STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968413	09/28/2018
NAME OF PROVIDER OR SUPPLIER **PLANTATION OAKS SENIOR LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **9309 S ORANGE BLOSSOM TRAIL** **ORLANDO, FL 32837**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A monitoring visit was conducted on and . Plantation Oaks Senior Living license # 12300 had a deficiency found at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview and record review, the facility failed to honor resident's rights to be treated with respect and did not post and make residents, families and visitors aware of a (Legionnaire's , a form of) outbreak and did not follow the recommendations of the local Health Department.

Findings:

A tour of the facility on at 2:00 PM and on at 10:00 AM noted that there were not any signs posted alerting residents, family or visitors of a (Legionnaire's) outbreak.

An e-mail received by the Agency on from Florida Department of Health in Orange County (DOH-Orange) , Program indicated the facility had a Legionnaire's (LD) outbreak. An environmental assessment and sample was conducted on . Results obtained on showed the facility had LD present throughout the facility. The DOH Orange County had advised and recommended the facility begin water remediation and provide residents, guests and staff notifications since the site visit on . The DOH Orange County had made several attempts to contact the facility's management between and but were unsuccessful.

During the follow up site visit on the facility had not begun water remediation or notified the residents. During another follow up visit on , the facility's owner said that water remediation had started on Friday ( ) by a hired company. He stated the hired company would provide the documentation to DOH-Orange. The information had not been received as of .

A letter dated from the Orange County DOH to the facility indicated that due to the possible association between the facility and the case of LD, there was concern that other people in the facility may be at increased risk for LD. DOH-Orange , Program recommended the following:
1. Consult with a water safety expert to evaluate and conduct appropriate remediation (e.g., hyper chlorination and/or eradication) of potable and other water systems that are potential aerosol-producing sources for . Steps should be taken to ensure that re-introduction and growth of in the plumbing system does not occur in the future, (e.g., develop a

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prevention plan). Please make sure to collect 1-liter bulk water samples from all sites. Swabs do not need to be taken from the , sites (i.e., incoming main, boilers). All testing should be coordinated by DOH-Orange.
2. has been found in potable hot water and risks of exposure include showering, drinking tap water, brushing with tap water, flushing using tap water or using tap water to prepare medication, and consumption of ice from automatic ice machines. Alternatives to these activities include using tub baths and bottled water, until the investigation is completed.
3. Signs should be posted advising residents, staff, and visitors of the possible exposure and risks. In addition, letters should be provided to inform residents and staff members.
4. LD should be considered as a possible cause of illness among residents and staff who have signs and symptoms consistent with LD. Persons suspected of having , or who have with or other symptoms suggestive of , should be evaluated by a clinician.

A letter addressed to the administrator from DOH-Orange dated indicated the letter was a follow-up to the investigation of a case of LD, confirmed by , , serogroup 1 test, in a resident of your facility. Results were received from testing of bulk water and environmental swab samples collected at the facility on , 2018. , , serogroup 1 was identified in 7/9 (78%) sites sampled, either from bulk water or environmental swab, or both. "It is imperative that the facility take additional steps to ensure elimination of from the water system."

The DOH-Orange , Program recommend the following:
1. Immediately consult with a water safety expert to evaluate and conduct appropriate remediation (e.g., hyperchlorination and/or eradication) of potable water systems that are potential aerosol-producing sources for . Steps should be taken to ensure that re-introduction and growth of in the plumbing system does not occur in the future. (e.g., develop a prevention plan).
a. Please notify DOH-Orange when remediation has been completed and by what method.
b. Please share test results performed by the remediation contractors for culture from post-remediation water sampling (1 liter bulk water samples) with DOH-Orange.
2. has been found in the potable water system in your facility and risks of exposure include showering, drinking tap water, brushing with tap water, flushing using tap water or using tap water to prepare medication, and consumption of ice from automatic ice machines. DOH-Orange recommends alternatives to these activities, such as using tub baths or sponge baths, and bottled water for oral consumption, until remediation has been completed and results from follow up water and environmental sampling are received and are negative.
3. DOH-Orange advises that residents, staff, and visitors be notified of the positive results and the risk

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for exposure.
4. LD should be considered as a possible cause of illness among residents and staff who have signs and symptoms consistent with LD. Persons suspected of having , or who have with or other symptoms suggestive of , should be evaluated by a clinician.
5. Report all possible cases of LD immediately to DOH-Orange 407-858-1420.

On at 2:00 PM, the administrator stated that DOH-Orange gave recommendations only. He said he hired a company who were experts at dealing with water restoration and he was following their recommendations. It was his expectation that they communicate with DOH-Orange and were doing so. The company he hired said the hyper-chlorination was not the best method. The water remediation said to keep the water filter as it always was. The other company came and did a walk through of how the water system worked/circulated. They had put systems in place and held an in-service with staff. The staff were directed to turn the water on and let it run for 5-10 minutes, before using. Residents were not taking head to toe showers but were using a washcloth to wash. The residents took medications with bottled water, which was kept in each medication cart. At the advice of the consultant, he did not post signs or inform residents/staff/families/visitors, as it was not a requirement.

An exit interview was conducted with the administrator on at 4:30 PM.

Class II