendations that were provided prior to the positive [illegible] sample. The Scientist stated that the facility did not implement any of the requirements that were provided after the sample result was positive for [illegible]. The Scientist stated that she sent a separate list of requirements to the Campus Administrator on [illegible]. A review of the local health department's [illegible] remediation and guidance requirements, conducted on [illegible], revealed that the local health department provided the facility with the following requirements on	A 152		

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A 152	Continued From page 12 . . . . . : We recommend you obtain professional consultation from a qualified water system expert for proper assessemnt and remediation of your water system. The remediation action plan must be reviewed by [the local health department] and results of follow-up montioring must be provided to [the local health department]. We have attached some accepted remediation and maintenance guidelines for you information and consideration. Chlorination: [see above description]. We require post-remediation testing follwing a detailed plan such as [occupational safety and health administration] remediation schedule below entitled: "test the domestic hot- or warm-water system for . . . . . " on the following schedule: A. weekly for the first month after resumption of operation; B. every two weeks for the next two months; and C. monthly for the next three months [and] if 10 or more CFU per ml of water are present, re-treat ... your entire system in consultaiton with your qualified water systems expert. You may also contact your water treatment provider to assist you through remediation. We require that [the facility's] Memory Care Unit, notify incoming residents in writing about the ongoing investigation of Legionnaires . . . . . cases with association to this facility. This provides residents an opportunity to make an informed decision based on their personal assessment of risks. We require that notification of current residents also occur as soon as possible. Management	A 152		

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A 152	Continued From page 13 should contact residents who visited [the facility's] Memory Care Unit in the last four weeks starting from [redacted] in writing about the ongoing investigation of Leginnaires' [redacted] cases associated with [the facility's] Memory Care Unit. This provides recent visitors the opportunity to seek medical care appropriately should they become ill with symptoms of [redacted]. For maintenance of the premise plumbing system and to minimize growth of [redacted], domestic hot water should ge stored at a minimum of 140 degree farenheit and delivered at aminimum of 105 degree farenheit to all points of delivery. Minimum temperatures of 122 degrees farenheit are required to prevent new growth of [redacted] within hot water systems. Follow-up with your industrial hygiene procedures to ensure proper temperatures are maintained. Monitor hot water temperatures at [redacted] locations from the hot water heaters. Annual inspections of the entire water system are advisable. These should include periodic draining, cleaning with a [redacted] solution, and flushing of all water storage tanks to remove biofilm, scale, and sediment. The importance of maintaining complete documentation of the facility premise plumbing maintenance, water management efforts, and temperture logs cannot be overstated. Report all possible cases of Legionnaires disease (staff or residents) immediately to the [local health department's] [redacted] Department ...any case of [redacted] that was not present on admission that cannot be explained by another diagnosis should be reported to the [local health department's] [redacted] Department ...	A 152		

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	AL11969017	A. BUILDING: _____ B. WING _____	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 152	Continued From page 14 Develop a written water safety management plan for the prevention and control of . Provide [local health department's] Department with a copy ... The requirements also noted the Domestic Hot Water Systems: Emergency Management and Best Practices Background Information, previously noted above. A review of the facility's sample result final report dated , conducted on , revealed that the sample was collected on from room's 2234 shower. On , the sample result was negative for . There were no other sample results to review. During an interview with Resident #3, conducted on at 02:43pm, Resident #3 stated that he was aware that his room had tested positive for and had to wait two weeks before he could move into the room. Resident #3 was not aware that a resident had tested positive for Legionnaires . Resident #3 stated that there were no postings in the facility related to the positive sample or the positive case of Legionnaires . Resident #3 stated that he did not receive a letter about or Legionnaires . During an interview with Resident #4, conducted on at 02:49pm, Resident #4 stated that she drinks water from the tap, and it did not taste good. Resident #4 stated that she was unaware that the facility had a positive sample of or a positive case of Legionnaires in the facility. Resident #4 stated that there were no postings in the facility related to or Legionnaires .	A 152		

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A 152	Continued From page 15 Resident #4 stated that she did not receive a letter about or Legionnaires . During an interview with Resident #5, conducted on at 02:57pm, Resident #5 stated that she drinks water from the tap. Resident #5 stated that she was unaware that the facility had a positive sample of or a positive case of Legionnaires in the facility. Resident #5 stated that there were no postings in the facility related to or Legionnaires . Resident #5 stated that she did not receive a letter about or Legionnaires . During an interview with Resident #6, conducted on at 02:57pm, Resident #6 stated that he drinks water from the tap. Resident #6 stated that he was unaware that the facility had a positive sample of or a positive case of Legionnaires in the facility. Resident #6 stated that there were no postings in the facility related to or Legionnaires . Resident #6 stated that he did not receive a letter about or Legionnaires . During an interview with an unidentified third-party service personnel, conducted on at 02:57pm, the unidentified third-party service personnel stated that she was unaware that the facility had a positive sample of or a positive case of Legionnaires in the facility. The unidentified third-party service personnel stated that there was no postings in the facility related to or Legionnaires . During an interview with Resident #7, conducted	A 152		

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A 152	Continued From page 16 on [redacted] at 03:06pm, Resident #7 stated that she drinks water from the tap. Resident #7 stated that she was aware that the facility had a positive case of Legionnaires because a random staff member told her. Resident #7 stated that there were no postings in the facility related to [redacted] or Legionnaires [redacted]. Resident #6 stated that he did not receive a letter about [redacted] or Legionnaires [redacted]. During an interview with Resident #8, conducted on [redacted] at 03:21pm, Resident #8 stated that she drinks water from the tap, and it sometimes had a strange smell. Resident #8 stated that she was unaware that the facility had a positive sample of [redacted] or a positive case of Legionnaires [redacted] in the facility. Resident #8 stated that there were no postings in the facility related to [redacted] or Legionnaires [redacted]. Resident #8 stated that he did not receive a letter about [redacted] or Legionnaires [redacted]. During an interview with Staff E (unlicensed Medication Technician), conducted on [redacted] at 03:14pm, Staff E stated that she was not aware that there was a positive sample of [redacted] or a positive case of Legionnaires [redacted] in the facility. Staff E stated that she did not know of any testing or flushing of plumbing systems within the facility. Staff E stated that she used tap water during her medication pass. During an interview with Staff F, conducted on [redacted] at 03:34pm, Staff F stated that she was aware that there was a positive case of Legionnaires in the facility from rumors. Staff F stated that the facility did not post anything in the facility related to [redacted] or	A 152		

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A 152	Continued From page 17 Legionnaires . . . . . Staff F stated that she did not know of any testing or flushing of plumbing systems within the facility. During an interview with the Program Director, at 03:25pm, the Program Director stated that there were no signs that were posted in the facility informing the public that the facility had a positive sample of the . . . . . and a positive case of Legionnaires . . . The Program Director stated that she did not receive an email regarding the requirements set forth by the local health department on . . . . . The Program Director stated that she did receive the recommendation set forth by the local health department on and that these were only recommendations and not requirements. During an interview with the Maintenance Director, conducted on at 03:45pm, the Maintenance Director stated that the facility performed weekly flushes to all of the facility's room which included four minutes of flushing of water in the sinks and hot water in the showers. The Maintenance Director stated that the facilty received a test kit for that had a trace positive result and perfomed the test himself. The Maintenace stated that he mailed the swab sample the same day and received the result on that the shower was negative for . . . . . Once we received the negative result, we went to flushing only the empty rooms. During an interview with the Campus Administrator, conducted on at 04:15pm, the Campus Administrator stated that the facility did have a posting regarding the positive case of Legionnaires . . . . . but took it down once the facility received the negative test	A 152		

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A 152	Continued From page 18 sample from . . . . The Administrator was unable to provide evidence that the facility had attempted to locate the source of . . . . . related to Resident #1's positive Legionnaires . . . . . in the Memory Care Unit. The Campus Administrator stated that none of the requirements that the local health department set forth were implemented as she just received the requirements on the day of survey because she had been off work duty. A review of the local County's water service invoice dated . . . . . at 11:54am, conducted on , revealed there was no evidence on the invoice that the local County's water service conducted tests, maintenance, or services at the assisted living building. There was no evidence that the local County's water service evaluated the water systems for safe consumption or the at the assisted living facility building. During a phone interview with a Service Representative of the facility's water softener and other equipment management company, conducted on at 04:25pm, the Service Representative stated that he was at the facility on and to perform routine maintenance of the water softener and the equipment such as the dishwasher, washer, quat sanitizer, laundry dispensers, and water softener as per the . . . . . services. The Service Representative stated that the facility at no time during each visit notified him that the facility had a positive case of Legionnaires . The Service Representative stated that there was another division within their company that would take over because their division did not handle with water. The Service Representative stated that	A 152		

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A 152	Continued From page 19 their division only handled routine maintenance. The Service Representative stated that at no time during either visit did their company test for anywhere in the facility. During an interview with the Campus Administrator, conducted on at 05:45pm, the Campus Administrator agreed that there was no on-going testing to check for the Class I	A 152		