

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

August 21, 2024

Jennifer Garcia Allegria Village 15101 Ford Road Dearborn, MI 48126

> RE: License #: AH820409060 Investigation #: 2024A0784073 Allegria Village

Dear Jennifer Garcia:

Attached is the Special Investigation Report for the above referenced facility. While a violation was identified in the report, a written corrective action plan is not required as appropriate corrective measures were taken to address the violation.

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 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 #	202440704072
Investigation #:	2024A0784073
Complaint Receipt Date:	07/02/2024
Investigation Initiation Date:	07/02/2024
Donord Duo Dodo	00/04/0004
Report Due Date:	08/31/2024
Licensee Name:	HFV Opco, LLC
Licensee Address:	Suite K
	395 Pearsall Avenue
	Cedarhurst, NY 11516
Licensee Telephone #:	(516) 371-9500
	(6.10) 6.1. 6666
Administrator/Authorized	Jennifer Garcia
Representative:	
Name of Facility	Allegrie Villege
Name of Facility:	Allegria Village
Facility Address:	15101 Ford Road
	Dearborn, MI 48126
Facility Telephone #:	(313) 584-1000
Original Issuance Date:	09/30/2021
July 100 dailed Date:	00/00/2021
License Status:	REGULAR
Effective Date:	03/31/2024
Expiration Date:	07/31/2024
	0.70.72021
Capacity:	132
Program Type:	ALZHEIMERS
	AGED

II. ALLEGATION(S)

Violation Established?

Lack of confidential treatment of resident medical documentation	Yes
Additional Findings	No

III. METHODOLOGY

07/02/2024	Special Investigation Intake 2024A0784073
07/02/2024	Special Investigation Initiated - Telephone Interview with complainant
07/03/2024	Inspection Completed On-site
07/08/2024	Contact - Document Received Email received from director of nursing (DON) Stephanie Russeau with investigative documentation
07/09/2024	Contact - Document Received Email from administrator Jennifer Garcia
08/21/2024	Exit - Email Report sent to Ms. Garcia

ALLEGATION:

Lack of confidential treatment of resident medical documentation

INVESTIGATION:

On 7/02/2024, the department received this online complaint.

According to the complaint, on 6/30/2024, at approximately 1:15pm, Associate 1 was witnessed asking a resident to sign, as a witness, a do not resuscitate (DNR) document for another resident. It is unknown who the resident is that was asked to sign the document or what resident the document belonged to.

On 7/02/2024, I interviewed Complainant by telephone. Complainant stated they did not know the name of the resident who was approached to sign the DNR or who the DNR belonged to. Complainant stated the situation happened in the dining room with several other residents sitting with the resident being asked to sign the DNR

document. Complainant stated Associate 1 is the person who asked the resident to sign the DNR.

On 7/03/2024, I interviewed director of nursing Stephanie Russeau at the facility. Ms. Russeau stated she was not aware of Associate 1 having had a resident sign a DNR on 6/30/2024. Ms. Russeau stated Associate 1 did work on that day. Ms. Russeau stated Associate 1 was not present at work and she would need to investigate the matter further.

On 7/08/2024 and 7/09/2024, I received an email from Ms. Russeau with included attached documents requested while onsite on 7/03/2024.

I reviewed a written statement from Associate 1, provided by Ms. Russeau. The statement indicated Associate 1 did have a resident sign a DNR in the dining area with other residents present. In the letter Associate 1 also indicated the resident who was asked to sign the DNR had no relationship with the person for whom the DNR was for.

On 7/09/2024, I received an email from administrator Jennifer Garcia indicating she did not agree with Associate 1's actions and that corrective measures are being taken to address this. Ms. Garcia indicated Associate 1 was given a formal corrective notice.

I reviewed an Employee Counseling Form for Associate 1, provided by Ms. Garcia which confirmed Ms. Garcias statements regarding formal counseling for Associate 1.

APPLICABLE RULE		
MCL 333.20201	Policy describing rights and responsibilities of patients or residents	
	(2)(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.	

ANALYSIS:	The complaint alleged a lack of protection for a resident's confidential medical information by Associate 1 when she asked an unrelated resident to sign a DNR form in a public space at the facility with other residents nearby. The investigation confirmed the allegations. While the facility was found to be in violation of this rule, appropriate actions have been taken to bring the facility into compliance.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

It is recommended that the status of the license remain the same. Due to the facility taking adequate corrective measures to address the violation, no corrective action plan is required.

Daron L. Clum	8/15/2024
Aaron Clum Licensing Staff	Date
Approved By:	

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