GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 17, 2026

Lexi Cousino
Allegria Village
15101 Ford Road
Dearborn, MI 48126

RE: License #: AH820409060
Investigation #: 2026A0627018
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 responsible party 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 (517) 335-5985.

Sincerely,

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems

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

I. IDENTIFYING INFORMATION

License #:	AH820409060
Investigation #:	2026A0627018
Complaint Receipt Date:	12/02/2025
Investigation Initiation Date:	12/17/2025
Report Due Date:	02/01/2026
Licensee Name:	HFV Opco, LLC
Licensee Address:	Suite K, 395 Pearsall Avenue, Cedarhurst, NY 11516
LicenseeTelephone #:	(516) 371-9500
Administrator:	Rhandi Smith
Authorized Representative/	Lexi Cousino
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	132
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There was Inadequate supervision and deficient fall-prevention measures.	Yes
The facility failed to notify the family of multiple falls or an injury of unknown origin, a visible head injury.	No
The facility failed to reassess the Resident after repeated falls and did not document changes in condition.	No
The facility used prohibited bed rails and makeshift restraints.	No
The facility failed to provide timely assistance after a fall.	No
Additional Finding	No

II. METHODOLOGY

12/02/2025	Special Investigation Intake 2026A0627018
12/17/2025	Special Investigation Initiated - On Site
12/19/2025	Contact - Document Received

ALLEGATION: There was Inadequate supervision and deficient fall-prevention measures.

INVESTIGATION: On 12/2/2025 the Bureau of Community and Health Systems received a complaint alleging that the facility failed to report a visible head injury, failed to notify family of multiple falls, is using prohibited bed rails and makeshift restraints, failed to provide timely assistance after a fall, failed to reassess after repeated falls and documented changes in condition, and there is inadequate supervision and deficient fall-prevention measures.

On 12/17/25, I interviewed Rhandi Smith, the Administrator of the facility. The Administrator reported that Resident A was a 93-year-old female that was admitted

to the facility on October 28, 2025, and was transferred from the facility to the hospital on November 10, 2025. Resident A was admitted to hospice services on October 30,2025 while at the facility. SP1 reported that Resident A was not at the facility for very long and because of her declining condition and falls, her family had her sent to the hospital. The facility has a current census of 79.

On 12/17/25 I reviewed the “Fall Prevention and Investigation Program” as a part of the facility’s “General Service Evaluation-Level of Care” assessment used to assess a resident’s likelihood of a fall. The fall assessment is required to be performed: “1. Pre-admission to the facility and …. 4. (for a) Significant change in status….”

The facility’s “General Service Evaluation-Level of Care” dated 9/21/25, was performed, pre-admission assessment by facility personnel for Resident A. On the document, the evaluation gave an overall care rating of 48 points showing “Moderate Assistance” was needed to care for Resident A. Her fall risk was assessed as a “Low Fall Risk.”

On 11/03/25, another Level of Care Evaluation for Resident A was initiated due to a change in her condition and a decline since the initial assessment. The evaluation gave a new overall rating of 64 points showing “Extensive Assistance” was needed to care for Resident A. The fall risk was assessed at an “Increased Risk for Falls.”

On 12/17/25 SP1 reported that Resident A was indeed moved from room 101 to room 202 to where there were more staff present for her care. The Hospice physician orders of 10/30/25 specified having rails for safety and a fall mat beside the bed.

Review of the Incident Report dated 11/9/25 noted that the care aide discovered Resident A on floor. Documented on the report under the section titled, “Corrective measure taken to prevent recurrence of this incident: Bed needs to be fully put together, railings are behind door” (sic).

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. **(4) The supervisor of resident care on each shift shall do all of the following:** **(b) Protect residents from accidents and injuries.**

ANALYSIS:	The facility conducted fall risk assessments for changes in Resident A's condition. On 10/30/2025, bed rails were ordered by the physician. The facility has possession of bed rails but failed to timely implement the order for bed rails by attaching them to Resident A's bed, as identified on the 11/09/2025 Incident Report. For this reason, the violation is identified.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility failed to notify the family of multiple falls or an injury of unknown origin, a visible head injury.

INVESTIGATION: The facility uses an Incident Report document titled "Reportable Incident" and defines it as: "-an intentional or unintentional event in which a resident suffers harm or is at risk for more than minimal harm such as, but not limited to abuse, neglect, exploitation, or unnatural death" Review of the facility's policy titled "Notification Requirements" directs staff to promptly notify family, guardian, and/or a designated agency when: "3. Any serious accident ….or incident occurs which involves the resident……"

Review of the facility's Incident Reports (IR) on 12/17/25, noted that IR's were completed on 11/8/25, 11/9/25, and 11/10/25 for Resident A falling. On the 11/8/25 IR document, the care aide found the resident on the floor at 7:48 pm with her over the bed table flipped over and food on the floor. Resident A told the care aide she wanted to go to bed. Her vital signs were: temp: 97.3, pulse: 89, respirations: 16, blood pressure: 157/81, and pulse oximetry: 92%. The care aide reported that Resident A had carpet burns on knees. The care aide documented calling the hospice nurse and leaving a message for Resident A's daughter via phone.

On the 11/9/25 IR document, the care aide was rounding on the resident at 7:20pm and found her on the floor mixed up in her covers. The care aide documented there was "No effect or injuries", but the med tech noted that there was a knot on Resident A's head but thought it was from another fall. Resident A's vital signs were documented as Pulse: 96, respirations: 17, blood pressure: 145/83, and pulse oximetry: 80%. There was no documentation stating that Resident A was having any difficulty in breathing. It was documented that their call to notify hospice at 7:20 pm was to a voice mail box that was full and that a call to Resident A's daughter had been placed at 7:25pm.

On the 11/10/25 IR document, at 7:33pm the care aide found Resident A on the floor and called for assistance to help put her in her chair. The IR went on to state that the med tech took her vital signs and called her family and hospice. There were no injuries observed. Vital signs were pulse: 92, respirations: 19, blood pressure:

117/69, and pulse oximetry: 92%. Hospice and Resident A's daughter were notified, EMS was called and Resident A was transferred to the hospital.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	For all three of these fall incidents, both hospice and Resident A's daughter were notified or an attempt to notify was documented, consistent with the facility's policy.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility failed to reassess the Resident after repeated falls and did not document changes in condition.

INVESTIGATION: On 12/17/25, I reviewed the facility's policy titled "Fall Prevention and Investigation Program" where in response to when a resident that falls that the General Service Plan will identify safety measures and be "Updated as the need arises."

On 12/17/25, I reviewed the clinical record and noted Resident A was initially evaluated for Level of Care by the facility on 9/21/25 for Assisted Living level of care while still living in the Independent Living area of the facility. The resulting score placed Resident A in need of a Moderate Assistance level of care.

On 12/17/25, I reviewed a second Level of Care assessment dated 11/3/25 as a result of a significant change in status in which resulted in a need for an Extensive Assistance level of care.

As a result of the new information, a Care Conference with the facility's Interdisciplinary Team members, and Resident A's daughter via telephone on 11/5/25 was conducted to acknowledge the decline in condition. Resident A's

medications were reviewed, her need for meal assistance, the facility's safety rail policy, the presence of private care staff (arranged by Resident A's family) is with her daily. The conference documentation notes that Resident A had not attended any out-of-room activities (since) admission (10/28/25). Resident is hospice status and in collaboration of services. A plan was formulated to transfer Resident A to the second floor where more staff were present. Family verbalized to IDT members that concerns were addressed in the meeting. Safety measures were revised and added to Resident A's Service Plan that included, Falls: at risk for falls, encourage to call for assistance; Safety: check every 2-3 hours; Cognition: requires assistance for moderate dementia with significant short-term memory and possibly long-term memory loss.

On 12/17/25, SP1 reported that during a conversation with Resident A's DPOA she had informed the DPOA that if she was concerned that her mother would fall under their care that maybe Resident A would be better served by a Rehab facility or skilled nursing facility to allow her time to regain her strength.

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:	The allegation that the facility failed to reassess after repeated falls and documented changes in condition is unsubstantiated as evidenced by the facility holding a care conference 5 days after Resident A was admitted to the facility and adding safety measures to the service plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility used prohibited bed rails and makeshift restraints.

INVESTIGATION: On 12/18/25 I interviewed the Hospice branch manager for Heart to Heart Hospice. The Branch Manager reported that Resident A was admitted to hospice on 10/30/2025 and remained under hospice services after transferring to a hospice bed at the hospital on 11/10/26. The hospice Branch Manager reported that there was no adverse documentation related to the facility's care of Resident A.

I reviewed the Hospice physician orders dated 10/30/25 that specified Resident A was to have no labs drawn, no hospitalization prior to calling hospice, be on comfort medications and "Pt's hospital bed must be with rails for safety. Hospital bed must

be in the lowest position, fall mat must be next to the bed at all times."(sic). Review of the Hospice Equipment Delivery Ticket dated 10/30/25 showed equipment delivery that included a hospital bed, half-length bed rails, an oxygen concentrator and tanks, a wheelchair, footplates, an over the bed table, a shower chair and a fall pad.

Review of the video footage provided by the complainant dated 11/10/25 at 7:30pm, noted half-length bed rails being in place and a chair pushed up against the bed at the time Resident A had gotten out of bed and fell.

On 12/17/25, SP1 reported that it is the facility's practice to use bedrails only if a physician orders it for safety. Record review noted that the hospice physician had ordered bed rails.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(4) The supervisor of resident care on each shift shall do all of the following: **(b) Protect residents from accidents and injuries.** **(c) Be responsible for safety of residents in case of emergency.**
ANALYSIS:	The allegation that the facility was using prohibited bed rails and makeshift restraints is unsubstantiated. There was an order from the hospice physician for bed rails and other safety interventions. The use of the chair pushed up against the bed was staff's attempt to remind Resident A to call for help before getting out of bed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility failed to provide timely assistance after a fall.

INVESTIGATION: On 12/19/25, a video was provided by the complainant that shows that at 7:12 pm on 11/10/25, Resident A is not in her bed and during the course of the 12-minute video can be seen raising her arms. A second video also dated 11/10/25, shows that at 7:33pm on November 10, 2025, Resident A had been discovered, and caregivers had put her up in a chair and had equipment present for taking her vital signs and evaluating her condition. The time stamp at 7:37 showed that EMS personnel were in the room. Resident A was visible sitting in the chair

without difficulty, talking to caregivers and EMS personnel and being responsive to the commotion in her room. Resident A was subsequently transferred to the hospital.

The service plan dated 11/03/2025, identified that Resident A should be observed every two to three hours. The fall safety measure of bed rails is visible in the video. The facility documents by exception, and specific documentation on the last observation of Resident A prior to the fall on 11/10/2025 was not present.

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:	Resident A could be seen on the floor for approximately 30 minutes in the video. However, the last time that Resident A was observed could not be established either through complainant video or facility documentation. Facility staff responded appropriately when Resident A was found and care was provided immediately.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes in the status of the license.

03/17/2026

Rick Brummette Date
Licensing Staff

Approved By:

03/17/2026

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