

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235593	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/07/2024
NAME OF PROVIDER OR SUPPLIER  Allegria Village		STREET ADDRESS, CITY, STATE, ZIP CODE  15101 Ford Rd Dearborn, MI 48126	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39958</p> <p>This citation pertains to intake MI00142789.</p> <p>Based on interview and record review, the facility failed to inform family of a fall for one resident (R603) of six residents reviewed for falls.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed, R603 admitted to the facility on [DATE] with pertinent diagnoses which included chronic atrial fibrillation and abnormalities of gait and mobility. R603's family was listed as the emergency contact.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R603 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 14, out of a total possible score of 15.</p> <p>Review of a progress note with a date of 2/17/24 at 2:23 p.m., revealed Around 1:50 PM, assigned CNA (Certified Nursing Assistant) reported to writer that resident told her that he fell . CNA did not observed resident on the floor, he was in bed, and call light on. Writer went in with co-worker, alert and oriented with periods of confusion, checked resident skin, no new skin issues noted, informed staff that he hit his head at the door . On coming nurse notified to monitor resident for any changes .</p> <p>In an interview on 3/6/24 at 2:31p.m. the Director of Nursing (DON) reported a resident's family should be notified when they fall. The DON confirmed R603's family was not notified of the fall.</p> <p>In an interview on 3/7/24 at 9:32 a.m. Concerned Family Member (CFM) F reported the facility did not notify them that R603 had a fall or was transferred to the hospital. CFM F reported the hospital called and informed them that R603 was in the ER with a brain bleed.</p> <p>Review of the facility document Guidelines &amp; Risk Management for Falls (undated) revealed, Instruction for completion . Contact the doctor, the family/emergency contact, DPOA and Guardian to inform of fall and whether to send to hospital .</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39958</p> <p>This citation pertains to intake MI00142789.</p> <p>Based on interview and record review, the facility failed to properly assess (obtain vital signs and complete neurological checks) after a reported, unwitnessed fall for one resident (R603) out of six residents reviewed for falls. R603 was on anti-coagulant therapy. R603's fall was followed by hospitalization for a brain bleed and subsequent death.</p> <p>Findings include:</p> <p>Review of an Admission Record in the EHR (Electronic Health Record) revealed, R603 admitted to the facility on [DATE] with pertinent diagnoses which included chronic atrial fibrillation and abnormalities of gait and mobility.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed R603 had no cognitive impairment as indicated by a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15.</p> <p>Review of a progress note with a date of [DATE] at 2:23 p.m., documented, Around 1:50 PM, assigned CNA (Certified Nursing Assistant) reported to writer that resident told her that he fell . CNA did not observed resident on the floor, he was in bed, and call light on. Writer went in with co-worker, alert and oriented with periods of confusion, checked resident skin, no new skin issues noted, informed staff that he hit his head at the door, he doesn't know how he got to the door, nothing noted to the scalp . Unit manager notified . On coming nurse notified to monitor resident for any changes .</p> <p>Review of a progress note with a date of [DATE] at 10:56 p.m., revealed, Resident received 5pm meds and tolerated well . Resident didn't complain of any discomfort or appear to be in any distress. A few moments later EMT (Emergency Medical Transportation) arrived stating that they were here for (R603's room) . On call Provider notified that resident called 911 for his self. Daughter called and notified us that he was currently in emergency surgery that he had bleeding on the brain. Writer called on call provider notified .</p> <p>Review of Physician orders revealed R603 had an order for Warfarin (blood thinner/anticoagulant) 5 mg (milligrams) by mouth at bedtime (9 pm).</p> <p>Review of a February 2024 Medication Administration Record (MAR) revealed R603 received Warfarin on , d+[DATE] and [DATE] at 9 pm.</p> <p>Review of an incident report, dated [DATE] revealed, R603 reported falling and hitting his head.</p> <p>Review of vital signs in the EHR revealed R603 did not have any documented blood pressure readings between 9 am and 6 pm on [DATE], on the date of the reported fall.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p>However, review of a hospital document, dated of [DATE] at 6:11 p.m., revealed R603 presented to the emergency department following a fall where he reported hitting his head. R603 was hypertensive (increased blood pressure) and tachycardic (increased pulse rate) upon arrival. A CT scan (used to diagnose internal injuries or damage) was performed and found R603 had a large brain bleed.</p> <p>In an interview on [DATE] at 2:16 p.m., the Nursing Home Administrator (NHA) A reported R603 did not have any neurological checks (used to assess changes in mental status and level of consciousness, pupil response, motor strength, sensation, and gait) performed on [DATE].</p> <p>In an interview on [DATE] at 2:26 p.m., the Director of Nursing (DON) reported R603 had an unwitnessed fall. The off-going nurse was leaving and endorsed to oncoming nurse to monitor R603. The Director of Nursing (DON) reported when a resident falls and hits their head neurological checks (neuro checks) should be completed. The DON reported neuro checks should be completed to assess the resident for changes. The DON reported R603's family called the facility and told them R603 had a brain bleed and died .</p> <p>In an interview on [DATE] at 8:53 a.m. CNA E reported R603 had on the call light which prompted her to go to the room. CNA E reported R603 was in bed and reported the fall and that he hit his head on the door. CNA E then reported telling the nurses about what R603 reported.</p> <p>In an interview on [DATE] at 10:20 a.m. Licensed Practical Nurse (LPN) C reported during shift report at approximately 2 pm, LPN I reported R603 fell and hit his head. LPN C then reported LPN I asked her to monitor R603 during the shift for neurological changes. LPN C reported she did not observe R603 until medication pass at approximately 5pm. LPN C reported the EMT's arrived on the unit when she walked to the medication cart after exiting R603's.</p> <p>Review of the Change in Condition policy revised February 2021, documented in part the following, Prior to notifying the physician or healthcare provider, the nurse will make a detailed observations and gather relevant information and pertinent information for the provider . 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .</p> <p>Review of a Guidelines &amp; Risk Management for Falls policy (undated) documented, Instruction for completion .</p> <p>Residents should be assessed head to toe.</p> <p>Note any injury.</p> <p>Unwitnessed falls initiate neuro checks immediately.</p> <p>Contact DON for all residents on anti-coagulants.</p> <p>Contact the doctor, the family/emergency contact, DPOA and Guardian to inform of fall and whether to send to hospital .</p>		