GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 13, 2024

Jennifer Garcia
Allegria Village
15101 Ford Road
Dearborn, MI 48126

RE: License #: AH820409060
Investigation #: 2024A1027034
Allegria Village

Dear Licensee:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820409060
Investigation #:	2024A1027034
Complaint Receipt Date:	02/23/2024
Investigation Initiation Date:	02/26/2024
Report Due Date:	04/22/2024
Licensee Name:	HFV Opco, LLC
Licensee Address:	Suite K 395 Pearsall Avenue Cedarhurst, NY 11516
Licensee Telephone #:	(516) 371-9500
Authorized Representative/ Administrator:	Jennifer Garcia
Name of Facility:	Allegria Village
Facility Address:	15101 Ford Road Dearborn, MI 48126
Facility Telephone #:	(313) 584-1000
Original Issuance Date:	09/30/2021
License Status:	REGULAR
Effective Date:	03/31/2023
Expiration Date:	03/30/2024
Capacity:	132
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked his oxygen, and call light was not answered timely.	Yes
Additional Findings	No

III. METHODOLOGY

02/23/2024	Special Investigation Intake 2024A1027034
02/23/2024	Contact - Document Received Additional allegations from the same complainant were received
02/26/2024	Contact - Telephone call received Voicemail received from complainant
02/26/2024	Contact - Telephone call made Telephone interview conducted with complainant
02/26/2024	Special Investigation Initiated - Telephone Telephone interview with complainant
02/27/2024	Inspection Completed On-site
02/29/2024	Contact - Document Received Email received from Ms. Garcia with requested documentation
03/01/2024	Contact - Telephone call made Telephone interview conducted with Relative A1
03/01/2024	Contact - Document Received Email received from Ms. Garcia with additional information and documentation
03/04/2024	Inspection Completed-BCAL Sub. Compliance
03/13/2024	Exit Conference Conducted with Jennifer Garcia by email

ALLEGATION:

Resident A lacked his oxygen, and call light was not answered timely.

INVESTIGATION:

On 2/23/2024, the Department received a complaint through the online complaint system which read on 2/22/2024, Resident A's oxygen was not available to him during lunch time. The complaint read Resident A had been at the facility for over a year, and this happened roughly 10 times this past year. The complaint read mistakes have been made when turning on the oxygen tank.

On 2/23/2024, additional allegations were received through the online complaint system which read on 02/10/2024, Resident A's oxygen tank released air into his room due to staff's neglect to check that it was working correctly. Additionally, the complaint alleged it took 11-12 minutes to respond to Resident A's call light.

On 2/26/2024, I conducted a telephone interview with the complainant whose statements were consistent with the allegations. The complainant stated Resident A's oxygen tanks were not recharged and the nasal cannula for his oxygen was not always in his nose. The complainant stated Resident A's call light was not working appropriately and staff took long to respond.

On 2/27/2024, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A was on 4 Liters oxygen continuously. Employee #1 stated Resident A had a concentrator in which the top of it charged his small portable oxygen tanks. Employee #1 stated Resident A utilized oxygen from his concentrator while in his room, then changed to a portal tank when he left his room. Employee #1 stated staff demonstrated they know how to use the oxygen machine as well change Resident A from the concentrator to a portable tank.

Employee #1 stated it was the expectation for staff to respond to call lights within 15 minutes; however, if all staff were providing care, then it would be longer. Employee #1 stated she reviewed call light response logs every morning and staff were written up if they were not responding to call lights within 15 minutes on their shift.

Additionally, Employee #1 stated there were three floors in which the 1st and 2nd floors were assisted living residents, and the 3rd floor was for memory care residents. Employee #1 stated Resident A resided on the 2nd floor in which there were two care aides and on medication technician on duty for first and second shift, then two care aides on duty for third shift with one medication technician on duty for all floors.

While on-site, I interviewed Employee #2 who stated staff checked on Resident A every two hours. Employee #2 stated Resident A, nor his spouse had not expressed concerns regarding his oxygen or care.

While on-site, I interviewed Ms. Garcia who stated staff were counseled and educated individually if she was informed that Resident A's oxygen was not appropriately administered. Ms. Garcia stated she felt staff knew how to appropriately utilize Resident A's oxygen concentrator and portable tanks.

While on-site, I interviewed Employee #3 stated Resident A utilized his oxygen concentrator in the morning until lunch, then he was switched to his portable tank during lunch and returned to using his concentrator while in his room. Employee #3 stated Resident A's portable oxygen tank would run low after lunch in which they would switch him to the concentrator. Employee #3 stated one time his portable oxygen tank ran out when he left the facility for a physician appointment. Employee #3 reviewed the steps of transferring Resident A from concentrator to the portable tank, then changing him back from the portable tank to the concentrator, as well as the process for charging the portable tanks. Employee #3 stated Resident A removed his nasal cannula tubing from his nose occasionally to blow his nose and required reminding from staff to replace it.

While on-site, I interviewed Employee #4 whose statements were consistent with previous staff interviews.

While on-site, I interviewed Resident A who stated sometimes staff required to be reminded of how to use the oxygen concentrator and portable tanks; however, his care was "*good*."

While on-site, I observed Resident A's oxygen concentrator was on 4 Liters and his oxygen tubing was connected to it in which the nasal cannula was in his nose. I observed two portable tanks, one of which was on charging part of at the top of the concentrator and read "full." I observed the other portable was in a holder in Resident A's room and "full." I observed instructions from Michigan Medical Equipment, Inc. of "*How To Refill Empty Oxygen Tanks*," as well as how to use the concentrator. I observed there were also handwritten sticky notes and a typed note on his wall with further instructions for staff. The instructions read consistent with Employees #3 and #4 interviews.

While on-site, I reviewed Resident A's face sheet which read he admitted to the facility on 2/9/2023 and Relative A1 was his responsible party as well as durable power of attorney for healthcare and finances.

On 3/1/2024, I conducted a telephone interview with Relative A1.

Relative A1 stated she usually visited Resident A daily in the mornings until lunch; however, she had COVID-19 and her most recent visit was one week ago.

Relative A1 stated staff required teaching on how to use Resident A's oxygen concentrator and tanks but now all staff worked his equipment appropriately.

Relative A1 stated Resident A would forget why he needed oxygen and would pull his oxygen tubing out of his nose in which he needed to be reminded to put the nasal cannula back in his nose. Relative A1 stated sometimes Resident A did not put the nasal cannula back in his nose correctly.

Relative A1 stated Resident A1 was incontinent and required staff assistance to utilize the toilet; however, there were times he called staff and would not wait for assistance. Relative A1 stated Resident A was a fall risk.

Relative A1 stated sometimes staff responded quickly to Resident A's call pendant, while other times, there has been a wait of about 20 minutes. Relative A1 stated one staff member would respond to his call pendant to assist him to the toilet. Relative A1 stated some staff would call another staff member for help.

Relative A1 stated Resident A has been sent to the hospital twice for short periods of time for issues with this breathing but returned to the facility without concern.

Relative A1 stated Resident A would state that he hated it at the facility and wanted to leave. Relative A1 stated Resident A would "*sundown*" and sometimes have behaviors. Relative A1 stated staff communicated with her by telephone if there were any concerns, incidents, or hospitalizations in which she would offer to sit with Resident A if needed.

Relative A1 stated Resident A's physician was also the physician that rounded at the facility.

On 3/1/2024, email correspondence with Ms. Garcia read in part the facility did not have a physician order for Resident A's 4 Liters of oxygen and she requested one from his physician.

I reviewed Resident A's service plan updated on 2/29/2024 which read in part he was two-person assist for transferring and toileting. The plan read in part Resident A required one person assistance for bathing/showering, personal hygiene, and undressing/dressing. The plan read in part:

"*Continuous oxygen at 4L liters via NC/concentrator to maintain a SPO2 of 90% or greater. E-tank carrier while in wheelchair. Monitor O2 gage per shift and as needed. Monitor that machine is working properly. Ensure that his oxygen properly on him throughout the day by provide q 2/hr. checks. Report concern or changes to the Med tech or Nurse*."

I reviewed Resident A's medication administration record (MAR) for January and February 2024 which read in part: Oxygen, give 3.5 Liters via nasal cannula continuously. The MARs read in part on some dates staff documented 4 Liters. The

MAR notes dated 1/8/2024, 1/10/2024 through 1/12/2024, 1/15/2024, 1/16/2024, 1/19/2024, and 1/20/2024 read staff required clarification from Resident A's physician because his family reported he should be on 4 Liters; however, the MAR read 3.5 Liters.

I reviewed the call light response time log for 1/1/2024 through 3/1/2024 which read in part the optimum call duration was 7 minutes and unacceptable call duration was 11 minutes. The call report read in part for the 2nd floor, where Resident A resided, the average call duration for 1st shift was 26:21 minutes, for 2nd shift was 29:58 minutes, and for 3rd shift was 34:50 minutes.

I reviewed Resident A's progress notes for February 2024.

Note dated 2/1/2024 written by Employee #2 read she spoke with Resident A's daughter about her concern regarding Resident A's oxygen tank in which her concerns would be addressed with staff.

Note dated 2/22/2024 written by Employee #1 read in part Resident A's daughter was concerned his oxygen tanks were running out too fast and not charging enough. The note read in part Employee #1 contacted Michigan Medical Supply to service the charging station and ask questions. The note read in part Employee #1 spoke with the supply service supervisor who explained the tanks take 3.5-4 hours to charge. The note read in part the supply supervisor reported the tank held a charge for 1.7 hours. The note read in part the supply supervisor suggested a second charging station, but due to Resident A's insurance, would not be provided at this time.

Note dated 2/23/2024 written by Employee #1 read in part she spoke with Resident A in which he denied concerns with his care or staff. The note read in part Employee #1 addressed Resident A's daughter concerns regarding proper use of refilling the oxygen tanks. The note read in part Employee #1 observed staff correctly recharging portable tanks and dialing them correctly. The note read in part she will continue to educate staff on the importance of recharging and correctly dialing the oxygen to 4 Liters and assuring oxygen tubing is correctly in place for Resident A to continuously receive oxygen.

Note dated 2/26/2024 written by Employee #2 read in part an email was received from Resident A's daughter informing her Resident A's oxygen tank was not charged.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	Review of Resident A's records revealed he had moved into the facility 2/9/2023, required oxygen continuously and staff assistance for his activities of daily living. Additionally, review of Resident A's records revealed although it would be expected that a physician order was received for Resident A's oxygen which read, he required 3.5 Liters on his MAR, there was confusion and inconsistency in staff documentation on how many liters Resident A required. Furthermore, staff attestations and review of progress notes revealed there were staff who required re-education on Resident A's oxygen equipment and use. Review of the call light response logs revealed the average call light response times for the 2nd floor was greater than the facility's expectations. Interview with Relative A1 revealed Resident A was forgetful in which he would remove his oxygen from his nose, as well as not always wait for assistance. Finally, email correspondence dated 3/5/2024 from Ms. Garcia and Employee #1 read in part Resident A's original oxygen order read 3.5 Liters of oxygen, in which his portable oxygen tanks' dial did not include half numbers, so they received orders for Resident A to receive 3 Liters oxygen continuously. The email read if Resident A's oxygen saturation fell below 90%, staff were to increase his oxygen to 4 Liters, as well as monitor his oxygen saturation every shift. Nonetheless, Resident A has resided at the facility for over one year; therefore, it would be expected to have clarification of his oxygen order, along with ability to maintain and use his oxygen equipment as well as response of call lights within expectations of facility. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

03/04/2024

Jessica Rogers Date
Licensing Staff

Approved By:

03/11/2024

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section