STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING _____ B. WING _____	03/31/2020

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

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** Based on observation, interview, and record review, the facility failed to properly maintain infection control practices during a COVID-19 Infection Control Survey for three Residents (Residents #1, #2, & #3) of three residents reviewed for infection control. This deficient practice resulted in the potential transmission of COVID-19 which had the ability to affect all 71 residents residing in the facility. This citation has five noted deficiencies: 1. The facility failed to perform proper staff/visitor entrance screening for COVID-19, including social distancing, and cleaning/disinfection of medical equipment. 2. The facility failed to cohort presumptive, identified COVID-19 residents. 3. The facility failed to eliminate group dining and group activities to prevent potential transmission of COVID-19. 4. The facility failed to provide consistent staffing assignments for residents to prevent transmission of suspected COVID-19. 5. The facility failed to identify and maintain a safe environment for reprocessing and disposal of contaminated medical equipment. Findings include: On 3/31/2020 at 9:00 a.m., during visitor entrance COVID-19 screening, Staff I placed a thermal thermometer directly on an entering Surveyor's left temple. Staff I took a disinfectant wipe and passed it quickly (approximately 2 seconds) over the contact end of the thermometer. Staff I instructed the next visitor to move forward to complete their temperature screening. When asked the kill time of the disinfectant wipe, Staff I responded, I don't know. When asked again, Staff I looked at the canister and stated, 10 seconds. During the Entrance Conference on 3/31/2020 at 9:33 a.m., the Nursing Home Administrator (NHA) and Registered Nurse (RN)/Infection Control Practitioner A confirmed five residents were under investigation for potential COVID-19 infections. RN A confirmed all five residents were in contact/droplet isolation pending lab results. When asked if residents were in private rooms, RN A responded, There are a couple of residents that do have roommates (not under investigation for COVID-19). Upon discussion of contact/droplet isolation, RN A said the room doors were kept closed. When asked if the disinfectant wipe used by Staff I during facility entrance screening met the Environmental Protection Agency (EPA) standards, RN A was uncertain. On 3/31/2020 at 10:00 a.m., a Surveyor along with RN A observed the yellow-topped canister of generic Disinfectant Wipes, in the presence of Staff I. RN A read the canister label silently, and said they were not the appropriate wipes. RN A removed the wipes from the table. Upon return from the observation, RN A stated, We will see where they (disinfecting wipes) came from. They are bleach free, and I don't know what the (kill) claim is for those wipes. When asked about training provided to the facility screening staff regarding cleaning/disinfecting of the thermometer after use, RN A stated, The point of the laser one (thermometer) is that they are not supposed to touch people. RN A was asked for a list of facility staff, visitors, and/or vendors that had been screened by Staff I from the beginning of the shift, prior to the Surveyors' entrance on 3/31/2020. RN A provided a list which indicated 104 individuals had been screened. Review of the facility provided Disinfecting Wipes Directions for Use, provided no kill claim for Coronavirus, and revealed the following: TO CLEAN AND DISINFECT/VIRUCIDAL DIRECTIONS: Wipe hard, nonporous surface with wipe until surface is visibly wet. Use enough wipes to keep surfaces visibly wet for 4 minutes. Allow surface to remain wet for 4 minutes. Let air dry . Review of facility provided Products with Emerging [MEDICAL CONDITION] Pathogens and Human Coronavirus claims for use against [DIAGNOSES REDACTED] (Severe Acute Respiratory Syndrome) - CoV2, dated 3/24/20, did not list the disinfectant wipes used during the visitor screening process. Review of the facility provided undated (Name Brand) Non-Contact Thermometer User Guide, revealed the following: .4. While holding the MEASURE button, aim the infrared lens at the patient's forehead, holding the thermometer approximately 1.5 (inches) - 2.5 away (from forehead) . During an observation on 3/31/2020 at 11:05 a.m., Vendors J and K were screened by Staff I for facility entrance. During an interview following acceptance into the facility, both Vendor J and K confirmed the thermal thermometer made contact with their skin while being screened. Review of Centers for Disease Control and Prevention (CDC), 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, p. 26, revealed the following regarding outbreaks in healthcare settings, in part: . undiagnosed , infectious patients and visitors were important initiators of these outbreaks .There is ample evidence for droplet and contact transmission; however, opportunistic airborne transmission cannot be excluded . Review of Resident Minimum Data Set (MDS) assessments revealed the following resident high-risk co-morbidities: Resident #1 - [MEDICAL CONDITION], heart failure, and [MEDICAL CONDITIONS] - who required supplemental oxygen. Resident #2 - [MEDICAL CONDITION] (CAD), heart failure, hypertension, and diabetes. Resident #3 - [MEDICAL CONDITIONS], hypertension, and [MEDICAL CONDITION] - who required supplemental oxygen. Resident #4 (roommate of Resident #2) - CAD, diabetes, [MEDICAL CONDITION], and heart failure - who required supplemental oxygen. Resident #5 (roommate of Resident #3) - urinary tract infection. Review of the facility resident roster confirmed Resident #2's roommate was Resident #4, and Resident #3's roommate was Resident #5. The roommates were not identified as suspect COVID-19 residents. Review of Centers for Disease Control and Prevention (CDC), 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, pgs. 57-58, revealed the following, in part: .Single-patient rooms are always indicated for patients .who require Contact or Droplet precautions .Cohorting is the practice of grouping together patients who are .infected with the same organism to confine their care to one area and prevent contact with other patients .Cohorting has been used extensively for managing outbreaks .Assigning or cohorting healthcare personnel to care only for patients infected .with a single target pathogen limits further transmission of the target pathogen to uninfected patients . During an interview on 3/31/2020 at 9:55 a.m., the NHA and RN A indicated residents testing positive for COVID-19 would be transferred to the third floor, currently not used for resident care. The NHA stated, It (quarantine unit on third floor) is pretty much ready to go - we would just have to move the resident's bed up there. During a follow-up interview on 3/31/2020 at 2:00 p.m., when asked why residents currently under investigation for COVID-19 were not being cohorted together, RN A stated, We are waiting on a positive (culture) before we open up the third floor. RN A confirmed multiple COVID-19 culture were still pending, including Resident #1's COVID-19 culture, collected on 3/19/2020, with inconclusive results forwarded to the CDC (Center for Disease Control). According to the facility-provided Emergency Response Plan and Facility Toolkit Infection Prevention Strategies & Guidance COVID-19, page 57, Revised 3/30/2020, revealed the following, in part: .Isolate symptomatic patients as soon as possible. Set up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with door closed . On 3/31/2020 at 12:05 p.m., observation of the locked Memory Care Unit (MCU), with Certified Nurse Aides (CNAs) B and C, found three residents seated in the dining room at one square table, elbow distance apart. CNA C indicated almost all residents in the MCU eat in the dining room. Empty tables were observed in the vicinity of these residents. During an interview within the MCU unit on 3/31/2020 at approximately 12:10 p.m., when asked how many residents were living in the MCU, Licensed Practical Nurse (LPN) D said there were 19. When asked if staff worked solely on the MCU unit, LPN D said he had worked the previous weekend on every single floor, even with awareness of presumptive COVID-19 residents. On 3/31/2020 at when asked about group activities, LPN D confirmed a group activity was conducted in the day room earlier that morning (3/31/2020), led by Activity/Therapy Aide E. Review of staff schedules for the previous week documented LPN D worked on various units on 3/24, 3/28, and 3/29/2020. On 3/31/2020 at approximately 12:15 p.m., when asked if she worked on various

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) floors, RN F confirmed working on another floor the previous weekend. On 3/31/2020 at approximately 12:18 p.m., the MCU dining room was observed with 13 residents seated near one another. Social distancing (6 feet) was not maintained. On 3/31/2020 at 2:33 p.m., when asked about group activities, group dining, and consistent staff assignments, RN A confirmed group dining was not suspended for residents in the MCU. RN A said residents were being kept six feet apart in the dining room, with consistent staffing. RN A confirmed group activities continued in the MCU. Emergency Response Plan and Facility Toolkit Infection Prevention Strategies & Guidance COVID-19, page 16-17, Revised 3/30/2020, revealed the following, in part: .General communal dining will be suspended at this time .General group activities will be suspended at this time . On 3/31/2020 at 12:29 p.m., and 12:36 p.m., Resident #3's and Resident #1's contact/droplet isolation room doors were observed open. On 3/31/2020 at approximately 12:40 p.m., when asked where contaminated personal protective equipment (PPE) was disposed, following exit from an isolation room, Staff H directed the Surveyors to a Conference Room on the second floor. The Conference Room door was wide open without signage designating the room as soiled utility for disposal of PPE. Staff H said used masks were disposed of in a small waste basket, found lined with a clear plastic bag. Upon inspection of the waste basket, an empty snack chip bag, paper towels, and staff hand-written notes were found with the discarded masks. No signage indicated the garbage was used for specific PPE disposal. A covered, plastic storage bin for reprocessing of face shields and goggles was located on a table to the back left of the room. No signage was present to indicate the purpose and provide instruction for reprocessing of PPE equipment (goggles/face shields). On 3/31/2020 at 2:27 p.m., when asked about the disposal of contaminated PPE in the Second Floor Conference Room, RN A confirmed the room had not been identified for reprocessing of medical equipment and disposal of medical waste. RN A agreed the conference room door should remain closed for separation of clean/dirty environment, and staff were not supposed to be eating in that room. On 3/31/2020 at approximately 1:45 p.m., when asked if group activities and group dining were discontinued due to COVID-19 concerns, the NHA stated, As far as I know they are. The NHA acknowledged the Surveyor infection control concerns with visitor screening and consistent staffing assignments.