STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING _____ B. WING _____	C 10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 49855

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F000	INITIAL COMMENTS DJ Jacobetti Home for Veterans was surveyed for a Recertification survey on 10/19/2022 . Intakes: MI00124430 and MI00125631 Census: 59	F000		
F880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: 483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards; 483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F880	Part A Element 1 Resident 29 and Resident 20 were evaluated by a provider and have experienced no negative outcome related to the deficient practice. Element 2 All members who receive liraglutide via pen injector have the potential to be affected by the deficient practice. All members who receive medication via pen injector have been assessed by a registered nurse for signs of infection related to the deficient practice. Any concerns identified were brought to the attention of their medical provider. All members who receive tracheostomy care in the home have the potential to be affected by the deficient practice. All members receiving tracheostomy care have been assessed by a provider for signs of infection related to the deficient practice. Any concerns were brought to the attention of the residents medical provider. Element 3 Manufacturer's instructions for the cleaning of contaminated pen injectors utilized by the home were reviewed and determined to be appropriate. LPN A and all nurses who administer medications via pen	11/21/22

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	Electronically Signed	11/09/2022

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F880	Continued From page 1 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. 483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. 483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. 483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: This citation has two parts: "A" and "B".	F880	injector were re-educated on proper cleaning of the pen with emphasis on actions to take should the injector pen be dropped. The home's Infection Control-Standard Precautions, Handwashing-Hand Hygiene policy was reviewed and determined to be adequate. LPN A and all licensed nurses were re-educated on the home's hand hygiene policy with emphasis on sanitizing hands after contact with items that have contact with dirty surfaces, like the floor, and prior to donning gloves. The home's procedure for tracheostomy care was reviewed and determined to be appropriate. LPN A and all nurses who provide tracheostomy care were re-educated on tracheostomy care with emphasis on wearing the appropriate PPE, including eye protection, and keeping gloves and the work field sterile as appropriate. Element 4 The facilitys Quality Assessment and Assurance (QAA) Committee has conducted a Root Cause Analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop an intervention or corrective action plan to prevent recurrence, as a part of the Quality Assurance and Performance Improvement (QAPI) program. The Director of Nursing, or Designee, will conduct a quality review of Infection Control Standards among licensed nurses to include performing appropriate hand hygiene, cleaning/disinfecting injector pens and donning appropriate personal protective equipment (PPE) during resident care each unit weekly x4 then monthly x2. The findings of these quality reviews will be	

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F880	Continued From page 2 A. Based on observation, interview, and record review, the facility failed to maintain a complete infection control program, as evidenced by failure to perform appropriate hand hygiene, clean/disinfect a medication injection pen, and don appropriate personal protective equipment (PPE) during resident care for two Residents (R20 and R29), out of four residents reviewed for infection control. These deficient practices resulted in the potential for transmission of infectious organisms and an increased risk for infection. Findings include: Resident #29 During a medication pass observation on 10/18/22 at 8:19 a.m., Licensed Practical Nurse (LPN) "A" prepared an insulin syringe filled with 70 units of long-acting insulin and an additional noninsulin diabetic medication (liraglutide, contained in an injection pen) for R29. LPN "A" did not cleanse the hub of the liraglutide pen prior to placing a new needle onto the pen injector. Upon entrance into R29's room, the insulin syringe and pen injector were placed on R29's uncleaned overbed table and without the use of a barrier cloth. LPN "A" dropped the liraglutide pen injector onto the floor prior to administration of the medication, which bent the pen injector needle. LPN "A" picked up the liraglutide pen from the floor with gloved hands, took the dirty pen out to the medication cart and placed it on a spiral-topped notepad (with written notes) on the cart. LPN "A" removed her dirty gloves and used her bare hands to remove the damaged needle from the pen. LPN "A" did not sanitize her hands after contact with the liraglutide pen, contaminated from contact with the floor, prior to donning new gloves. LPN "A" placed a clean needle on the	F880	reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met. The Director of Nursing is responsible for sustained compliance. Part B Element 1 No residents were named in this citation. Element 2 All members have the potential to be affected by the deficient practice. Element 3 A water management team has been developed. The facility risk assessment has been conducted to identify where Legionella and other opportunistic waterborne pathogens could grow and develop in the facility water system, identification of control points was performed. Critical limits were identified, and a regularly scheduled data monitoring program was put in place. Documentation that describes the facility water system including the facility risk assessment will be maintained by the environmental director. The Administrator, maintenance director and infection preventionist haven taken the following course and have proof the course was completed. Preventing Legionnaires Disease: A Training on Legionella Water Management Programs (PreventLD Training) A review of the plan and its effectiveness will occur annually. Element 4 The facilitys Quality Assessment and Assurance (QAA) Committee has	

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F880	Continued From page 3 pen injector without cleansing of the hub, for a second time. The outside of the pen was never cleaned or sanitized. The medication was administered to R29, and the dirty pen was placed inside LPN "A's" medication cart. Review of the (Name Brand) liraglutide injection "Instructions for Use" dated 12/2020, revealed the following, in part: " ...If you drop your [Name Brand] pen, repeat "First Time Use For each New Pen" (steps A through D). Be careful not to bend or damage the needle ... First Time Use for Each New Pen: Step A. Check the Pen ... wash hands with soap and water before use ... Wipe the rubber stopper with an alcohol swab ... Routine Use ... Wipe the rubber stopper with an alcohol swab ... If cleaning is needed, wipe the outside of the pen ..." Review of the "Infection Control, Standard Precautions, Handwashing-Hand Hygiene" policy, dated 4/28/21, revealed the following, in part: "...Use an alcohol-based hand rub containing at least 62% (percent) alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial and water for the following situations: ... Before preparing or handling medications ... After handling used dressing, contaminated equipment, etc. ... After contact with objects (e.g., medical equipment) in the immediate vicinity of the member ... After removing gloves ... The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." During an interview on 10/18/22 at 11:03 a.m., the Director of Nursing (DON) acknowledged he had been informed of the [Name Brand] pen injector being dropped onto the floor. The DON	F880	conducted a Root Cause Analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop an intervention or corrective action plan to prevent recurrence, as a part of the Quality Assurance and Performance Improvement (QAPI) program. The environmental director will provide a report on water plan/surveillance to the facility QAPI Committee quarterly.	

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F880	Continued From page 4 confirmed the pen should have been cleaned and sanitized when picked up from the floor and not placed on top of the medication cart without a barrier following use. The DON acknowledged that the pen hub should have been cleansed with an alcohol wipe prior to placing the needle on the [Name Brand] pen. The DON expressed understanding of the concerns related to infection control with the above observation. Resident #20 During an observation of tracheostomy (trach) care on 10/18/22 at 12:14 p.m., LPN "A" entered R20's room with face mask, gown, and gloves donned. No eye protection (goggles or face shield) was worn while sterile cotton-tipped applicators were inserted into R20's trach, rotated quickly multiple times, and withdrawn to encourage mucous expectoration from the trach and upper respiratory tract. R20 cough multiple times with this repeated procedure, and a significant amount of mucous was expectorated. LPN "A" returned to the medication cart, in the door of R20's room, picked up the goggles still on the medication cart, returned to R20, and placed the goggles down on R20's uncleaned (dirty) overbed table. Hand hygiene was performed, and sterile gloves donned. LPN "A" used her right hand to handle dirty medical supplies on the overbed table set up with a clean barrier. LPN "A" stated, "My right hand will now be my dirty hand." R20's trach was removed and placed in the cleaning solution. LPN "A" picked up the goggles, sitting on R20's dirty overbed table, and placed them on her face using her sterile gloved "clean" left hand. At this point both hands donned in sterile gloves, were contaminated. LPN "A" used the right hand to hold the trach cleaner, and left hand to hold trach. The cleaned trach was placed in a new	F880		

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F880	Continued From page 5 clean solution divider in the sterile trach kit. LPN "A" wiped under R20's trach color with a sterile gauze and placed the clean trach on sterile gauze both handled by the contaminated left glove. Review of a list of TBP residents provided by the facility revealed R20 was on "Enhanced Barrier" precautions related to his tracheostomy and PEG (percutaneous endoscopic gastrostomy/feeding) tube. During an interview on 10/18/22 at 12:44 p.m., LPN "A" confirmed she did not wear eye protection during the cleaning of the trach with multiple sterile cotton-tipped applicators, that produced significant mucous from R20. LPN "A" stated, "I looked down and realized that my goggles were on his overbed table, and I picked them up with my sterile left hand and put them on." LPN "A" acknowledged the lack of any sterile hand at that point of the observation. LPN "A" confirmed she continued to work with two dirty gloves during cleaning and re-insertion of R20's trach. LPN "A" said she had additional sterile gloves in the drawer that she could have changed into, had she realized her error. Review of the "Lippincott Nursing Procedures, Seventh Edition", dated October 17, 2015, provided by the facility on 10/18/22, revealed the following, in part: "... Explain the procedure to the patient, even if he's unresponsive. Tell him that suctioning (clearing the respiratory tract of secretions) usually causes transient coughing or gagging but that coughing helps to remove secretions ... Put on a mask and goggles or mask with face shield and other personal protective equipment as appropriate ... Tracheostomy Care ... Cleaning a nondisposable inner cannula: Put on sterile	F880		

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F880	Continued From page 6 gloves..." During an interview on 10/18/22 at 1:30 p.m., the DON confirmed LPN "A" should have worn eye protection in the form of goggles, or face shield when cleaning of the trach that resulted in mucous expectoration. The DON also acknowledged that all facility staff were currently required to wear eye protection while present in resident care areas, due to high community spread of COVID-19. B. Based on interview and record review, the facility failed to develop a comprehensive Water Management Plan (WMP) to address the control and spread of Legionella bacteria in the facility water system, in accordance with QSO 17-30 Hospitals/CAHs/NH, Revised 7-6-2018. The facility failed to develop and implement a water management program that considers the ASHRAE 188 (American Society of Heating, Refrigerating and Air-Conditioning Engineers) and the CDC (Centers for Disease Control) tool kit. The failure to develop a comprehensive Water Management Plan has the potential for the proliferation and transmission of Legionella in the circulating water of the building and the spread of Legionella infections in all 52 residents. Findings include: On 10/18/22 at approximately 3:30 PM, an interview with the Nursing Home administrator was conducted to review the Water Management Plan (WMP) for Legionella control in the potable water supply of the facility. The document titled "Air and Water Management Program Sec 02 Policy 14" was provided for review.	F880		

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F880	Continued From page 7 A review of the above document was conducted to determine the scope of the plan. Under the section titled "GUIDELINES", the document directed the facility to: "3. A risk assessment will be conducted by the air and water management team annually to identify where Legionella and other opportunistic .... Pathogens could grow ... 5. Based on the risk assessment, control points will be identified. 6. Control measures will be applied to address potential hazards at each control point. 7. Testing protocols and control limits will be established for each control measure. 8. The air and water management team shall regularly verify that the air and water management program is being implemented as designed. 9. The effectiveness of the water management program shall be evaluated no less than annually." The policy had not been followed with the development of a comprehensive water management plan. The following components were absent from the facility WMP: A. Designation of a Water Management Team (WMT), identifying names and their roles. B. An assessment of the facility's water system to identify risk locations such as areas of stagnation or low flow, disinfection level and/or temperature control. C. Identification of control points where effective monitoring and mitigation measures can be used. D. Identification of critical limits related to the risk areas identified and which can be controlled. E. Implementation of regular scheduled monitoring program collecting data on limits set. F. An evaluation process to determine how the	F880		

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F880	Continued From page 8 WMP is functioning. G. An annual review of the plan and collected information to ensure the plan was effective. On 10/19/22 at approximately 10:15 AM, the NHA confirmed that the facility had not developed the above components of the water management plan.	F880		

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