

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 08/22/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208</p> <p>This citation pertains to intakes MI00146255 and MI00146314.</p> <p>Based on interview and record review the facility failed to provide adequate supervision for one resident (R77) out of one resident reviewed for elopement, resulting in the potential for heat exposure and being struck by a motor vehicle when R77 left an appointment unsupervised.</p> <p>Findings include:</p> <p>Record review of facility's Investigation Summary and Conclusion (no date), revealed R77 was taken to an appointment on 7/31/24 at approximately 8:30 AM via facility bus transportation. R77 was left unattended. At approximately 3:51 PM the facility was made aware that R77 was not present for pick-up. Further review revealed that R77 was found at 8:30 PM and returned to the hospital.</p> <p>Record review of R77's electronic medical record (EMR) revealed admission into the facility on [DATE] with a pertinent diagnosis of aphasia following a cerebral infarction (unable to comprehend language related to a stroke). According to the Brief Interview for Mental Status (BIMS) dated 7/12/24, R77 scored 11/15 (impaired cognition). Review of Minimum Data Set (MDS) dated [DATE], R77 required partial to substantial assistance with Activities of Daily Living (ADLS). Further review of EMR revealed resident did not have a guardian in place.</p> <p>Record review of temperatures for Detroit on 7/31/24 documented a high of 90 degrees Fahrenheit.</p> <p>During an interview on 8/21/24 at 2:15 PM with Director of Nursing (DON), it was reported that R77 was taken to an appointment and was not escorted with supervision. When asked if the resident should have had supervision related to impaired cognition, DON said, R77 should have had been provided with supervision. When asked was there a potential the resident could have been struck by a vehicle or impaired by heat exposure, DON said, Yes.</p> <p>During an interview on 8/21/24 at 3:14 PM with Nursing Home Administrator (NHA), it was reported that the resident was found by an ambulance service walking along I-94 expressway and was taken back to the hospital. It was then reported that residents with a BIMs of 12 or below will now receive an escort for supervision when going to outside appointments.</p> <p>(continued on next page)</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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy Safety and Supervision (no date) documented, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Further review of policy found no interventions in policy to escort residents that are cognitively or physically impaired to appointments outside of the facility.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634</p> <p>Based on observation, interview and record review the facility failed to provide meals that were palatable for three residents (R7, R9 and R22) out of three resident that consumed meals in rooms, resulting in cold and visually unappealing foods. This deficient practice had the potential to affect all residents that consume food from the kitchen.</p> <p>Findings Include:</p> <p>R9</p> <p>On 8/20/2024 at 11:20 AM, R9 was queried about meals. R9 said, that he does not care for the food and often skips meals. R9 explained, sometimes the food is cold and it does not taste that good.</p> <p>Record review revealed R9 was admitted into facility on 7/26/24 with a pertinent diagnosis of Type II diabetes. According to Brief Interview for Mental Status, (BIMS) dated 8/1/24, R9 scored of 15 out of 15 (intact cognition).</p> <p>R22</p> <p>On 8/20/2024 at 2:30 PM, R22 was interviewed and reported not being able to eat the food because it is cold.</p> <p>Record review revealed R22 was admitted into the facility on [DATE] with a pertinent diagnosis of necrotizing fasciitis(flesh eating bacteria). According to BIMs dated 7/18/24, R22 scored 15 out of 15 (intact cognition).</p> <p>15194</p> <p>R7</p> <p>On 8/20/24 at 11:30 A.M and on 8/21/24 at 1:10 P.M., R7 complained the food was cold and served with a clear piece of tightly, fitted wrap to cover the food. R7 stated, the clear wrap left food soggy at times. The resident indicated eating meals in the room and did not want to eat in the dining room.</p> <p>Review of the Admission Face sheet indicated R7 was admitted to the facility on [DATE] for hospice care with diagnoses that included: heart failure, hypertension, and Chronic obstructive pulmonary disease (COPD). R7 had a BIMS (Brief interview for status) of 13 of 15 for cognition and required one person assist to complete Activities of Daily living.</p> <p>On 8/22/24 at 1:00 P.M. a lunch test tray was performed on the First floor. Temperatures taken were as follows:</p> <p>Chopped Steak with gravy- 103.2 Degrees (D) Fahrenheit (F).</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Au Gratin Potatoes -110 D.F</p> <p>Peas and Carrots-83- D.F</p> <p>Vanilla Pudding- 53.2-D.F.</p> <p>Each food item was served in Styrofoam containers and covered with clear saran wrap. The saran wrap was tightly wrapped over the entree causing excess condensation (water) and food to appear mashed and merged. Supervisor A who was present during the testing was queried concerning the use of any heating element used to maintain the food temperature. The supervisor reported the heating system previously used to maintain the food temperature was broken for approximately two years and was unsure of the status of repair or replacement.</p> <p>Supervisor A was informed of the food complaints received related to cold food and food served smashed from the tight saran wrap, particularly residents who ate their meals in their rooms. Supervisor A reported the status of the equipment repair would have to be addressed with the administrator in the absence of the Director of the department.</p> <p>On 8/22/24 at 2:15 P.M. the Administrator was made aware of the concerns related to the cold food but provided no evidence when the heating unit would be repaired or replaced.</p> <p>On 8/22/24 at 2:00 P.M. and 3:30 P.M. a policy was requested but not provided. Upon exiting the facility at 4:35 P.M. no other information was presented pertaining to the cold food.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194</p> <p>Based on observation, interview and record review the facility failed to maintain functional equipment and a sanitary environment 1) Replace the floor carpeting of the halls on the first, second and third floor of the facility 2) Clean the ceiling air vents in three kitchenettes, 3) replace and or repair the broken heating system for resident's food and 4) Ensure functional water faucets were attached to the hand washing sinks properly. These deficient practices had the potential to affect all 69 residents in the facility.</p> <p>Findings include :</p> <p>On 8/20/24 at 9:00 A.M. through 8/22/24 at 3:20 P.M. the carpeting on the first, second and third floor was observed heavily soiled, stained and severely worn. Visible collections of dust and lint were noted around the edges of the flooring.</p> <p>On 8/22/24 at 11:08 A.M. Maintenance Director E was interviewed concerning the cleaning of the carpet and said his department was not responsible for cleaning of the carpet, however indicated the housekeeping department could address the concern.</p> <p>On 8/22/24 at 2:55 P.M. interview with Housekeeping Director C revealed the facility did not have a cleaning rotation for the carpet. In the past the carpet was cleaned every three months and as needed for stains. Housekeeping Director C indicated carpeting had been removed in the Assisted living of the building but had no specific time frame when the carpeting would be addressed in the long-Term Care portion of the building.</p> <p>On 8/21/24 at 1:00 P.M., during observation in the kitchen and kitchenette of the facility the following concerns were identified:</p> <ol style="list-style-type: none"> 1. In the main Kitchen area-a broken dish machine. Reported by Dining Supervisor A it was not replaceable or repairable since it broke on July 11,2024. 2. Approximately 4 Missing Freezer curtain slots in the main freezer near the dock area, no rubber gasket around lower bottom of the freezer door, causing accumulated ice and frost on the door and entry. The missing bottom rubber gasket allowed potential entry of rodents and foreign matter 3. Broken heating system (Conduction system) used to maintain resident food temperatures during serving. Dining Supervisor reported heating system had not been functional and used in 2 years. 4. Floor ceiling plate cover in the kitchen area adjacent to the B elevator was detached leaving an opening in the floor. <p>Kitchenettes</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. Ceiling vents in two of three kitchenettes (First and third floor) were heavily soiled with lint, dust and grease. On the first-floor visible spider webs were noted suspended over the food cart during service.</p> <p>2. Second floor coffee machine- broke.</p> <p>3. Ice machine on the third floor not functioning.</p> <p>4. On the first and third floor the left hand faucet of the hand washing sinks and eye washing apparatus was not working properly.</p> <p>50634</p> <p>R9</p> <p>On 8/20/2024 at 11:20 AM, R 9 was queired about if he had any concerns with the facility. R9 explained they had previously been a resident of the facility and it has gone down in the upkeep. R9 said, it used to be much cleaner now it appears that the staff do not clean the way they use to. R9 said sometimes things are dropped on the floor and staff just walk over them intead of picking them up.</p> <p>Record review revealed R9 was admitted into facility on 7/26/24 with a pertinent diagnosis of Type II diabetes. According to Brief Interview for Mental Status, (BIMS) dated 8/1/24, R9 scored of 15 out of 15 (intact cognition).</p> <p>R22</p> <p>On 8/20/2024 at 2:30 PM, R22 was inteviwed and explained staff could do a better job of cleaning.</p> <p>Record review revealed R22 was admitted into the facility on [DATE] with a pertinent diagnosis of necrotizing fascitis(flesh eating bacteria). According to BIMs dated 7/18/24, R22 had scored 15 out of 15 (intact cognition).</p> <p>On 8/22/24 At 2:56 P.M. the Administrator was interviewed concerning the broken equipment. The Administrator said, a requisition for replacement/rental contract of the dish machine had just been approved (8/15/24), however review of the document revealed there was no evidence of any implementation date of service or installation. The Administrator acknowledged concerns related to the other broken equipment but provided no explanation when the facility would address the issues observed during the tour.</p>		