STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		235724	B. W	/ING	10/18/	2022
	DVIDER OR SUPPLIER	ETERANS		STREET ADDRESS, CITY, STATE, ZIP COI 425 FISHER ST MARQUETTE, MI 49855	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETE DATE
E000	Initial Comments	3	E000			
E004 SS=F	Preparedness Si Michigan Depart Regulatory Affair Certification. At for Veterans of M substantial comp participation in M 483.73, Emerger Develop EP Plar CFR(s): 483.73(a 403.748(a), 416. 460.84(a), 482.1 484.102(a), 485. 485.727(a), 485. 494.62(a). The [facility] mus Federal, State ar preparedness re develop establish comprehensive of program that me section. The emergency F and maintain an that must be [rev every 2 years. T following: * [For hospitals a 485.625(a):] Emergency P	54(a), 418.113(a), 441.184(a), 5(a), 483.73(a), 483.475(a), 68(a), 485.542(a), 485.625(a), 920(a), 486.360(a), 491.12(a), et comply with all applicable nd local emergency quirements. The [facility] must	E004	E004: In accordance with 483 current Emergency Preparedri been reviewed and updated a Fire safety officer and assistar officer were educated on the a requirement. The Emergency Preparedness plan will be revi annually to ensure compliance be created in Tels Workorder ensure an annual update and plan by the Administrator and Director to maintain compliance compliance is 11/21/2022	ess Plan has s of 11-2-22. ht Fire safety innual review ewed e. A task will System to review of the Facilites	11/21/22
		DER/SUPPLIER REPRESENTATIVE'S SIGNA		TITLE	()	X6) DATE

Any Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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11/09/2022

							7. 0930-0391
STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. E	BUIL	JLTIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		235724	B. V	WIN	G	10/18	/2022
_	OVIDER OR SUPPLIER BETTI HOME FOR V	ETERANS			STREET ADDRESS, CITY, STATE, ZIP CO 425 FISHER ST MARQUETTE, MI 49855	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
E004	requirements. T develop and mail emergency prep the requirements hazards approad * [For LTC Facili Plan. The LTC fa maintain an eme must be reviewe annually. * [For ESRD Fac Plan. The ESRD maintain an eme must be [evaluat 2 years. This REQUIREM by: Based on record facility failed to d	ency preparedness he [hospital or CAH] must intain a comprehensive aredness program that meets s of this section, utilizing an all-	E004	4	DEFICIENCY)		
	the event of an e	0					
	On October 18, 2 PM and 5:30 PM facility failed to n Emergency Prep 42 CRF 487.73(a	2021 between the hours of 4:15 I, record review revealed the naintain and updated their paredness Plan as required by a). Records revealed the most as completed on August 5,					

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 235724 10/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **425 FISHER ST** DJ JACOBETTI HOME FOR VETERANS MARQUETTE, MI 49855 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) E004 Continued From page 2 E004 This finding was confirmed by the Assistant Fire Safety Officer and Administrator at the time of record review.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/16/2024

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - ORIGINAL BUILDING B. WING 235724 10/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 425 FISHER ST DJ JACOBETTI HOME FOR VETERANS MARQUETTE, MI 49855 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)COMPLETE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) K000 INITIAL COMMENTS K000 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 Marguette 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: Egress Doors K222 K222 12/2/22 K222 (1): In accordance with 7.2.1.5, CFR(s): NFPA 101 SS=F 7.2.1.5.3, and 7.2.1.5.6 horizontal exit door will be removed at loading dock Earess Doors entrance/exit. Previously used exterior Doors in a required means of egress shall not be door will be used again as exit door for LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITI F (X6) DATE

Any Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING 01 - ORIGINAL BUILDING	(X3) DATE SURV COMPLETE	
		235724	B. WIN	G	10/18/2	2022
	OVIDER OR SUPPLIER BETTI HOME FOR V	ETERANS		STREET ADDRESS, CITY, STATE, ZIP COL 425 FISHER ST MARQUETTE, MI 49855)E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
K222	use of a tool or k using one of the arrangements: CLINICAL NEED LOCKING Where special lo clinical security r only one locking each door and p rapid removal of locks; keying of a at all times; or of available to the s 18.2.2.2.5.1, 18. SPECIAL NEED Where special lo safety needs of t Clinical or Secur being met. In ad electrical locks th upon loss of pow protected by a su system and the I complete smoke constantly monit within the locked and detection sy the doors upon a 18.2.2.2.5.2, 19. DELAYED-EGRI ARRANGEMEN Approved, listed systems installed shall be permitte low and ordinary protected throug supervised autor approved, super system. 18.2.2.2.4, 19.2.	latch or a lock that requires the sey from the egress side unless following special locking DS OR SECURITY THREAT ocking arrangements for the needs of the patient are used, device shall be permitted on rovisions shall be made for the occupants by: remote control of all locks or keys carried by staff ther such reliable means staff at all times. 2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 S LOCKING ARRANGEMENTS ocking arrangements for the he patient are used, all of the ity Locking requirements are dition, the locks must be nat fail safely so as to release ver to the device; the building is upervised automatic sprinkler ocked space is protected by a detection system (or is ored at an attended location I space); and both the sprinkler stems are arranged to unlock activation. 2.2.2.5.2, TIA 12-4 ESS LOCKING TS delayed-egress locking d in accordance with 7.2.1.6.1 d on door assemblies serving hazard contents in buildings hout by an approved, matic fire detection system or an vised automatic sprinkler	K222	loading dock. K222 (2): In accordance with 7 7.2.1.5.3, and 7.2.1.5.6 unapp open device was removed. Sta reminded to not use unapprov devices. All staff were educate using unapproved hold open of Doors will be audited monthly presence of unapproved hold of devices. K222 (3): In accordar 7.2.1.6.1.1 (3), the 1 East Stai delayed-egress door was repa date of 10-19-2022. The code was found to be defective caus preform properly. A new code was installed and resolved the the delayed-egress door was a functioning properly. All delayed doors will continue to be inspe monthly basis and completion logged in the Tels Workorder S	roved hold aff was ed hold open ed on not levices. for the open nce with rwell ired on the alert magnet issue and again ed-egress cted on a will be	

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	UILI	ILTIPLE CONSTRUCTION DING 01 - ORIGINAL BUILDING	(X3) DATE SUR COMPLETE	VEY ED
		235724	5.11			10/18	/2022
	DVIDER OR SUPPLIER	ETERANS			STREET ADDRESS, CITY, STATE, ZIP COE 425 FISHER ST MARQUETTE, MI 49855	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
K222	ARRANGEMEN Access-Controlle installed in accor permitted. 18.2.2.2.4, 19.2. ELEVATOR LOE ARRANGEMEN Elevator lobby e: accordance with door assemblies throughout by ar automatic fire de approved, super system. 18.2.2.2.4, 19.2. This STANDARE Based on observ failed to ensure of egress are not e requires the use side unless mee arrangements fo with 18.2.2.2.5.1 locking arrangen 18.2.2.2.4. This all occupants in f Findings Include	ROLLED EGRESS LOCKING TS ed Egress Door assemblies rdance with 7.2.1.6.2 shall be 2.2.4 BBY EXIT ACCESS LOCKING TS xit access door locking in 7.2.1.6.3 shall be permitted on in buildings protected approved, supervised tection system and an vised automatic sprinkler 2.2.4 D is not met as evidenced by: vation and interview, the facility doors in a required means of quipped with a latch or lock that of a tool or key from the egress ting the special locking r clinical needs in accordance and 18.2.2.2.6, special needs nents in accordance with ayed egress locking in 18.2.2.2.4, access-controlled accordance with 18.2.2.2.4, or kit access in accordance with deficient practice could affect the event of evacuation.	K222				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - ORIGINAL BUILDING B. WING 10/18/2022 235724 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **425 FISHER ST** DJ JACOBETTI HOME FOR VETERANS MARQUETTE, MI 49855 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX PREFIX COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K222 Continued From page 3 K222 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.

(X2) MULTIPLE CONSTRUCTION

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PRINTED: 04/16/2024 FORM APPROVED OMB NO. 0938-0391

(X5)

DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

(X3) DATE SURVEY COMPLETED

		E & MEDICAID SERVICES				OMB NO	. 0938-039
STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	UILDING		(X3) DATE SURV COMPLETE	
		235724	B. W	VING		10/18/2	2022
	OVIDER OR SUPPLIER	'ETERANS		42	EET ADDRESS, CITY, STATE, ZIP COU 5 FISHER ST ARQUETTE, MI 49855	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
K321 K321 SS=E	with 18.3.2.1. Th a 1-hour fire-rate rated door witho 8.7.1.1). Doors s automatic-closin Hazardous area system in accord 8.4. Describe the floc hazardous areas REMARKS. 18.3.2.1, 7.2.1.8 Area Automa N/A a. Boiler and Fu b. Laundries (lar c. Repair, Maint d. Soiled Linen I e. Trash Collect (exceeding 64 g f. Combustible S (over 50 and les g. Combustible S (over 100 squard h. Laboratories G Hazard - see K3 This STANDARI Based on obser failed to ensure by a fire barrier	is - Enclosure 01 is - Enclosure s are protected in accordance he areas shall be enclosed with ed barrier, with a 3/4-hour fire- ut windows (in accordance with shall be self-closing or ig in accordance with 7.2.1.8. s are protected by a sprinkler dance with 9.7, 18.3.2.1, and or and zone locations of s that are deficient in a, 8.4, 8.7, 9.7 atic Sprinkler Separation el-Fired Heater Rooms rger than 100 square feet) enance, and Paint Shops Rooms (exceeding 64 gallons) ion Rooms allons) Storage Rooms/Spaces s than 100 square feet) Storage Rooms/Spaces e feet) (if classified as Severe	K321 K321	K du lir re du w cc w o l tc fii A u K au le w pu in cl o c	321(1.): At the time of inspect oor to mechanical room 4 wa uring repairs of a leak in the ones to the air handling unit. Seminded to not use unapprove evices when they are not currorking in the space. To ensu compliance with 19.3.2.1.3, of ere being used as an unappropen device were removed from the air handling unit is a seminative of the seminative of the space of the seminative of th	s held open chill water taff was ed hold open rently re ojects that roved hold om the area d latch of the 0-19-2022. using s. 9-2022, in e door torage room closure and ontinue to be all other self- acility. A log ly being	11/21/22

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - ORIGINAL BUILDING B. WING 10/18/2022 235724 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **425 FISHER ST** DJ JACOBETTI HOME FOR VETERANS MARQUETTE, MI 49855 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID PREFIX PREFIX COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) K321 Continued From page 5 K321 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. **Cooking Facilities** K324 K324 K324: On the date of 10-20-2022 in 11/21/22 CFR(s): NFPA 101 SS=F accordance with NFPA 101, 19.3.2.5, The cooktop stove located inside the Cooking Facilities Volunteers lounge, was equipped with a Cooking equipment is protected in accordance keyed power disconnect with a 120-minute with NFPA 96, Standard for Ventilation Control timer with a locked switch in a restricted and Fire Protection of Commercial Cooking location. Staff that utilize the space were Operations, unless: then educated on the functionality of the *residential cooking equipment (i.e., small disconnects that were installed and their

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUN **CENTERS FOR MEDICARE & MEDIC**

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

DJ JACOBETTI HOME FOR VETERANS

AND PLAN OF CORRECTION

(X4) ID PREFIX

TAG

K324

DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BL	MULTIPLE CONSTRUCTION JILDING 01 - ORIGINAL BUILDING	(X3) DATE SUR COMPLET		
	235724	B. W	ING	10/18	3/2022	
VIDER OR SUPPLIER	ETERANS		STREET ADDRESS, CITY, STATE, ZIP CO 425 FISHER ST MARQUETTE, MI 49855	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE ENCY) Udit task of facility ill be placed in the		
(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	COMPLETE	
toasters) are used cooking in accord 19.3.2.5.2. *cooking facilities smoke compartme comply with the of 19.3.2.5.3, or *cooking facilities 30 or fewer patien under 18.3.2.5.4, Cooking facilities 96 per 9.2.3 are r hazardous areas corridor. 18.3.2.5.1 throug 19.3.2.5.5, 9.2.3, This STANDARD Based on observe failed to ensure of in accordance with	as microwaves, hot plates, ed for food warming or limited dance with 18.3.2.5.2, ies open to the corridor in nents with 30 or fewer patients conditions under 18.3.2.5.3, ies in smoke compartments with ents comply with conditions , 19.3.2.5.4. is protected according to NFPA not required to be enclosed as b, but shall not be open to the gh 18.3.2.5.4, 19.3.2.5.1 through	K324	purpose. A monthly audit task cooking equipment will be pla Tels workorder system to ens compliance.	aced in the		

Based on observation, and failed to ensure cooking faci in accordance with NFPA 96 requirements of 18.3.2.5.2, 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.

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CONSTRUCTION	(X3) DATE SUR\	
and plan of	CORRECTION	IDENTIFICATION NUMBER: 235724		ILDING 01 - ORIGINAL BUILDING	COMPLETE 10/18/	
	OVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP		2022
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF Continued From This finding was	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) page 7 confirmed by the Assistant Fire	ID PREFIX TAG K324	MARQUETTE, MI 49855 PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
K372 SS=E	observation. Subdivision of Bi CFR(s): NFPA 1 Subdivision of Bi Construction 2012 NEW Smoke barriers s at least a one ho constructed in ac barriers shall be atrium wall. Smo duct penetrations 18.3.7.3, 18.3.7. Describe any me in REMARKS. This STANDARIE Based on observa failed to ensure s constructed to a rating in accorda 18.3.7.3 and 8.6 could affect more occupants in the Findings Include On October 18, 2 observation reve penetration abov not conforming to 101 8.5.6.2. All s	uilding Spaces - Smoke Barrier shall be constructed to provide our fire resistance rating and ccordance with 8.5. Smoke permitted to terminate at an ike dampers are not required in s of fully ducted HVAC systems. 4, 18.3.7.5, 8.3 echanical smoke control system D is not met as evidenced by: vation and interview, the facility smoke barriers were minimum 1-hour fire resistance ince with 8.5 as required by .7.1(1). This deficient practice e than an isolated number of event of a fire.	K372	K372(1.): In accordance wit 8.5.6.2, the approved fire ra that was applied to a penetr smoke barrier above cross (1-15), was reapplied to ens adhesion and to prevent fut the material. Smoke barrier to be inspected quarterly th building and will continue to the Tels Workorder System staff were educated on the maintaining smoke barriers K372(2.): During time of ins discovered that the fire rate was installed to the penetra smoke barrier above cross (2-7), had lost adhesion to t barrier. Upon later inspectio of 10-19-2022, the correspon the smoke barrier wall had filled with an approved fire r Out of abundance of caution penetration opening on the side was reapplied with fire material to ensure lasting co NFPA 101 8.5.6.2 Smoke continue to be inspected qu throughout the building and be logged in the Tels Worko	ted caulking ation in a corridor doors ure proper ure failure of s will continue oughout the be logged in Maintenance mportance of bection, it was d caulking that tion to the corridor doors he smoke n on the date nding side of been properly ated material. h, the corresponding rated caulking pmpliance with parriers will arterly will continue to	11/21/2

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES				APPROVED 0. 0938-0391
STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	ULTIPLE CONSTRUCTION LDING 01 - ORIGINAL BUILDING	(X3) DATE SUR COMPLETE	/EY
		235724	B. WIN	IG	10/18/	2022
	OVIDER OR SUPPLIER BETTI HOME FOR V	ETERANS		STREET ADDRESS, CITY, STATE, ZIP CC 425 FISHER ST MARQUETTE, MI 49855	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
K372	deficient practice and fire spread i This finding was Safety Officer via observation. On October 18, 7 observation reve penetration abov conforming to th 8.5.6.2. All smok of approved mat around penetrati approved, prope capable of restrict deficient practice and fire spread i This finding was	 page 8 cting the transfer of smoke. This e can contribute to rapid smoke n the event of a fire. confirmed by the Assistant Fire a interview at the time of 2022 at approximately 3:50 PM, ealed a smoke barrier wall ve cross corridor doors "2-7" not e requirements of NFPA 101 to barriers shall be constructed erial and any void spaces ions shall be filled with erly rated intumescent material cting the transfer of smoke. This e can contribute to rapid smoke n the event of a fire. confirmed by the Assistant Fire a interview at the time of 	K372			
K374 SS=E	CFR(s): NFPA 1 Subdivision of B Doors 2012 NEW Doors in smoke minute fire prote inch thick solid b Required clear v 18.3.7.6(4) and Nonrated protec inches from the permitted. Horize 7.2.1.14. Swingi that each door s	uilding Spaces - Smoke Barrier barriers have at least a 20 ction rating or are at least 1-3/4 ponded core wood. vidths are provided per	K374	K374: On the date of 10-19-2 compliance with NFPA 101 8 corridor doors labeled (1-15), repaired to ensure proper clo positive latch. Cross corridor continue to be inspected mor completion will be documente the Tels Workorder System. I staff were educated on maint corridor doors to ensure prop	.5.4.4, cross were sure and doors will withly and ed into a log in Maintenance aining cross	11/21/22

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STATEMENT	FDEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CONSTRUCTION	(X3) DATE SUR	<u>). 0938-039</u> VEY
AND PLAN OF		IDENTIFICATION NUMBER:		JILDING 01 - ORIGINAL BUILDING	COMPLETE	
		235724	B. W	ING	10/18/	2022
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
DJ JACO	BETTI HOME FOR V	ETERANS		425 FISHER ST MARQUETTE, MI 49855		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
K374	Continued From or astragals are Positive latching 18.3.7.6, 18.3.7.	required at the meeting edges. is not required.	K374			
	This STANDARI	D is not met as evidenced by:				
	facility failed to e barriers are 1 3/ doors or have a closing or autom minimum width o 18.3.7.6, 18.3.7. practice could at	ervation and interview, the ensure that doors in smoke 4 inch solid bonded wood-core 20 minute fire rating, are self- natic-closing and provide a of 32 inches as required by 7, and 18.3.7.8. This deficient ffect more than an isolated pants in the event of a fire.				
	Findings Include	:				
	observation reve doors (1-15) do required by NFP	2022 at approximately 3:30 PM, ealed the 1 South cross corridor not completely self close as A 101 8.5.4.4. This deficient tribute to the spread of smoke yent of a fire.				
		confirmed by the Assistant Fire a interview at the time of				
K521 SS=E	HVAC CFR(s): NFPA 1	01	K521	K521: In accordance with N 10.7.3.6, the flexible vent tu installed on both the Physic	bing that was	11/21/22
	comply with 9.2	ion, and air conditioning shall and shall be installed in the manufacturer's 1, 9.2		department dryer, and the f were both removed and rein rigid vent piping in compliar guidelines. Dryer vents will inspected and cleaned bi-an months of December and J Completion of cleaning and	West dryer, astalled with ce with NFPA continue to be anually in the une.	
	This STANDARI	D is not met as evidenced by:		be documented on both the Workorder System, as well	Tels	

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SS=F

STATEMENT C AND PLAN OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235724	A. BI	MULTIPLE CONSTRUCTION JILDING 01 - ORIGINAL BUILDING ING	(X3) DATE SUR COMPLETI 10/18	ED
	OVIDER OR SUPPLIER BETTI HOME FOR V	/ETERANS		STREET ADDRESS, CITY, STATE, ZIP CO 425 FISHER ST MARQUETTE, MI 49855	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
K521	failed to ensure conditioning is ir installed in acco specifications as This deficient pr	n page 10 vation and interview, the facility heating, ventilation and air n compliance with 9.2, and rdance with the manufacturer's s required by 18.5.2.1 and 9.2. actice could affect more than an of occupants in the event of a	K521	tags affixed to the dryers. Ma staff were educated on maint to ensure compliance. Date c is 11/21/2022	aining dryers	
	PM and 3:20 PM residential dryer floors did not ha	e: 2022 between the hours of 2:35 A observation revealed the 's located on the first and second ve exhaust vents that meet the NFPA 211 10.7.3.6.				
	clothes dryers si of rigid sheet me material and sha smooth minimum thickne [0.024 in. (0.61 i	n interior surface (2) They shall have a esses equivalent to No. 24 galvanized steel gauge	They shall be constructed to other noncombustible ve a ior surface They shall have a equivalent to No. galvanized steel gauge for Type 2 ts and No. 28 gauge] for Type 1			
	This finding was confirmed by the Assistant Fire Safety Officer via interview at the time of observation.					
K700	Operating Featu		K700	K700: In accordance with He	althcare	11/21/22

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

List in the REMARKS section any LSC Section

18.7 and 19.7 Operating Features requirements

CFR(s): NFPA 101

Operating Features - Other

Facilities Fire Safety Rule 29.1809 Fire Reporting Rule 9 (3), the fire reporting

policy was updated to instruct the facility

incident to the State of Michigan as soon

administrator or designee, to report any fire

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CENTER	S FOR MEDICARE	E & MEDICAID SERVICES					. 0938-0391
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	,	LTIPLE CONSTRUCTION DING 01 - ORIGINAL BUILDING	(X3) DATE SURV COMPLETE	ΈY
		235724	B. V	VINC	3	10/18/2	2022
NAME OF PRO	OVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP COD 425 FISHER ST	E	
DJ JACOE	BETTI HOME FOR V	ETERANS			MARQUETTE, MI 49855		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
K700	but are deficient. applicable Life S citation, should b This STANDARE Based on record facility failed to e safety plan for re meets the require Licensing and Re Facilities Fire Sa Reporting Rule 9 could affect all of	essed by the provided K-tags, This information, along with the afety Code or NFPA standard be included in Form CMS-2567. O is not met as evidenced by: review and interview, the insure there is a written fire eporting a fire incident that ements of the Department of egulatory Affairs, Healthcare fety Rule 29.1809 Fire O (3). This deficient practice ccupants in the event of fire.	K700)	as possible but no later than th next business day. The facility administrator and Fire Safety o educated on the process for re fire. An annual review of the fire policy will be conducted to ensi- reporting requirements are follo is placed in the Tels work order that will trigger an annual revie- place. Date of compliance is 17	fficer were porting a e reporting ure that owed. A task r system w takes	
	PM record review Safety Plan indic longer than 6 hor State of Michigan shall notify the S possible but not business day foll by Department o Affairs, Healthca 29.1809 Fire Rep This finding was Safety Officer via	2022, at approximately 12:33 w revealed the provided Fire sated a fire incident lasting urs shall be reported to the n. The administrator or designee tate of Michigan as soon as later than the end of the next lowing a fire incident as required f Licensing and Regulatory re Facilities Fire Safety Rule porting Rule 9 (3). confirmed by the Assistant Fire a interview at the time of record					
K741 SS=E	include not less t 1. Smoking sha	01	K741	1	K741: In accordance with 18.7. facility has updated its smoking staff to provide clarity on smoki regulations. Smoking is only pe designated smoking areas that from entrances and that are eq metal containers with self-closi	policy for ng ermitted in are away uipped with	11/21/22

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

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STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235724	A. BUILI	LTIPLE CONSTRUCTION DING 01 - ORIGINAL BUILDING	(X3) DATE SUR COMPLET	
	ovider or supplier BETTI HOME FOR V	ETERANS		STREET ADDRESS, CITY, STATE, ZIP CO 425 FISHER ST MARQUETTE, MI 49855	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
K741	combustible gas and in any other area shall be po SMOKING or sh international syn 2. In health ca is prohibited and all major entrand language that pr required. 3. Smoking by responsible shal 4. The require where the patier 5. Ashtrays of safe design shal smoking is perm 6. Metal conta devices into whi shall be readily a smoking is perm 18.7.4, 19.7.4	tment where flammable liquids, es, or oxygen is used or stored hazardous location, and such sted with signs that read NO all be posted with the holo for no smoking. re occupancies where smoking I signs are prominently placed at ces, secondary signs with ohibits smoking shall not be patients classified as not I be prohibited. ment of 18.7.4(3) shall not apply it is under direct supervision. noncombustible material and I be provided in all areas where itted. iners with self-closing cover ch ashtrays can be emptied available to all areas where itted.	K741	used as ash trays. All staff w on smoking in designated are audit will be performed mont that smoking occurs in desig only. Date of compliance is 1	eas only. An hly to ensure nated areas	
	Based on record facility failed to e were adopted ar required by 18.7 affect more than occupants in the Findings Include On October 18, record review re policy did not ali facility Administr policy indicates					

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							<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 235724				(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ORIGINAL BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/18/2022	
		B. W					
	OVIDER OR SUPPLIER BETTI HOME FOR V	ETERANS		425	STREET ADDRESS, CITY, STATE, ZIP CODE 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	Assistant Fire Sa not permitted on "cross the street Additional intervi revealed smokin This deficient pra where to smoke, improperly dispo	page 13 d. Further interview with the afety Officer revealed smoking is campus and smokers must " if they wish to smoke. "ew with the Administrator g is not permitted on campus. actice can lead to confusion on creating a potential hazard for sed of cigarette paraphernalia. confirmed by the Administrator he time of record review and	K741				
K920 SS=E	interview. 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			10.2 70, wer plug Doc on t rece offic circ Stat imp dire to p elec insp the com	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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 01 - ORIGINAL BUILDING	COMPLETED			
		235724	B. WING		10/18/2022			
NAME OF PR	OVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE					
DJ JACO	BETTI HOME FOR \	/ETERANS		125 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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE		
K920	Continued From	n page 14	K920					
	This STANDAR	D is not met as evidenced by:						
	failed to ensure area in which th 10.2.3.6 of NFP TIA 12-5 and ex only temporarily 99 and 590.3(D practice could a	vation and interview, the facility power strips are listed for the ey are used as required by A 99 and 400-8 of NFPA 70, and stension cords are placed in use as required by 10.2.4 of NFPA) of NFPA 70. This deficient ffect more than an isolated pants in the event of electric						
	Findings Include	e:						
	observation reve plugged into and desk in the Doc should plug dire	2022, at approximately 3:37 PM, ealed a multi-plug adapter was other multi-plug adapter under a tors Office. Multi-plug adapters ectly into wall receptacle. This e has the potential to overload cuit.						
		s confirmed by the Assistant Fire ia interview at the time of						
	PM, observation was plugged int behind the filing Clerks Office. M directly into wall	18, 2022, at approximately 3:41 n revealed a multi-plug adapter o another multi-plug adapter cabinet in the 1 North Unit lulti-plug adapters should plug l receptacle. This deficient e potential to overload the						
		s confirmed by the Assistant Fire ia interview at the time of						

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