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 _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
E000	Initial Comments On October 18, 2022, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Dj Jacobetti Home for Veterans of Marquette was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E000		
E004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) 403.748(a), 416.54(a), 418.113(a), 441.184(a), 460.84(a), 482.15(a), 483.73(a), 483.475(a), 484.102(a), 485.68(a), 485.542(a), 485.625(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at 482.15 and CAHs at 485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal,	E004	E004: In accordance with 483.73(a), the current Emergency Preparedness Plan has been reviewed and updated as of 11-2-22. Fire safety officer and assistant Fire safety officer were educated on the annual review requirement. The Emergency Preparedness plan will be reviewed annually to ensure compliance. A task will be created in Tels Workorder System to ensure an annual update and review of the plan by the Administrator and Facilites Director to maintain compliance. Date of compliance is 11/21/2022	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	11/09/2022

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 _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
E004	Continued From page 1 and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at 483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at 494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain an Emergency Preparedness plan that must be reviewed and updated at least annually. This deficient practice could affect all occupants in the event of an emergency. Findings Include: On October 18, 2021 between the hours of 4:15 PM and 5:30 PM, record review revealed the facility failed to maintain and updated their Emergency Preparedness Plan as required by 42 CRF 487.73(a). Records revealed the most recent update was completed on August 5, 2020.	E004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
E004	Continued From page 2 This finding was confirmed by the Assistant Fire Safety Officer and Administrator at the time of record review.	E004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K000	INITIAL COMMENTS On October 18, 2022, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Dj Jacobetti Home For Veterans of Marquette was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility was constructed in three phases. The original building constructed in 1954, of Type I(332) construction walks out to the ground floor and has 3 floors above. The second phase was built in 1964, of Type I(332) construction with a ground floor walkout and has 2 floors above. The third phase was built in 1988, of Type II(222) construction with open parking below and two stories above. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 81 certified beds. At the time of the survey the census was 59. The requirement at 42 CFR, subpart 483.90(a) is NOT MET as evidenced by:	K000		
K222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be	K222	K222 (1): In accordance with 7.2.1.5, 7.2.1.5.3, and 7.2.1.5.6 horizontal exit door will be removed at loading dock entrance/exit. Previously used exterior door will be used again as exit door for	12/2/22

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

Electronically Signed | 11/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	**425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K222	Continued From page 1 equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K222	loading dock. K222 (2): In accordance with 7.2.1.5, 7.2.1.5.3, and 7.2.1.5.6 unapproved hold open device was removed. Staff was reminded to not use unapproved hold open devices. All staff were educated on not using unapproved hold open devices. Doors will be audited monthly for the presence of unapproved hold open devices. K222 (3): In accordance with 7.2.1.6.1.1 (3), the 1 East Stairwell delayed-egress door was repaired on the date of 10-19-2022. The code alert magnet was found to be defective causing it to not preform properly. A new code alert magnet was installed and resolved the issue and the delayed-egress door was again functioning properly. All delayed-egress doors will continue to be inspected on a monthly basis and completion will be logged in the Tels Workorder System.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	**425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K222	Continued From page 2 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in a required means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless meeting the special locking arrangements for clinical needs in accordance with 18.2.2.2.5.1 and 18.2.2.2.6, special needs locking arrangements in accordance with 18.2.2.2.5.2, delayed egress locking in accordance with 18.2.2.2.4, access-controlled egress doors in accordance with 18.2.2.2.4, or elevator lobby exit access in accordance with 18.2.2.2.4. This deficient practice could affect all occupants in the event of evacuation. Findings Include: 1) On October 18, 2022 at approximately 2:05 PM, observation revealed there was a new horizontal sliding exit door installed at the loading dock entrance/exit with a locking arrangement that does not meet the	K222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	**425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K222	Continued From page 3 requirements of 7.2.1.5, 7.2.1.5.3, and 7.2.1.5.6. Observation revealed the horizontal sliding door can only be used if a code is entered in a keypad nearby OR if a special knowledge latch on the sliding door assembly is switched. There is no panic hardware or break away feature that can be used in the event of an emergency to open the door. This deficient practice can result in egress difficulties in the event of an emergency. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation. 2) On October 18, 2022 at approximately 2:05 PM, observation revealed the delayed-egress door that was previously the exterior door for the loading dock entrance/exit was propped open with an unapproved hold open device. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation. 3) On October 18, 2022, at approximately 3:02 PM observation revealed the 1 East stairwell delayed-egress exit door does not function as required by 7.2.1.6.1.1 (3). Upon testing the door three times, the delayed-egress function does not work and the only way to exit through the door is enter a code on a keypad, which deactivates the locking mechanism. This deficient practice prohibits occupants from exiting through this exit door in the event of evacuation. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation.	K222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K321 K321 SS=E	Continued From page 4 Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure hazardous areas are protected by a fire barrier having a 1-hour fire-resistance rating or protected by an automatic extinguishing	K321 K321	K321(1.): At the time of inspection, the door to mechanical room 4 was held open during repairs of a leak in the chill water lines to the air handling unit. Staff was reminded to not use unapproved hold open devices when they are not currently working in the space. To ensure compliance with 19.3.2.1.3, objects that were being used as an unapproved hold open device were removed from the area to maintain proper closure and latch of the fire rated door on the date of 10-19-2022. All staff were educated on not using unapproved hold open devices. K321 (2.): On the date of 10-19-2022, in accordance with 19.3.2.1.3, the door leading into the Flash cooler storage room was repaired to ensure proper closure and positive latch. This door will continue to be inspected monthly, along with all other self-closing doors throughout the facility. A log of these inspections is currently being completed monthly in the Tels Workorder System.	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K321	Continued From page 5 system in accordance with 8.7.1, as required by 18.3.2.1. This deficient practice could affect more than an isolated number of occupants in the event of a fire. Findings Include: 1) On October 18, 2022 at approximately 1:45 PM, observation revealed the self-closing door for mechanical room 4 was held open by an unapproved hold open device and does not conform to the requirements of 19.3.2.1.3. Further observation revealed the door was propped open by multiple cardboard boxes. This deficient practice can contribute to fire growth and smoke spread. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation. 2) On October 18, 2022 at approximately 2:07 PM, observation revealed the self-closing door for the Flash cooler storage room does not completely close and latch as required by 19.3.2.1.3. This deficient practice can contribute to fire growth and smoke spread. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation.	K321		
K324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small	K324	K324: On the date of 10-20-2022 in accordance with NFPA 101, 19.3.2.5, The cooktop stove located inside the Volunteers lounge, was equipped with a keyed power disconnect with a 120-minute timer with a locked switch in a restricted location. Staff that utilize the space were then educated on the functionality of the disconnects that were installed and their	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	**425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K324	Continued From page 6 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96, unless meeting the requirements of 18.3.2.5.2, 18.3.2.5.3 or 18.3.2.4.4, as required by 18.3.2.5.1 through 18.3.2.5.4, 9.2.3, and TIA 12-2. This deficient practice could affect all occupants in the event of a cooking emergency/fire. Findings Include: On October 18, 2022 at approximately 2:45 PM, observation reveled the residential stove located in the volunteer lounge was powered "on" and was unattended or unsupervised and not currently being used. Further interview revealed the stove does not have a locked switch or a switch in a restricted location that deactivates the cooktop or range and is not on an automatic disconnect timer not to exceed 120 minute capacity as required by NFPA 101, 19.3.2.5.	K324	purpose. A monthly audit task of facility cooking equipment will be placed in the Tels workorder system to ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K324	Continued From page 7 This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation.	K324		
K372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barriers were constructed to a minimum 1-hour fire resistance rating in accordance with 8.5 as required by 18.3.7.3 and 8.6.7.1(1). This deficient practice could affect more than an isolated number of occupants in the event of a fire. Findings Include: On October 18, 2022 at approximately 3:32 PM, observation revealed a smoke barrier wall penetration above cross corridor doors "1-15" not conforming to the requirements of NFPA 101 8.5.6.2. All smoke barriers shall be constructed of approved material and any void spaces around penetrations shall be filled with approved, properly rated intumescent material	K372	K372(1.): In accordance with NFPA 101 8.5.6.2, the approved fire rated caulking that was applied to a penetration in a smoke barrier above cross corridor doors (1-15), was reapplied to ensure proper adhesion and to prevent future failure of the material. Smoke barriers will continue to be inspected quarterly throughout the building and will continue to be logged in the Tels Workorder System. Maintenance staff were educated on the importance of maintaining smoke barriers. K372(2.): During time of inspection, it was discovered that the fire rated caulking that was installed to the penetration to the smoke barrier above cross corridor doors (2-7), had lost adhesion to the smoke barrier. Upon later inspection on the date of 10-19-2022, the corresponding side of the smoke barrier wall had been properly filled with an approved fire rated material. Out of abundance of caution, the penetration opening on the corresponding side was reapplied with fire rated caulking material to ensure lasting compliance with NFPA 101 8.5.6.2.. Smoke barriers will continue to be inspected quarterly throughout the building and will continue to be logged in the Tels Workorder System.	11/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K372	Continued From page 8 capable of restricting the transfer of smoke. This deficient practice can contribute to rapid smoke and fire spread in the event of a fire. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation. On October 18, 2022 at approximately 3:50 PM, observation revealed a smoke barrier wall penetration above cross corridor doors "2-7" not conforming to the requirements of NFPA 101 8.5.6.2. All smoke barriers shall be constructed of approved material and any void spaces around penetrations shall be filled with approved, properly rated intumescent material capable of restricting the transfer of smoke. This deficient practice can contribute to rapid smoke and fire spread in the event of a fire. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation.	K372		
K374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels,	K374	K374: On the date of 10-19-2022, in compliance with NFPA 101 8.5.4.4, cross corridor doors labeled (1-15), were repaired to ensure proper closure and positive latch. Cross corridor doors will continue to be inspected monthly and completion will be documented into a log in the Tels Workorder System. Maintenance staff were educated on maintaining cross corridor doors to ensure proper closure.	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K374	Continued From page 9 or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 This STANDARD is not met as evidenced by: Based upon observation and interview, the facility failed to ensure that doors in smoke barriers are 1 3/4 inch solid bonded wood-core doors or have a 20 minute fire rating, are self-closing or automatic-closing and provide a minimum width of 32 inches as required by 18.3.7.6, 18.3.7.7, and 18.3.7.8. This deficient practice could affect more than an isolated amount of occupants in the event of a fire. Findings Include: On October 18, 2022 at approximately 3:30 PM, observation revealed the 1 South cross corridor doors (1-15) do not completely self close as required by NFPA 101 8.5.4.4. This deficient practice can contribute to the spread of smoke and fire in the event of a fire. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation.	K374		
K521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by:	K521	K521: In accordance with NFPA 211 10.7.3.6, the flexible vent tubing that was installed on both the Physical Therapy department dryer, and the 1 West dryer, were both removed and reinstalled with rigid vent piping in compliance with NFPA guidelines. Dryer vents will continue to be inspected and cleaned bi-annually in the months of December and June. Completion of cleaning and inspection will be documented on both the Tels Workorder System, as well as signature	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K521	Continued From page 10 Based on observation and interview, the facility failed to ensure heating, ventilation and air conditioning is in compliance with 9.2, and installed in accordance with the manufacturer's specifications as required by 18.5.2.1 and 9.2. This deficient practice could affect more than an isolated number of occupants in the event of a dryer fire. Findings Include: On October 18, 2022 between the hours of 2:35 PM and 3:20 PM observation revealed the residential dryers located on the first and second floors did not have exhaust vents that meet the requirements of NFPA 211 10.7.3.6. NFPA 211 10.7.3.6 Exhaust ducts for clothes dryers shall meet the following criteria: (1) They shall be constructed of rigid sheet metal or other noncombustible material and shall have a smooth interior surface (2) They shall have a minimum thicknesses equivalent to No. 24 galvanized steel gauge [0.024 in. (0.61 mm)] for Type 2 ducts and No. 28 gauge [0.016 in. (0.406 mm)] for Type 1 ducts. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation.	K521	tags affixed to the dryers. Maintenance staff were educated on maintaining dryers to ensure compliance. Date of compliance is 11/21/2022	
K700 SS=F	Operating Features - Other CFR(s): NFPA 101 Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements	K700	K700: In accordance with Healthcare Facilities Fire Safety Rule 29.1809 Fire Reporting Rule 9 (3), the fire reporting policy was updated to instruct the facility administrator or designee, to report any fire incident to the State of Michigan as soon	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K700	Continued From page 11 that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there is a written fire safety plan for reporting a fire incident that meets the requirements of the Department of Licensing and Regulatory Affairs, Healthcare Facilities Fire Safety Rule 29.1809 Fire Reporting Rule 9 (3). This deficient practice could affect all occupants in the event of fire. Findings Include: On October 18, 2022, at approximately 12:33 PM record review revealed the provided Fire Safety Plan indicated a fire incident lasting longer than 6 hours shall be reported to the State of Michigan. The administrator or designee shall notify the State of Michigan as soon as possible but not later than the end of the next business day following a fire incident as required by Department of Licensing and Regulatory Affairs, Healthcare Facilities Fire Safety Rule 29.1809 Fire Reporting Rule 9 (3). This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of record review.	K700	as possible but no later than the end of the next business day. The facility administrator and Fire Safety officer were educated on the process for reporting a fire. An annual review of the fire reporting policy will be conducted to ensure that reporting requirements are followed. A task is placed in the Tels work order system that will trigger an annual review takes place. Date of compliance is 11/21/2022.	
K741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: 1. Smoking shall be prohibited in any room,	K741	K741: In accordance with 18.7.4, the facility has updated its smoking policy for staff to provide clarity on smoking regulations. Smoking is only permitted in designated smoking areas that are away from entrances and that are equipped with metal containers with self-closing lids to be	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K741	Continued From page 12 ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. 2. In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. 3. Smoking by patients classified as not responsible shall be prohibited. 4. The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. 5. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. 6. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on records review and interview, the facility failed to ensure that smoking regulations were adopted and meet all provisions as required by 18.7.4. This deficient practice could affect more than an isolated number of occupants in the event of a fire. Findings Include: On October 18, 2022 at approximately 12:45 PM record review revealed the facility's smoking policy did not align with the requirements of facility Administration. The provided smoking policy indicates smoking and chewing tobacco is permitted for Memory Care employees in the	K741	used as ash trays. All staff were educated on smoking in designated areas only. An audit will be performed monthly to ensure that smoking occurs in designated areas only. Date of compliance is 11/21/2022.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K741	Continued From page 13 outside courtyard. Further interview with the Assistant Fire Safety Officer revealed smoking is not permitted on campus and smokers must "cross the street" if they wish to smoke. Additional interview with the Administrator revealed smoking is not permitted on campus. This deficient practice can lead to confusion on where to smoke, creating a potential hazard for improperly disposed of cigarette paraphernalia. This finding was confirmed by the Administrator via interview at the time of record review and interview.	K741		
K920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K920	K920(1) and (2): In compliance with 10.2.3.6 of NFPA 99 and 400-8 of NFPA 70, and TIA 12-5, multi-plug adapters that were plugged directly into another multi-plug adapter were removed from both the Doctors Office and the Unit Clerks Office. on the date of 10-21-2022, addition receptacles were added to the Doctors office to supply the room with enough circuits to power all of their equipment. Staff were then educated on the importance of plugging multi-plug adapters directly into the wall mounted receptacles to prevent potential overload of the electrical circuit. Building wide electrical inspections will continue monthly to ensure the proper use of multi-plug adapters, and completion will be logged in the Tels Workorder System	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235724	A. BUILDING 01 - ORIGINAL BUILDING B. WING _____	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DJ JACOBETTI HOME FOR VETERANS	425 FISHER ST MARQUETTE, MI 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) COMPLETE DATE
K920	Continued From page 14 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure power strips are listed for the area in which they are used as required by 10.2.3.6 of NFPA 99 and 400-8 of NFPA 70, and TIA 12-5 and extension cords are placed in use only temporarily as required by 10.2.4 of NFPA 99 and 590.3(D) of NFPA 70. This deficient practice could affect more than an isolated number of occupants in the event of electric hazard. Findings Include: On October 18, 2022, at approximately 3:37 PM, observation revealed a multi-plug adapter was plugged into another multi-plug adapter under a desk in the Doctors Office. Multi-plug adapters should plug directly into wall receptacle. This deficient practice has the potential to overload the electrical circuit. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation. 2) On October 18, 2022, at approximately 3:41 PM, observation revealed a multi-plug adapter was plugged into another multi-plug adapter behind the filing cabinet in the 1 North Unit Clerks Office. Multi-plug adapters should plug directly into wall receptacle. This deficient practice has the potential to overload the electrical circuit. This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation.	K920		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE