GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Jennifer Garcia
Allegria Village
15101 Ford Road
Dearborn, MI 48126

November 27, 2024

RE: License #: AH820409060
Investigation #: 2024A1022086
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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409060
Investigation #:	2024A1022086
Complaint Receipt Date:	09/19/2024
Investigation Initiation Date:	09/20/2024
Report Due Date:	11/19/2024
Licensee Name:	HFV Opco, LLC
Licensee Address:	Suite K 395 Pearsall Avenue Cedarhurst, NY 11516
Licensee Telephone #:	(516) 371-9500
Administrator/Authorized Rep	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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	132
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) does not receive appropriate care.	Yes

III. METHODOLOGY

09/19/2024	Special Investigation Intake 2024A1022086
09/20/2024	Special Investigation Initiated - Letter Request for information sent to facility.
10/10/2024	Inspection Completed On-site
11/21/2024	Contact - Document Received Email exchange with administrator
11/27/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) does not receive appropriate care.

INVESTIGATION:

On 09/18/2024, through 10/02/2024 the Bureau of Community and Health Systems (BCHS) received multiple email messages from the complainant that in part read, “Came to see my dad (the Resident of Concern/ROC) today, he was in the dining room and did not have oxygen on… and I asked if he wanted oxygen, and he said yes… I (the complainant) asked for a new tank of oxygen and no tank was ever brought to us throughout the day, we asked a little after lunch. This happened on both 9/13 & 9/17… after calling (the BCHS) office on Friday the wait times are increasing. The residents are pressing call button, and it took someone close to a half hour to get someone to come in… Residents’ family members have to help them get in out of bed because staff isn’t coming in a timely manner… When I got here around 12:45 (on 10/02/2024), my father was in his room in his wheelchair with a food tray in front of him. I asked him why he didn’t go to eat lunch in the dining room - he told me no one came for him… The call lights were out on Monday (09/30/2024) - I found out after my father waited 40 minutes for help. I had asked an aide for assistance after waiting 20 minutes, she responded that she would send someone. No one came until I found another aide 20 minutes later after the shift change.

The call light system is still not working (on 10/04/2024) …"

On 09/25/2024, I interviewed the complainant by phone. The complainant reiterated her concern that residents including the ROC had to wait excessively long times for assistance. Regarding the availability of oxygen, the complainant clarified that whenever the ROC was in his room, he had sufficient oxygen from the oxygen concentrator in his room, but when he left his room for meals or to go outdoors, it had become difficult for him to get a portable oxygen tank. The complainant acknowledged that another family member was the ROC's power of attorney (POA) and due to the family dynamics, she (the complainant) did not always know what decisions had been made by the family member who was the ROC's POA.

On 10/10/2024, at the time of the onsite visit, I interviewed the administrator/authorized representative (AR). When I asked about the ROC, the administrator acknowledged that the ROC's family dynamics were challenging. The ROC's spouse was his POA, and she had elected to exclude the ROC's daughter from the ROC's care conferences and requested that no information about the ROC be shared with the daughter. The POA had subsequently enrolled the ROC in hospice care. The AR went on to say that because the ROC frequently removed the nasal cannula that delivered oxygen into his nostrils, hospice had changed his oxygen order to be administered "as needed." When the AR was asked what criteria the facility was using to determine if the ROC needed oxygen, the AR replied that the ROC should receive oxygen if he asked for it or if he was observed with difficulty breathing. According to the AR, the ROC's daughter seemed to believe that the ROC needed oxygen when the ROC had not asked for it and was not having difficulty breathing. When asked about the availability of portable oxygen tanks, the AR stated that hospice provided the ROC with tanks and while there were 1 or 2 extra tanks in his room, for safety reasons, tanks were stored in an oxygen closet on the hallway. The AR stated that if there were no tanks in the room and the ROC needed oxygen when he left the room, a new tank could be obtained from the caregiver.

When asked about response to call light activation, the AR acknowledged that the facility had a corrective action plan in place to address lengthy wait times in response to a previous finding of violation. The administrator stated that caregivers continued to be expected to respond to call lights in 11 minutes or less, which was the facility's standard. According to the AR, the facility's "Wellness leadership team holds the team accountable for call light response times." However, a review of the call light response report for 09/01/2024 through 09/10/2024 revealed multiple instances of a response time being greater than 20 minutes. On 11/21/2024, via an email exchange, the AR acknowledged that the facility had not been monitoring or auditing the call light response log to identify call light response times greater than their expected standard for a response.

When asked about the call light system "not working" between 09/30/2024 and 10/03/2024, the AR stated that she had no knowledge that there was a malfunction

on those dates. The AR did acknowledge a malfunction that occurred several weeks previously whereas the monitor which was kept in the caregivers' work room did not work, but calls registered on an iPad, which was carried by the shift supervisor. When a call came in, the shift supervisor would contact the responsible caregiver. When the monitor was functioning, it emitted a loud noise that would alert caregivers that a resident had activated their call button.

At the time of the onsite visit, the ROC was observed in bed in his room. The ROC's spouse was with him. The ROC was receiving oxygen through a nasal canula that was attached to an oxygen concentrator. The ROC's wheelchair was also in the room. On the back of the wheelchair was a portable oxygen tank. The tank's gauge indicated that the oxygen tank was approximately 2/3 empty. There were 4 additional oxygen tanks in the room, but none of them were equipped with a gauge, so it was not evident if they were full or empty tanks. When the ROC's spouse was asked if they had to wait long when he activated his call light, the ROC's spouse stated that that wait times could be longer than what would be optimal.

According to the ROC's progress notes, on 08/19/2024, the ROC's family members selected a hospice agency to provide care to the ROC. He was admitted to hospice care on 08/29/2024. His hospice admission orders included, "oxygen 2 to 4 liters per minute via nasal cannula as needed." According to his service plan, the ROC's oxygen was "only to be used as (a) comfort measure," as needed for shortness of breath.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(e) A patient or resident is entitled to receive adequate and appropriate care**
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:	Based on the review of call light response times, residents frequently had to wait more than 20 minutes for a caregiver to respond to their request for assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 11/27/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

11/27/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

11/25/2024

_____

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