

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Dj Jacobetti Home for Veterans		STREET ADDRESS, CITY, STATE, ZIP CODE 425 Fisher Street Marquette, MI 49855	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

TITLE

(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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, [NAME] 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 ([NAME] 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 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 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</p>		