STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235724	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ Jacobetti Home for Veterans	**425 Fisher Street , Marquette, Michigan, 49855**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS DJ Jacobetti Home for Veterans was surveyed for a Recertification survey on 12/11/25. Intakes: 1361257. Census= 61	F0000		12/23/2025
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F0584	R4, R37, R50, R57 and R 62 were assessed and found to be at baseline. Tray cards and care plans were reviewed to ensure member food service preferences were specified correctly. All members that have expressed a preference regarding their meal service could be affected by this deficient practice. All members that have expressed preferences regarding meal service have been assessed and found to be at baseline. Tray cards and care plans were reviewed to ensure member food service preferences were specified correctly. The facility policy Member Self-Determination and Participation v2 was reviewed and determined to be adequate. Dietary staff were educated on locating and honoring member meal service preferences. Root cause is incomplete education of new dietary staff. 5 members will be audited weekly x4 weeks, then monthly for 3 months to ensure members receive the meal service of their choice. Results will be brought to the QAPI committee and reviewed until substantial compliance is achieved. The administrator is responsible for sustained compliance. Compliance date is 1/15/2026.	01/15/2026

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 reverse for further 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.

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

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F0584 SS = E	Continued from page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide a homelike environment and honor the meal service preferences for five Residents (R4, R37, R50, R57, R62) of 15 residents reviewed. Findings include: On 12/9/2025 at 11:58 AM, the lunch meal was observed in the 2nd floor dining room. Four staff members were present and serving lunch. All residents in the dining room were served their lunches on institutional trays. Resident #4 (R4) was observed with a tray card containing preferences which read:" blue placemat NO TRAY [sic]". R4 did not have a blue placemat, and his meal was resting on a tray which sat on the table. Further observations included R37, R50, R57 and R62 all received their meals on trays while their tray cards indicated they did not prefer a tray. (Their tray cards read: "NO TRAY".) During an interview on 12/11/2025 at 8:44 AM, the Certified Dietary Manager (CDM) "B" stated it was his practice to make the facility as homelike as possible and he stated, "Trays are not homelike." During an interview on 12/11/2025 at 8:53 AM, the Nursing Home Administrator (NHA) discussed the culture of the facility and stated residents should not get a tray if that was their preference.	F0584		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,	F0600	CNA H no longer works in the home. Member #18 was assessed following the fall and was determined to have had no injuries and is at his baseline. Social work followed up with the member after the fall and did not note and deviations in mood of cognition and remains at his baseline. All members that were under the care of the employee were determined to have been at risk from this deficiency. All members that had incidents or injuries	01/15/2026

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F0600 SS = G	Continued from page 2 involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: This citation pertains to intake 1361257. Based on observation, interview, and record review the facility failed to prevent staff to resident physical abuse for one Resident (R18) out of one reviewed for abuse. This deficient practice resulted in a fall, emotional distress, and fear based on the reasonable person. Findings include: R18 Review of R18's Electronic Medical Record (EMR) revealed admission to the facility on 10/2/25 with diagnosis including frontotemporal neurocognitive disorder, aphasia, and adjustment disorder with mixed disturbance of emotions and conduct. R18's Brief Interview for Mental Status (BIMS) score in October 2025 was unable to be completed, but staff noted R18 to be severely cognitively impaired. R18 has a Designated Power of Attorney (DPOA) to make health and financial decisions. R18 was independent for ambulation. Review of R18's Care Plans read, in part, "Gary has potential to be physically aggressive towards staff r/t (related to) dementia and inability to communicate his needs. (Date initiated: 10/14/25)...Interventions/Tasks...(R18's) triggers for physical aggression include being redirected away from what he is trying to do...The resident's behaviors is de-escalated by providing distraction with an activity of interest, allowing as much independence as possible and giving him space (Date initiated:11/26/25)...When (R18) becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in an activity or a walk; If response is aggressive, staff to walk calmly away, and approach later (Dante Initiated: 10/14/25) Review of the Facility Reported Incident (FRI) dated 12/8/25 read, in part, "On December 2, 2025 at approximately 10:00 a.m., The Director of Nursing (DON) was notified of a concern during a camera review of a witnessed fall that	F0600	Continued from page 2 while under the care of the employee were reviewed and no concerns were noted. Members that had a BIMS of 12 or above who may have been cared for by the employee were interviewed and did not express any complaints or concerns. The policies and procedures of the home were reviewed and deemed appropriate. All staff of the home were re-educated to appropriate responses for aggressive and/or behavioral members. The home will randomly audit employees weekly x4 then monthly for appropriate interventions learned through re-education. The audits will not be discontinued until substantial compliance has been met as determined by the QAPI committee. The administrator is responsible for sustained compliance. Compliance date is 1/15/2026.	

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F0600 SS = G	Continued from page 3 occurred on December 1, 2025 at approximately 1815 (6:15 p.m.) with a member of the Memory Care Unit, (R18). According to reports, (R18) was ambulating with a staff member, (Certified Nurse Aide (CNA) "H") when he was attempting to pull a Christmas decoration off the wall. Statements describe (R18) pulling backward forcefully, and when the decoration was pulled from the wall, it causes him to lose his balance and fall to the floor, causing him to come to rest on his right side. He (R18) was assessed immediately by the nurse on duty who did not note any injuries at that time and his DPOA was notified of the fall without injury. Initially following the fall, the home did not have concerns for abuse. After clinical review on the morning of 12/2/25, the home reviewed camera footage to confirm if (R18) had hit his head during the fall, and upon video review concerns for abuse were noted..." The facility's video surveillance was reviewed with the Nursing Home Administrator (NHA) on 12/10/25 at 2:38 p.m. The timing on the video was noted to be 12/1/25 at 6:09 p.m. with CNA "H" and R18 located in the main hallway of the memory care unit and across from the sitting area. R18 is observed attempting to take down a Christmas decoration on the wall. CNA "H" comes over to R18 and attempts to stop him by taking R18's hands and removing them from the decoration. R18 then attempts to strike CNA "H" with his right hand two times with CNA "H" blocking both hits with his left forearm. CNA "H" is then observed extending his left arm towards R18 and placing his left hand on R18's on his abdomen below the breast. CNA "H" removes his hand briefly then places his left hand again on R18, this time higher in the chest area while taking a step forward toward R18. CNA "H" then is seen taking a forward rocking motion with his hand making contact with R18's left upper chest/shoulder area. This is when R18 starts to lose his balance and stumbles backwards, hitting his right side onto the floor. An interview with the NHA on 12/10/25 at approximately 2:50 p.m. confirmed that CNA "H" should not have placed his hands on R18 and did not follow R18's Care Plans. An attempted phone call with CNA "H" was conducted on 12/10/25 at approximately 3:00 p.m. There was no return phone call before the end of the survey on 12/11/25. Review of the facility's "Recognizing Signs & Symptoms of Abuse" policy read, in part, "The home will not condone any form of member abuse or neglect… 'Abuse' is defined as the willful infliction of injury…intimidation, or punishment with resulting physical harm, pain or mental anguish…Physical Abuse includes, but is not limited to hitting, slapping, biting, punching, or kicking…Some situations of abuse do not result in an observable physical injury, or the psychosocial effects of abuse may not be immediately apparent…other members may not	F0600		

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F0600 SS = G	Continued from page 4 be able to speak due to a medical condition and/or cognitive impairment (e.g., stroke, coma, Alzheimer's disease), cannot recall what has occurred, or may not express outward signs of physical harm, pain, or mental anguish. Neither physical marks on the body nor the ability to respond and/or verbalize is needed to conclude that abuse has occurred…The follow situations are recognized as those that are likely to cause psychosocial harm which may take months or years to manifest and have long-term effects on the member and his/her relationship with others:…(d) Any staff-to-member physical, sexual, or mental/verbal abuse…"	F0600		
F0810 SS = D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide dining adaptive equipment for three Residents (#4, #56, & #62) of four residents reviewed for dining assistive devices. Findings include: On 12/9/2025 at 11:58 AM, the lunch meal was served in the 2nd floor dining room. Four staff members were present and serving lunch. The following was observed: Resident #4 (R4) - - R4 was observed with a tray card containing instructions which included, "Adaptive Equip(ment): Blue Handled Mug with Lid", "Scoop plate" (plate with an edge to facilitate catching food), "Blue placemat" (made of material to prevent plate slippage) and "All Soup in a Mug". R4 had his meal on a regular non-scooped standard plate sitting on the service tray without a blue mat and his soup was not in a mug but instead served in a bowl. R4 did not receive his coffee in a blue handled mug. Resident #56 (R56) - - R56 was observed with a tray card containing instructions which included, "Adaptive Equip: Built-Up	F0810	R4, R56, R62 were assessed and found to be at baseline. Tray cards and ADL care plans were reviewed to ensure member adaptive equipment needs were specified correctly. All members that require adaptive equipment could be affected by this deficient practice. All members that are required to utilize adaptive equipment have been assessed and found to be at baseline. Tray cards and care plans were reviewed to ensure member adaptive equipment needs were specified correctly. The facility policy Assistive Devices and Equipment was reviewed and determined to be adequate. Dietary and Nursing staff were educated on providing proper adaptive equipment to members. Root cause is incomplete education of dietary staff. 5 members will be audited weekly x4 weeks, then monthly for 3 months to ensure members receive the proper adaptive equipment. Results will be brought to the QAPI committee and reviewed until substantial compliance is achieved. Administrator is responsible for sustained compliance. Compliance date is 1/15/2026.	01/15/2026

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F0810 SS = D	Continued from page 5 Utensils, Cold liquids: 2-handle Cup with Straw…, Mug with Tumbler lid for Hot Liquids, Straw". R56 did not receive built up utensils or a 2 handled cup for his beverages. R56 had hot soup served in a bowl and not in a mug for hot liquids as printed on his tray card. Resident #62 (R62) - - R62 was observed with a tray card containing instructions which included, "Adaptive Equip: Blue Handled Mug with lid." R62 had a cup of coffee in a regular mug with lid – a special blue handled mug was not used. During the breakfast meal service on 12/10/2025 at 7:52 AM, R62 was observed with a tray card containing instructions which included, "Adaptive Equip: Blue Handled Mug with lid." R62 stated he would like a cup of coffee. Certified Nursing Assistant (CNA) "D" served R62 coffee but did not use a blue handled mug with lid. When asked about the different mug, CNA "D" did not know R62 had specifications for a blue handled mug on his tray card. During the lunch meal service on 12/10/2025 at 12:17 PM, R62 was observed with a tray card containing instructions which included, "Adaptive Equip: Blue Handled Mug with lid." R62 had coffee in a regular mug and did not receive a blue handled mug with lid. R4 was observed with a tray card containing instructions which included, "Adaptive Equip: Blue Handled Mug with lid" but did not receive a blue handled mug with lid for the hot beverage. The electronic medical record (EMR) was reviewed for R4, and the quarterly nutrition assessment note dated 11/6/2025 included, "…He uses built up utensils, a scoop plate, and blue dycem as a placemat. These help to increase eating independence. He can feed himself after set up and he is able to make his needs known…" The ADL (Activity of Daily Living) care plan included interventions of: "…uses a scoop plate for meals, blue dycem as a place mat, built up utensils. All beverages should be served in a cup with a disposable lid with a straw…At times, he is able to feed himself with set up, other times he needs staff to feed him due to tremors. He does drink hot liquids out of a standard mug with disposable straw lid and straw." The care plan also included a problem of weight gain and the same interventions were repeated with additional notes which read, "Kitchen staff will sometimes offer foods to be served in individual bowls instead of the scoop plate, and they usually ask (R4) what he prefers. Date Initiated : 09/11/2025." During the lunch meal	F0810		

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F0810 SS = D	Continued from page 6 observation on 12/09/2025 at 11:58 AM, R4 did not have a scoop plate or individual bowls, instead his meal was served on a regular non-scooped standard plate sitting on the service tray without a blue mat. The EMR was reviewed for R56, and the care plan included a problem of: "(R56) has potential for altered NUTRITION related to his diagnosis of Dementia, Diabetes, and Parkinson's Date Initiated: 09/18/2025". The interventions included: "DIET: Soft with ground meats. Built-up utensils. 2 handled mug with a lid and straw for cold beverages… Date Initiated: 09/29/2025". The EMR was reviewed for R62, and the care plan included a problem of: "…an ADL self-care performance deficit… Revision on: 04/24/2023." The interventions for this problem included… "(R62) to have hot liquids with blue handled mug with lid for safety, to avoid spills and potential burns. Cool hot items slightly with a little ice." There was an additional care plan problem listed as a history of weight gain and loss. The interventions for this problem also included, "Cool coffee to luke warm with ice prior to giving to (R62)" and "(R62) to have hot liquids with blue handled mug with lid for safety, to avoid spills and potential burns. Staff should cool slightly with a little ice. Date Initiated: 05/12/2025." During the breakfast meal service observation on 12/10/2025 at 7:52 AM, CNA "D" served R62 coffee but did not add ice or give R62 a blue handled cup as per the several care plan interventions. During an interview on 12/11/2025 at 8:44 AM, the Certified Dietary Manager (CDM) "B" stated the staff serving the residents should follow the tray cards and give the adaptive equipment as indicated on the cards.	F0810		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F0812	No members were determined to be affected by the deficient practice. Can was removed and the drain line and floor drain were cleaned. Proper air gap was achieved. Expired and improperly dated food was discarded. Towels were discarded and dish machine was repaired. Oreo bits were discarded. Slicer was cleaned and sanitized properly. All members could be affected by these deficient practices. Upon identification of the concern, the facility promptly reviewed the 24-hour report on 12/12/2025 at approximately 9:00 am and identified no indications of foodborne illness Facility policies Food Safety Requirements v3 and Date Marking for Food Safety was reviewed and determined to	01/15/2026

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F0812 SS = F	Continued from page 7 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety, resulting in the potential to spread food borne illness among all residents that consume food from the kitchen. Findings include: On 12/10/2025 at 1:40 PM During a facility main kitchen tour with Certified Dietary Manager (CDM) "B" and Assistant Dietary Manager (ADM) "C", the vegetable wash sink was observed without an air gap. A tin can was observed surrounding the outlet drain, sitting on the floor drain. When asked about the tin can, CDM "B" stated the can was in place as a splash guard since before he came on board at the facility. When moved, the can, drain line and floor drain were noted heavily soiled with black slime mold and food debris. On 12/10/2025 at 2:15 PM while on a tour of the 2 North kitchen on the second floor with Certified Dietary Manager (CDM) "B" and ADM "C", ready-to-eat food items were noted with a dispose by date totaling 8 days. Items included cream corn souffle cup with a made-on date of 12-9 and a dispose-by date of 12-16, chef salad 12-9 through 12-16, tossed salad 12-9 through 12-16, and shredded cheddar cheese with 12-9 through 12-16. Upon review of the facilities log sheet on the outside of the refrigerator with the CDM, it was noted the facility policy is that all foods are to have been kept for no more than seven days, including the day of preparation. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT,	F0812	Continued from page 7 be adequate. Dietary staff were educated on proper labeling, dating and monitoring food. Dietary staff were also educated on cleaning and sanitizing food contact surfaces. Dietary staff were also educated on properly maintaining kitchen equipment. Root cause is new dietary staff with incomplete education. Kitchens will be audited weekly x4 weeks, then monthly for 3 months to ensure food contact surfaces remain clean and sanitary, food is used or disposed of prior to its expiration date and is properly labeled, air gaps are properly maintained, and kitchen equipment is clean and in proper working order. Results will be brought to the QAPI committee and reviewed until substantial compliance is achieved. Administrator is responsible for sustained compliance. Compliance date is 1/15/2026.	

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F0812 SS = F	Continued from page 8 TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. On 12/10/2025 at 2:30 PM while on a tour of the 2 North kitchen and dining rooms with CDM "B" and ADM "C" the Hobart high temp dish machine was noted with towels lying on the floor tucked up under the front of the machine. CDM "B" stated the machine has been leaking when it is running and water comes out onto the floor, and the towels have been put in place to prevent water from getting further out onto the kitchen floor. According to the 2022 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. "(A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. On 12/10/2025 at 3:15 PM Observed a bag of Oreo bits sitting on a shelf in the kitchen with the top of the bag open exposing the cookie bits inside. Staff did not know who these belonged to, or how long they had been there. ADM "C" disposed of them. According to the 2022 FDA Food Code section 3-305.11 Food Storage. (A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. On 12/10/2025 at 3:25 PM while in the main kitchen, it was noted the slicer had been covered with a plastic bag to keep it clean. The ADM "C" stated it had been cleaned and then covered to keep it clean. When asked how the unit is cleaned after being used for prepping food, ADM "C" stated the pieces that are able to be removed from the unit are taken to the three-compartment sink to be washed, rinsed and then sanitized. When the plastic bag was removed to inspect the slicer, the underneath side of the removable blade and casing were observed to have been left soiled with food debris after the last prep period. According to the 2022 FDA Food Code section 4-601.11	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235724	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ Jacobetti Home for Veterans	**425 Fisher Street , Marquette, Michigan, 49855**

(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) COMPLETION DATE
F0812 SS = F	Continued from page 9 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. “(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.	F0812		