GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Jennifer Garcia
Allegria Village
15101 Ford Road
Dearborn, MI 48126

February 20, 2024

RE: License #: AH820409060
Investigation #: 2024A1011007
Allegria Village

Dear Ms. 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the licensee's 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,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street P.O. Box 30664
Lansing, MI 48909
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409060
Investigation #:	2024A1011007
Complaint Receipt Date:	02/07/2024
Investigation Initiation Date:	02/07/2024
Report Due Date:	04/08/2024
Licensee Name:	HFV Opco, LLC
Licensee Address:	395 Pearsall Avenue Suite K 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:	ALZHEIMERS AGED

ALLEGATION(S)

	Violation Established?
On 1/29/24 Resident A was in the dining room choking and there was no staff present.	Yes
The room of a former resident, Resident C, had black mold and blood stains on the floor.	No
The facility's ceiling is leaking and causing mold.	No
Medications from deceased residents are being stored in a resident room.	No
Medications from deceased residents are being administered to other residents when their medications run out.	No
Resident E's physical appearance is concerning, and she is left to lay in bed or stay in a wheelchair.	No
The facility's hot water was out for 1 ½ weeks. Residents are not being bathed or showered.	No
Additional Findings	Yes

Allegations of the facility being short of staff were recently investigated in Special Investigation Report (SIR) #2024A0784023 and will not be re-investigated here.

II. METHODOLOGY

02/07/2024	Special Investigation Intake 2024A1011007
02/07/2024	Special Investigation Initiated - Telephone Called APS worker, who forwarded the allegations from an anonymous source. Interview conducted.
02/08/2024	Inspection Completed On-site Interviews conducted, records reviewed and observations made.
02/20/2024	Exit Conference – Conducted with licensee authorized representative/administrator Jennifer Garcia by telephone.

ALLEGATION:

On 1/29/24 Resident A was in the dining room choking and there was no staff present.

INVESTIGATION:

On 2/07/2024, I received the allegations from the department's intake unit. The allegations were initially received by adult protective services (APS) from an anonymous source. APS forwarded the allegations to the department.
I then interviewed the APS worker by telephone and obtained additional information about the allegations and her investigation.

On 2/08/2024, I interviewed the licensee's authorized representative/administrator, Jennifer Garcia, and administrative Staff persons #1 and #2 on-site. Ms. Garcia affirmed there was a choking incident during dinner meal in the dining room on 1/29/2024. Ms. Garcia said caregiver Staff #3 was assigned to be in the dining room with the residents. However, Staff #3 left the dining room and took trays of food down the hallway to another staff for delivery to residents that take meals in their rooms. Ms. Garcia said Staff #3 was fully trained as a caregiver at the time and she was expected to remain in the dining room with the residents at all times.

Ms. Garcia and administrative Staff #1 explained the dinner incident that Resident A began choking and said Resident B's family member, who reportedly is a physician, began Heimlich maneuver and successfully cleared the airway. Staff #1 was in the facility at the time, denied having witnessed the incident, but responded to the crowd that formed in the dining room immediately afterwards. Staff #1 said Resident B's family member reported having given Resident A two back blows to dislodge the food. Resident A was then complaining of sternum pain. Staff #1 said she sent Resident A to the hospital for examination. Staff #1 said Resident A returned to the facility the same day with no noted injuries.

Staff #1 said Resident A was on a regular diet and independently fed herself, at the time of the incident. Staff #1 presented 1/29/2024 hospital discharge papers that included education for response to a choking victim, directions to prevent choking, as well as following up with her physician. Staff #1 then presented a 2/2/2024 prescription from Resident A's physician that reads, "speech evaluation + treat dx: dysphagia". Staff #1 said the evaluation is scheduled.

Ms. Garcia presented an incident report written by caregiver Staff #4 that reads, on 1/29/24 at 6:10 pm "As I and [Staff #3] was (sic) passing trays. As (sic) we were walking down to the dining room one of the servers came up to us to let us know that [Resident A] was choking. As we ran up to her one the (sic) Resident family member did a Heimlich on [Resident A] once. She had to catch her breath. She was okay."

The incident report did not identify the dining room server that notified Staff #3 and Staff #4.

Upon my request, Staff #1 called and interviewed Staff #3 and Staff #4 individually by speaker phone, but neither staff could specifically recall the dining room server that notified them of the choking incident. One gave a general physical description of the server. Staff #4 did say Staff #3 was assisting her in delivering trays to the residents' rooms and that they were in another hallway at the time they were notified.

The dining room supervisor, Staff #5, then informed us that she spoke to the dining service staff scheduled to work in the kitchen on 1/29/2024. Staff #5 said it was her understanding that dining server Staff #6 was new and observed Resident A choking and did not know what to do. Staff #6 went into the kitchen and notified dining server Staff #7, who then left the kitchen and went to notify caregiver Staff #3.

Staff #1 presented a sign-in sheet of a new staff training titled "Dining room safety!" being implemented on 2/07 and 2/08/2024, as a result of this incident. It indicates one care employee must be in the dining room at all times during meal service and reviews choking precautions, meal safety, resident visits in dining room, no cell phones in dining room, staying until all residents complete the meal and leave the dining area and to ensure resident dining needs.

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.**
For reference: R325.1901	**Definitions.**
	Rule 1. As used in these rules: **(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm,**

	humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The home did not assure an organized program of protection on 1/29/2024, when Resident A was left in the dining room during dinner meal with no caregiver staff present to address her choking.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The room of a former resident, Resident C, had black mold and blood stains on the floor.

INVESTIGATION:

The allegations identified a specific room number. Ms. Garcia presented a note that Resident C resided in the room from 3/19/2021 to 12/04/2023. Presently, a new resident occupies the room.

Maintenance Staff #8 said of Resident C's room that at one time, some months ago, a flood occurred in the room above and caused a ceiling problem. Staff #8 said Resident C was moved out of the room temporarily because staff had to cut out the drywall to address the issue and clean the mess. Staff #8 denied any issue with mold and said the carpet had been stained but it was cleaned.

On 2/08/2024, I observed the room of former resident, Resident C, having no mold nor floor stains. I then spoke with the current occupant of the room, Resident D, and he said there has been no mold in the room and no stains on the floor.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(4) Rooms and all items in them shall be completely cleaned following the discharge of each resident.

ANALYSIS:	No mold and no floor stains were observed in the room of former Resident C, and the current occupant, Resident D, also denies having seen such.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility's ceiling is leaking and causing mold.

INVESTIGATION:

Maintenance Staff #8 explained the facility's hydronic heating and cooling system with absorption coolers that run above the drop ceiling tiles, circulating water through the pipes to heat and cool the building. Staff #8 said that at times the system will build up condensation on the pipes that drip onto the dropped ceiling tiles. The ceiling tiles then reveal the stains, and they are replaced. Staff #8 said at times insulation has to be replaced to mitigate the issue, but he denied there being mold issues.

Walking the hallways and into rooms on the first and second floor, I observed only a couple ceiling tiles with minimal stains.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	The facility's heating and cooling system occasionally causes some staining to drop ceiling tiles. Maintenance staff is aware and addresses the issue to prevent mold build up.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications from deceased residents are being stored in a resident room.

INVESTIGATION:

The allegations identified a specific room number. There is no resident residing in this room. Observation of the room, along with Ms. Garcia, Staff #1 and Staff #2, revealed the room was being used for storage of many items. Ms. Garcia explained

that the five medication carts in the room belong to a pharmacy that the facility had a previous contract. The contract ended some time ago, and the pharmacy has yet to pick up the carts. Three of the medication carts were unlocked and no medications were observed. The remaining two carts could not be opened. Staff #1 attempted to open the carts with the medication cart keys but was unable to do so. Ms. Garcia said she has worked at the facility since August and said those cart keys were lost before she arrived.

Administrative Staff #1 and Staff #2, who supervise the staff that administer medications, denied the facility storing any medications from residents who are deceased.

APPLICABLE RULE	
R 325.1977	**New construction, addition, major building modification, or conversion after effective date of these rules.**
	(2) Facilities for dispensing of medications shall be designed to be under the control of responsible residents or designated staff. Central dispensing locations shall keep medications locked and equipped with handwashing, work counter, and storage facilities.
ANALYSIS:	Administrative staff deny storage of medications from deceased residents. Observation of the specified resident room and three of the medication carts revealed no medications being stored in the room. The remaining two carts could not be opened.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications from deceased residents are being administered to other residents when their medications run out.

INVESTIGATION:

Ms. Garcia and administrative Staff #1 and #2 denied having caregiver staff administer medications from deceased residents to other residents when their medications run out. Staff #2 explained the facility's protocol when a resident passes away, is for her and Staff #1 to dispose of the medications together, to witness the event. Also, Ms. Garcia explained the facility's electronic medication administration record notifies the facility's current pharmacy whenever residents' medications are running low so that refills occur timely. The current pharmacy makes deliveries daily, so that there is no issue with residents running out of medications.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) Prescribed medication that is no longer required by a resident must be properly disposed of consistent with the policy established by the home and manufacturer guidelines.
ANALYSIS:	There is no evidence to indicate the facility is administering medications from deceased residents to other residents when their medications run out.
CONCLUSION:	**VIOLATION NOT ESTABLSHED**

ALLEGATION:

Resident E's physical appearance is concerning, and she is left to lay in bed or stay in a wheelchair.

INVESTIGATION:

According to the allegations, Resident E is very frail, appears underweight, her skin looks like its tearing with wounds covered in bandages that hang off with skin still connected. The resident is reportedly left to lay in bed or stay in a wheelchair.

Ms. Garcia and Staff #1 explained that Resident E is 90 years old. Her physician offered a feeding tube, but Resident E and her family elected to have hospice care instead since 12/15/2023. Staff #1 said Resident E is doing "wonderfully" as she continues to participate in activities. Staff #1 said Resident E is verbal, has made no complaints, and she does require two-person assistance with transfers. Staff #1 said Resident E does have a bandage over a skin tear due to thin skin. There is no issue with it hanging or tearing.

On 2/8/2024, I observed Resident E seated in her wheelchair at the dining room table. She appeared clean, neatly dressed, with no exposed bandages. Although she appeared thin, Resident E also appeared comfortable with her head held high. I interviewed Resident E briefly. She spoke strongly and her answers were definitive and appropriate to the questions. Resident E said she has no complaints with the care she receives, and that she knows how to attain staff attention whenever she needs assistance. Resident E affirmed that staff do respond promptly to her requests. She denied having been left in her bed or wheelchair unattended. I then observed a caregiver assist Resident E with eating.

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:	There was no evidence that Resident E has not had her personal needs attended.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility's hot water was out for 1 ½ weeks. Residents are not being bathed or showered.

INVESTIGATION:

Maintenance Staff #8 said there was a problem with the hot water boiler on or about 1/16/2024 for approximately 24 hours. Staff #8 said he and others attempted to repair the boiler by replacing a sensor and flame rod, but without success. In the interim, they have re-routed hot water from another boiler for this area of the building and hired a mechanical contractor firm to address the issue. The contractor removed the burner and is waiting on parts to repair the boiler.

Staff #1 said with the water being out only one day, the residents were bathed the following day.

On 2/8/2024, I checked water at a resident room faucet. The water did reach the minimum temperature of 105ºF and was comfortable.

APPLICABLE RULE	
R 325.1970	**Water supply systems.**
	(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.

ANALYSIS:	According to Staff #8 one of the facility's hot water boilers did fail and it is in process of being been repaired. Consequently, residents were without hot water for one day. According to Staff #1 the residents had to bathe the following day. In the interim, hot water has been re-routed from another boiler until the repairs can be completed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 1/29/2024, Resident A had a choking incident that required assistance from another individual to clear her airway. She was sent to the hospital and returned with discharge papers that included directions of what can be done to prevent choking. The discharge papers read, to eat slowly, chew food well before swallowing, cut food into small bite-size pieces, avoid drinking excessive beer, wine, and mixed drinks (alcohol), and make sure oral devices or dentures fit properly. Resident A's records also include a 2/2/2024 physician prescription that reads "speech evaluation + treat dx: dysphagia". Staff #1 said the evaluation is scheduled.

Review of Resident A's service plan revealed it is dated 1/17/2022 with the most recent revision on 7/21/2023. The eating/meals/nutrition section of the service plan still indicates Diet: Gluten free, regular/thin liquids and that the resident is able to feed herself. Staff to offer mealtime reminders. As of 2/08/2024 Resident A's service plan was not updated after the choking incident to address significant change in Resident A's care needs including the diagnosis of dysphagia, the physician's order for a speech evaluation to treat the dysphagia, and the hospital discharge instructions of how to prevent another choking incident.

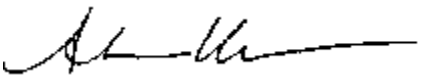
APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Resident A's service plan was not updated after having a choking incident to address the significant change in Resident A's care needs including the diagnosis of dysphagia, the physician's order for a speech evaluation to treat the dysphagia, and the hospital discharge instructions of how to prevent another choking incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/20/2024, I reviewed the findings of this report with the licensee's authorized representative/administrator Jennifer Garcia by telephone.

III. RECOMMENDATION

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



2/13/2024

Andrea Krausmann Date
Licensing Staff

Approved By:

02/20/2024

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