# Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied. for SVHs applicable by level of care.

**General Information:**

**Facility Name:** D.J. Jacobetti Home for Veterans

**Location:** 425 Fisher Street Marquette, MI 49855

**Onsite / Virtual:** Onsite

**Dates of Survey:** 4/17/23 through 4/20/23

**NH / DOM / ADHC:** NH

**Survey Class:** Annual

**Total Available Beds:** 126

**Census on First Day of Survey:** 102

**Surveyed By:** Tonya Green, RN; Mark Bennett, RN; Michelle Boadwine, RN; Desiree' Mosley, MPH; Paul Calderwood (LSC); Cicely Robinson, VACO.

| VA Regulation Deficiency | Findings |
|---|---|
| | Initial Comments:<br><br>A VA Annual Survey was conducted from April 17, 2023 through April 20, 2023 at the D.J. Jacobetti Home for Veterans. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. |
| **§ 51.110 (e) (1) Comprehensive care plans.**<br>(1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and | Based on interview, record review, and facility policy review, the facility failed to develop a Care Plan for one (1) of 21 residents reviewed for Quality of Care.<br><br>Resident #4 was assessed as having suicidal ideation. The resident did not have a Care Plan addressing this concern.<br><br>The findings include:<br><br>Review of the facility's "Care Planning and Member Assessment. Care Plans. Comprehensive Care Plans" policy, last reviewed on 2/22/23, revealed: "Policy: The purpose of this policy is to develop and implement a comprehensive person – centered care plan for each member, consistent with members rights that includes measurable objectives and timeframes to meet a member's medical, nursing, and mental and psychosocial needs that are identified in the member's comprehensive assessment. |

| | |
|---|---|
| (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part.<br><br>**Rating** – Not Met<br>**Scope and Severity** - D<br>**Residents Affected** – Few | Guidelines:<br>…3. G. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger – specific interventions will be used to identify ways to decrease the member exposure to triggers which re-traumatize the member, as well as identify ways to mitigate or decrease the effect of the trigger on the member."<br><br>Review of Resident #4's clinical record revealed the resident was admitted to the facility on 1/2/22, with diagnoses which included: Neurocognitive Disorder with Lewy Bodies; Parkinson's Disease; Delusional Disorder; Anxiety Disorder and Post-Traumatic Stress Disorder and Depression.<br><br>Review of Resident #4's Quarterly Minimum Data Set (MDS), dated 5/4/22, under Section D: Mood revealed the resident was assessed as having thoughts that he/she would be better off dead or of hurting him/herself in some way for two (2) – six (6) days during the assessment review timeframe.<br><br>Review of Resident #4's Annual MDS, dated 2/1/23, under Section D: Mood revealed the resident was assessed as having thoughts that he/she would be better off dead or of hurting him/herself in some way for two (2) – six (6) days during the assessment review timeframe.<br><br>Review of Resident #4's Social Work Progress Note, dated 2/1/23, revealed: "Mood and Behavior Status: …He/she also endorsed thoughts that [they] would be better off dead. This writer explored this further with the member. The member did not endorse having a plan to carry out."<br><br>Review of Resident #4's Care Plans revealed there was no Care Plan developed to address the resident's suicidal ideation.<br><br>During an interview, on 4/19/23, at 2:27 p.m., the Director of Nursing (DON) stated the mood assessments on the MDS were completed by the Social Worker. He/she stated that, after reviewing the resident's MDSs and the notes from the Psychiatrist, he/she determined the resident to be severely depressed. He/she stated a Care Plan should have been developed addressing the resident's suicidal ideation. He/she stated they reached that conclusion especially since the resident did state in the mood assessment on two (2) MDS Assessments that he/she felt he/she would be better off dead.<br><br>During an interview, on 4/9/23, at 2:35 p.m., the Social Worker Manager revealed the resident was being closely followed by in-house psych services. He/she stated the resident's spouse decided he/she wanted the resident to be seen at the Veteran's |

| | |
|---|---|
| | Administration (VA). He/she stated the resident started going to the VA for psych services. He/she stated the spouse decided he/she no longer wanted the resident to leave out of the facility so, once again, the resident was being followed by the in-house psych service provider. He/she stated the resident did have a break in service during this time. He/she stated the resident mostly complained about wanting their cars. He/she stated the staff was aware of the resident's suicidal ideation. He/she stated he/she did agree the resident's suicidal ideation should have been care planned for staff not familiar with the resident. |
| **§ 51.120 (h) Enteral Feedings.**<br>Based on the comprehensive assessment of a resident, the facility management must ensure that—<br>(1) A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings was unavoidable; and<br>(2) A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.<br><br>**Rating** – Not Met<br>**Scope and Severity** - D<br>**Residents Affected** – Few | Based on observations, interviews, and record review, the facility failed to provide appropriate treatment and services to residents fed by enteral nutrition (tube feeding) by failing to 1) Verify the placement of a gastrostomy (feeding) tube prior to initiating the feeding and, 2) Maintain the head of the bed at 30 degrees or higher for at least 30 minutes after feeding administration. This deficient practice affected one (1) of one (1) resident reviewed from a total of 28 residents sampled (Resident #8).<br><br>The findings include:<br><br>The facility produced a policy titled, "Feeding Tube, Flushing," which was dated 8/4/21. Step nine (9) of the policy read: "Prior to flushing the feeding tube, the administration of medication or providing tube feedings, the nurse verified the proper placement of the feeding tube by completing the following:<br>a. Draw up 30 mL [milliliters] of air into a 60 mL syringe.<br>b. Attach the syringe to the tube and inject the 30 mL of air into the feeding tube.<br>c. Draw back on syringe to slowly obtain 5-10 mL of aspirate, and empty into a clean medicine cup.<br>d. Dip the pH strip into the aspirate in the medicine cup.<br>e. Compare the color of the strip with the color on the chart provided by the manufacturer."<br><br>Step 14 of the policy read, "Prevent aspiration risk by keeping the head of the bed elevated at a minimum of 30 degrees."<br><br>Review of the Mic-Key gastrostomy tube manufacturer guidelines revealed the following:<br><br>"Before feeding, check the tube to be sure that it is not clogged or displaced outside the stomach. To do this, connect the extension set to the MIC-KEY* feeding tube and attach a Monoject catheter tip syringe with 10 ml's [milliliters] of water to the extension set feeding port. Pull back on the plunger. When you see stomach contents in the tube, flush the MIC-KEY* feeding tube with water. Stomach contents are normally yellow |

| | |
|---|---|
| | or clear unless there is food in the stomach. If you feel resistance as you inject the water, pull back stomach contents again, then try to re-inject the water. Check for leaking around the stoma. Another method is to draw 5 to 10 ml's of air into a syringe. Place a stethoscope on the left side of the abdomen just above the waist. Inject the air into the extension set feeding port and listen for the stomach to "growl." Try again if you do not hear it. If you still do not hear it, do not proceed to feed. Contact the specialist and report the problem."<br><br>Review of Resident #8's medical record revealed an admission date of 11/8/21. Resident #8's primary medical diagnosis was Hemiplegia affecting Right Dominant Side. His/her secondary medical diagnoses included Dementia, Intracranial Injury with Loss of Consciousness, and Traumatic Hemorrhage of Cerebrum. A quarterly Minimum Data Set (MDS) assessment, dated 2/2/23, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. Resident #8 required extensive to total assistance with activities of daily living. The assessment identified the presence of a tracheostomy and a feeding tube. Continued review of the medical record revealed the presence of a Mic-Key gastrostomy tube.<br><br>On 4/19/23, at 12:20 p.m., an observation of feeding administration via gastrostomy tube was conducted for Resident #8 with Licensed Practical Nurse (LPN) A. After performing hand hygiene and applying gloves, LPN A connected the feeding extension to Resident #8's gastrostomy tube and inserted a syringe into the feeding tube port. LPN A then raised the syringe to his/her left ear for about three (3) seconds and then proceeded to administer water flushes along with one (1) eight (8) ounce container of Jevity 1.5 calorie formula. LPN A did not check the placement of Resident #8's gastrostomy tube prior to initiating the flushes or feeding. Immediately after the feeding observation, LPN A called two (2) staff members into Resident #8's room and requested that they provide care for him/her and assist the resident in moving up in bed. Approximately five (5) minutes after the feeding was finished, the two (2) employees lowered the head of the bed flat and began rolling Resident #8 to his/her left and right sides for incontinence care. When asked whether the head of the bed should remain elevated for any period of time after a feeding was completed, LPN A stated, "No, [Resident #8] will be fine."<br><br>Review of Resident #8's comprehensive Care Plan revealed a focus area for tube feeding. The goal indicated Resident #8 would remain free from complications related to tube feeding. A related intervention directed staff to keep the head of the bed elevated to at least 30 degrees during feedings and for 30 minutes after the feeding. |

| | |
|---|---|
| | On 4/19/23, at approximately 2:15 p.m., a follow up interview was conducted with LPN A. He/she was asked to explain the process for verifying placement of a gastrostomy tube prior to using it. LPN A stated, "What I do is connect the syringe to the tube and I listen to see if I can hear it gurgling." LPN A clarified that he/she listened by removing the piston from the syringe and holding the syringe up to his/her ear. LPN A was then asked whether he/she was familiar with the facility's policy for verifying placement. LPN A stated, "This is just the way I've always done it." LPN A would not confirm whether he/she had received training on the facility's process for verifying tube placement. |
| **§ 51.120 (l) Special needs.**<br>The facility management must ensure that residents receive proper treatment and care for the following special services:<br>(1) Injections;<br>(2) Parenteral and enteral fluids;<br>(3) Colostomy, ureterostomy, or ileostomy care;<br>(4) Tracheostomy care;<br>(5) Tracheal suctioning;<br>(6) Respiratory care;<br>(7) Foot care; and<br>(8) Prostheses.<br><br>**Rating** – Not Met<br>**Scope and Severity** - D<br>**Residents Affected** – Few | Based on observations, interviews, and record review, the facility failed to provide proper respiratory care by failing to 1) Appropriately monitor residents with orders for incentive spirometry, and 2) Administer humidification when needed for residents with tracheostomies. These deficient practices affected one (1) of one (1) resident with orders for incentive spirometry (Resident #7) and one (1) of one (1) resident with a tracheostomy (Resident #8) from a total of 28 residents sampled.<br><br>The findings include:<br><br>1. Review of Resident #7's medical record revealed an admission date of 2/22/22. Resident #7's primary medical diagnosis was Type 2 Diabetes. Secondary medical diagnoses included Obstructive Sleep Apnea, Major Depressive Disorder, and Chronic Diastolic Heart Failure. An Annual Minimum Data Set (MDS) assessment, dated 2/16/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.<br><br>On 4/17/23, at approximately 11:45 a.m., an interview was conducted with Resident #7 regarding the care and services he/she received at the facility. Resident #7 explained that he/she was "getting over pneumonia," but was feeling a little better.<br><br>Review of Resident #7's Physician Orders revealed an order, dated 3/20/23, for incentive spirometry every shift to promote cough and deep breathing.<br><br>Review of Resident #7's Progress Notes revealed an entry by the provider, on 3/21/23, which indicated that Resident #7 had a chest x-ray performed which reflected early stages of pneumonia. Incentive spirometry was ordered to promote lung expansion.<br><br>Continued review of Resident #7's Progress Notes revealed an entry, dated 4/10/23, which referenced the incentive spirometer |

| | |
|---|---|
| | and read, “member can’t find it in [Resident #7]’s bed today. Marked as not done.” There was no evidence of communication to the provider. The note was authored by Licensed Practical Nurse (LPN) A.<br><br>A Progress Note, dated 4/15/23, at 11:34 a.m., referenced the incentive spirometer and indicated that Resident #7 said he/she had been using it “but is not.” There was no evidence of communication to the provider. The note was authored by LPN A.<br><br>A Progress Note, dated 4/16/23, 12:16 p.m., referenced the incentive spirometer and indicated Resident #7 said he/she was using it but was not. There was no evidence of communication to the provider. The note was authored by LPN A.<br><br>On 4/18/23, at approximately 11:15 a.m., a second interview was conducted with Resident #7. He/she was asked whether he/she used the device the provider had prescribed to help him/her breathe better. Resident #7 stated, “I don’t know what you are talking about. I don’t have anything like that in my room.”<br><br>On 4/18/23, at approximately 11:30 a.m., LPN A was asked whether he/she was familiar with Resident #7. LPN A explained that he/she was assigned to care for Resident #7 and was familiar with his/her respiratory care. LPN A explained that Resident #7 had recently had “some sort of respiratory infection.” When asked whether Resident #7 used the incentive spirometer, LPN A stated the resident was claiming he/she was using it, but that it likely wasn’t true. When asked whether he/she had ever seen Resident #7 with, or assisted Resident #7 to use, the incentive spirometer, LPN A stated, “I’ve never seen it.” When asked whether Resident #7 still needed the incentive spirometer, LPN A stated, “I don’t know.” LPN A then stopped the Unit Manager who was walking past in the hallway. The Unit Manager stated, “I’m sure [Resident #7] is using it, but I’ll look into it.”<br><br>During a follow up interview with LPN A and the Unit Manager, on 4/19/23, at 2:20 p.m., LPN A stated he/she had not checked with the provider about whether or not Resident #7 still required the incentive spirometer and was unsure of whether the device was available for Resident #7’s use.<br><br>2. Review of Resident #8’s medical record revealed an admission date of 11/8/21. Resident #8’s primary medical diagnosis was Hemiplegia affecting Right Dominant Side. His/her secondary medical diagnoses included Dementia, Intracranial Injury with Loss of Consciousness, and Traumatic Hemorrhage of Cerebrum. A quarterly Minimum Data Set |

| | |
|---|---|
| | (MDS) assessment, dated 2/2/23, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. Resident #8 required extensive to total assistance with activities of daily living. The assessment identified the presence of a tracheostomy.<br><br>Review of Resident #8's Physician Orders revealed an order, dated 9/28/22, for humidified room air as needed.<br><br>On 4/19/23, at 12:20 p.m., an observation of enteral feeding and tracheostomy care was conducted for Resident # 8 with LPN A. Upon entering the room, a large amount of thick, green/yellow mucus was observed in and around the tracheostomy. Resident #8's humidification machine was turned off and the tracheostomy mask was laying on the floor. Significant audible congestion was still evident after the care was provided. LPN A did not offer Resident #8 tracheostomy suctioning or humidification.<br><br>An interview was conducted with LPN A immediately following the observation. LPN explained that Resident #8 had a history of refusing tracheostomy suctioning and that staff "sometimes put on the humidifier." When asked how staff would know when to apply the humidification, LPN A stated, "When the secretions are thick and yellowish." LPN A was asked whether the secretions just observed during care would be categorized as thick and yellowish, LPN A stated, "I would think so." LPN A then continued to document on the computer and not apply the humidifier. |
| **§ 51.120 (n) Medication Errors.**<br>The facility management must ensure that—<br>(1) Medication errors are identified and reviewed on a timely basis; and<br>(2) strategies for preventing medication errors and adverse reactions are implemented.<br><br>**Rating** – Not Met<br>**Scope and Severity** - D<br>**Residents Affected** – Few | Based on observations, interviews, and record review, the facility failed to prevent medication errors by failing to 1) Administer appropriate dosages of stool softener as ordered by the provider, and 2) Administer insulin timely after meals, and 3) Obtain blood glucose results for residents with insulin orders that included parameters to hold the medication. There were three (3) medication errors observed from a total of 27 opportunities for error.<br><br>The findings include:<br><br>The facility's policy governing medication administration practices was reviewed. The policy titled, "Medication Administration," was dated 4/14/21. Step eight (8) of the policy directed staff to "Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters."<br><br>On 4/19/23, at 10:08 a.m., an observation of medication administration was conducted for Resident #26 with Licensed Practical Nurse (LPN) A. LPN A dispensed three (3) Senna |

| | |
|---|---|
| | tablets into the medication container lid and attempted to pour them into the medication cup. The pills spilled out onto the medication cart. LPN A disposed of the three (3) Senna pills. He/she then dispensed two (2) more Senna tablets into the container lid and poured them into the medication cup.<br><br>Review of Resident #26's Physician Orders revealed an order for three (3) Senna tablets to be administered for a diagnosis of Constipation.<br><br>On 4/19/23, at 10:27 a.m., an observation of medication administration was conducted for Resident #6 with LPN A. LPN A prepared seven (7) units of Novolog insulin, injected the insulin into Resident #6's right abdomen, and left the room. After LPN A left the room, Resident #6 was asked whether he/she had eaten breakfast. Resident #6 stated, "I think so a while ago."<br><br>Review of Resident #6's Physician Orders revealed an order for Novolog seven (7) units to be administered subcutaneously after meals at 8:00 a.m., with another dose due to be given at 12:00 p.m.<br><br>On 4/19/23, at 10:33 a.m., an observation of medication administration was conducted for Resident #28 with LPN A. LPN A prepared seven (7) units of Novolog insulin, injected the insulin into Resident #28's left abdomen, and left the room. LPN A did not check Resident #28's blood glucose prior to administration of the insulin. Immediately after the insulin injection, Resident #28 was asked whether he/she had already eaten breakfast. Resident #28 stated, "Yes, about two hours ago."<br><br>Review of Resident #28's Physician Orders revealed an order, dated 1/21/23, for Novolog (seven) 7 units to be injected subcutaneously after meals for a diagnosis of Diabetes. A special parameter on the order directed licensed nursing staff to hold the insulin for a blood glucose level less than 130. The insulin was ordered to be given at 8:30 a.m., and the next dose was to be given at 12:00 p.m.<br><br>During a follow up interview with LPN A, on 4/19/23, at approximately 2:20 p.m., LPN A was asked what Resident #28's blood glucose result was prior to the administration of his/her insulin. LPN A stated, "[Resident #28] doesn't get them checked regularly. I think they are monthly." LPN A was asked to review Resident #28's Physician Orders. LPN A confirmed that the insulin order, dated 1/21/23, was active and included a special parameter to hold the insulin for a blood glucose less than 130. LPN A then stated, "I messed that one up, didn't I?" When asked whether he/she routinely administered insulin for |

| | |
|---|---|
| | up to two (2) hours following a resident's meal, LPN A stated, "I'm just always busy. Hopefully, I will get a lunch today." |
| **§ 51.190 (b) Preventing spread of infection.**<br>(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident.<br>(2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease.<br>(3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>**Rating** – Not Met<br>**Scope and Severity** - D<br>**Residents Affected** – Few | Based on observations, interviews, and record review, the facility failed to ensure 1) Staff were performing adequate hand hygiene before and after care, and 2) Staff were preparing and administering medications in accordance with the facility's own infection prevention policies.<br><br>The findings include:<br><br>The facility's policy governing medication administration practices was reviewed. The policy titled, "Medication Administration," was dated 4/14/21. Step four (4) of the policy directed staff to wash hands prior to administering medication. Step 13 of the policy directed staff to remove medications from their source, taking care not to touch medications with bare hands. Step 16 of the policy directed staff were to wash hands again after medications were administered.<br><br>The facility's policy governing the processes for administration of injections was reviewed. The policy titled, "Injections, Administration," was dated 5/1/21. Step four (4) of the policy indicated that gloves and other PPE were required for administering medications that might involve contact with blood or body fluids.<br><br>On 4/19/23, at 9:55 a.m., an observation of medication administration was conducted for Resident #25 with Licensed Practical Nurse (LPN) A. LPN A did not perform hand hygiene or apply gloves prior to the following observations:<br><br>- LPN A dispensed a Norco tablet into his/her bare hand and then placed it into a medication cup.<br>- LPN A dispensed an Ativan tablet into his/her bare hand, split the medication using his/her fingers, and placed the medication into a medication cup.<br>- LPN A dispensed a Trileptal tablet (packaged in a yellow bag which read "Hazardous Drug") into his/her bare hand and then placed it into a medication cup.<br>- LPN A dispensed two (2) Seroquel tablets into his/her bare hand and then placed them into a medication cup.<br>- LPN A dispensed an Olanzapine tablet into his/her bare band and then placed it into a medication cup.<br>- LPN A dispensed a Plavix tablet into his/her hand and then placed it into a medication cup.<br><br>LPN A then proceeded to Resident #25's room, administered the medications to Resident #25 by mouth, using pudding and a spoon. LPN A did not perform hand hygiene after administering the medications or leaving Resident #25's room. |

| | |
|---|---|
| | On 4/19/23, at 10:08 a.m., an observation of medication administration was conducted for Resident #26 with LPN A. LPN A did not perform hand hygiene or apply gloves prior to the following observations:<br><br>- LPN A dispensed an Oxycodone tablet into his/her bare hand and then placed it into the medication cup.<br>- LPN A dispensed two (2) Carpidopa/Levodopa tablets into his/her bare hand and placed them into the medication cup.<br>- LPN A dispensed a Myrbetriq tablet into his/her bare hand and placed it into the medication cup.<br>- LPN A dispensed a Florastor capsule into his/her bare hand and placed it into the medication cup.<br>- LPN A dispensed a Citalopram tablet into his/her bare hand and placed it into the medication cup.<br>- LPN A dispensed a Potassium Chloride tablet into his/her bare hand, split it in half using his/her fingers, and placed each half in a separate medication cup.<br><br>LPN A then proceeded to Resident #26's room, administered the medications to Resident #26 by mouth, using pudding and a spoon. LPN A did not perform hand hygiene after administering the medications or leaving Resident #26's room.<br><br>On 4/19/23, at 10:27 a.m., an observation of medication administration was conducted for Resident #6 with LPN A. LPN A did not wash his/her hands prior to the following observations:<br><br>- LPN A prepared 7 units of Novolog insulin for injection. LPN A entered Resident #6's room and applied a glove to his/her left hand and advised Resident #6 that he/she was going to administer insulin. LPN A wiped an area on Resident #6's right abdomen one (1) time with an alcohol prep pad, which he/she then placed onto Resident #6's overbed table. LPN A administered the insulin injection with his/her bare right hand, removed the needle, activated the needle safety, and placed the used alcohol prep pad onto the injection site with his/her bare right hand. A small droplet of blood was visible at the injection site. LPN A did not perform hand hygiene after administering the insulin and went directly to the medication cart to prepare medications for the next resident.<br><br>On 4/19/23, at 10:33 a.m., an observation of medication administration was conducted for Resident #28 with LPN A. LPN A did not wash his/her hands prior to the following observations: |

| | |
|---|---|
| | - LPN A prepared seven (7) units of Novolog insulin for injection. LPN A entered Resident #28's room and applied a glove to his/her left hand. LPN A asked Resident #28 where he/she would like the insulin injection. Resident #28 pointed to the left abdomen. LPN A wiped an area on Resident #6's left abdomen once with an alcohol prep pad and placed the used pad on the overbed table. LPN A used his/her right bare hand to inject the insulin. LPN A then removed the needle, activated the needle safety, and placed the used alcohol prep pad onto the injection site. LPN A wiped the site three (3) times with the used alcohol prep pad, disposed of the needle, removed the glove from his/her left hand, and left the room. LPN A did not perform hand hygiene after administering the insulin and went directly to the medication cart to prepare medications for the next resident.<br><br>On 4/19/23, at 12:20 p.m., an observation of enteral feeding and tracheostomy care were conducted for Resident # 8 and was conducted with LPN A. Upon entering Resident #8's room, LPN A washed his/her hands and applied clean gloves. LPN A administered water flushes and enteral nutrition to Resident #8 via a gastrostomy tube. After completing the procedure, LPN A immediately began providing care for Resident #8's tracheostomy site with the same gloves used to administer water flushes and enteral nutrition. LPN A used those same gloves to remove the tracheostomy site dressing, clean the site, placed a new dressing, removed the inner tracheostomy cannula, cleaned the cannula, and replaced it. Immediately after the care was concluded, LPN A was asked whether he/she normally performed hand hygiene and changed gloves between the two (2) tasks. LPN A stated, "Yes, I usually do. I guess I just forgot."<br><br>On 4/19/23, at approximately 2:15 p.m., a follow up interview was conducted with LPN A. LPN A was asked whether he/she was familiar with the facility's policy for administering insulin injections and the need for wearing gloves for that procedure. LPN A stated, "Yes, I know I'm supposed to wear them. It's just a habit of mine." LPN A acknowledged the potential for contact with bodily fluids and the potential for transmitting communicable diseases when he/she failed to wash his/her hands after that contact. LPN A also acknowledged that medications should not be touched with bare hands and should be dispensed directly from the packaging into medication cups. |