GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 29, 2024

Jennifer Garcia
Allegria Village
15101 Ford Road
Dearborn, MI 48126

RE: License #: AH820409060
Investigation #: 2024A0784023
Allegria Village

Dear Jennifer Garcia:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409060
Investigation #:	2024A0784023
Complaint Receipt Date:	01/18/2024
Investigation Initiation Date:	01/19/2024
Report Due Date:	03/18/2024
Licensee Name:	HFV Opco, LLC
Licensee Address:	395 Pearsall Avenue Suite K Cedarhurst, NY 11516
Licensee Telephone #:	(516) 371-9500
Administrator/Authorized Representative:	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?
Lack of adequate dental care for Resident A.	No
Lack of adequate wound care for Resident B.	No
The facility is short staffed.	No
Insufficient linens.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/18/2024	Special Investigation Intake 2024A0784023
01/18/2024	Contact - Telephone call made Attempted contact with Witness 1 provided on information from APS. Witness 1 answered and upon my introduction disconnected the call. A call back was made, however Witness 1 disconnected the call a second time.
01/19/2024	Inspection Completed On-site
01/19/2024	Special Investigation Initiated - On Site
01/19/2024	Exit – In Person Conducted with administrator/authorized representative Jennifer Garcia
02/07/2024	Contact - Telephone call made Attempted contact with Resident A Authorized Representative. Message left requesting return call
02/07/2024	Contact - Telephone call received Interview with Resident A Authorized Representative

ALLEGATION:

Lack of adequate dental care for Resident A

INVESTIGATION:

On 1/18/2024, the department received this complaint from adult protective services (APS) centralized intake indicating APS denied the allegations for investigation.

According to the complaint, Resident A has dental issues and treatment has not been sought even though administration is aware of these issues.

On 1/19/2024, I interviewed administrator/authorized representative Jennifer Garcia at the facility. Ms. Garcia stated she has not been aware of any issues pertaining to Resident A's dental care. Ms. Garcia stated the facility has a dentist who visits the facility and that if any issues had been reported, she would have ensured Resident A was seen by the dentist. Ms. Garcia stated Resident A does not communicate well but is able to complete some tasks with staff assistance such as brushing her teeth.

On 1/19/2024, I observed Resident A at the facility. Resident A appeared comfortable, clean, and well groomed. Resident A was unable to be interviewed due to her mental orientation.

On 2/07/2024, I interviewed Resident A's authorized representative (Resident AR) by telephone. Resident AR stated she visits Resident A regularly throughout the week and was unaware of any issues with her teeth. Resident AR stated staff at the facility have been good at communicating issues or concerns with her as they arise stating "they call me even when she refuses a shower". Resident AR stated she did not have any concerns regarding the care Resident A is receiving at the facility.

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:	The complaint alleged Resident A had dental issues and that the facility did not seek appropriate care to address those issues. There is insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Lack of adequate wound care for Resident B

INVESTIGATION:

According to the complaint, Resident B has wounds which are not receiving proper wound care.

When interviewed, Ms. Garcia stated Resident B has wounds on both of his legs from the knee area down to his feet which are caused from edema [swelling caused due to excess fluid accumulation in the body tissue]. Ms. Garcia stated the edema is causing Resident B's skin to stretch to the point that it causes swelling leading to weeping [a wound that discharges fluid]. Ms. Garcia stated Resident B's leg wounds are wrapped regularly by hospice services. Ms. Garcia stated that, if necessary, staff at the facility are trained to provide basic wound care and that she is not aware of Resident B's wounds being treated inadequately or improperly. Ms. Garcia stated Resident B's wounds have been weeping, but that hospice has reported no concerns. Ms. Garcia stated hospice has been to the facility almost daily and that if additional dressing, or care, is needed, hospice has made it clear that they can be contacted for assistance. During the onsite, I observed Resident A sitting in his wheelchair at the facility. Ms. Garcia pulled Resident B's pant legs up to his knees on both logs. Both legs were wrapped from the ankle to just below his knee. While the bandages appeared new, Resident B did have spots of weeping through the bandages.

I reviewed Resident B's January 2024 *Skilled Nursing Visit Notes* from *Beacon Hospice of Michigan LP*, provided by Ms. Garcia. The notes read consistently with statements provided by Ms. Garcia regarding Resident A's wound care indicating hospice had been to the facility on 1/12/2024, 1/13/2024, 1/14/2024, 1/15/2024 and 1/18/2024. Notes dated 1/18/2024 read, in part, "Patient brought back to his room for wound care. Both leg wounds healing slowly. Edema to BLE [Bilateral Lower Extremity] and bilateral feet improving. Left foot +2, BLE and right foot +1".

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The complaint alleged Resident A had wounds which were not being adequately treated. The investigation revealed Resident A has wounds to his left and right lower legs cause by edema which are being appropriately evaluated and treated by hospice care on an almost daily basis.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

According to the complaint, the facility has at least 15 residents and only staffs one person each shift.

When interviewed, Ms. Garcia stated the facility has a total of 61 residents. Ms. Garcia stated the residents are split between the first-floor assisted living (AL), second floor AL and third floor memory care (MC) with approximately 21 residents on the first floor, 26 on the second floor and 15 on the third floor. Ms. Garcia stated that for AL, each floor is assigned two care staff and one medication technician (med tech) on first and second shift and two care associates for each floor on third shift with one med tech for the whole building as there are not many medications on that shift that need to be passed. Ms. Garcia stated that for MC, three care associates are scheduled on first and second shift, with two care associates on third.

I reviewed the resident census, provided by Ms. Garcia, which read consistently with statements she provided.

I reviewed staff schedules for December and January 2024, provided by Ms. Garcia, which read consistently with statements she provided.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The complaint alleged the facility was short staffed. The investigation did not reveal evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Insufficient Linens

INVESTIGATION:

According to the complaint, the facility does not have enough towels or washcloths available for residents.

When interviewed, Ms. Garcia stated the facility has had issues running low on towels and washcloths for use with residents. Ms. Garcia stated this is something she is working on addressing and has ordered extra towels and washcloths to have more on hand.

On 1/19/2024, I interviewed Associate 1 at the facility. Associate 1 stated linens, such as towels, washcloths, and sheets, are expected to be provided by the residents/resident families. Associate 1 stated that if all of a resident's linens are currently being washed, the facility does have some in the basement of the building, however there are times when not enough clean linens are available. During the inspection, I observed each of the designated linen closets for each of the resident floors. None of the linen closets had extra linens, including washcloths, towels, or sheets.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(2) The home shall assure the availability of clean linens, towels, and washcloths. The supply shall be sufficient to meet the needs of the residents in the home. Individually

	designated space for individual towels and washcloths shall be provided.
ANALYSIS:	The complaint alleged the facility did not maintain a sufficient supply of linens. The investigation revealed that the facility primarily depends on residents to provide their own linens and does not maintain a sufficient supply of extra linens to ensure they are available to residents if none of their linens are clean.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Resident B's service plan, provided by Ms. Garcia. The plan did not include any documented instruction or information regarding Resident B's need for wound care.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference: R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	While the investigation revealed sufficient evidence to indicate Resident B was receiving adequate wound care, Resident B's service plan did not include any instruction or information pertaining to his need for wound care. Based on the finding, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

2/27/2024

Aaron Clum — Date
Licensing Staff

Approved By:

02/29/2024

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