STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235593	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria Village	15101 Ford Rd Dearborn, MI 48126

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure an effective means of communication was established in a timely manner for one resident (R89) out of one resident reviewed for communication, resulting in language barriers and resident frustration. Findings include: On 9/22/25 at 11:23 AM, R89 was observed sitting in her wheelchair in her room. R89's Resident Representative (RR) was sitting in the room also. R89's RR said that R89 understands and speaks Arabic, but not English. R89's RR said he is present with R89 from 7:30 AM to 7:30 PM and that the facility should have Arabic-speaking staff available to interpret for R89 at other times. According to R89's RR, there was no method provided for communicating with R89 when he was away from the facility. On 9/22/25 at 11:40 AM, Patient Advocate B entered R89's room. Patient Advocate B confirmed that R89 should have been provided with a communication board upon arrival on Friday (9/19/25). Patient Advocate B added, We have staff that speak Arabic that can interpret for (R89). R89's RR said there was no Arabic speaking staff available this past weekend. On 9/23/25 at 11:30 AM, a laminated document (communication board) with pictures and English descriptive words underneath each picture was observed on R89's bedside table. R89's RR indicated that R89 would have difficulty using this document. On 9/23/25 at 11:38 AM, Licensed Practical Nurse (LPN) D said because R89 does not speak English she would use nonverbal communication, including gestures and pointing to assess R89's needs. Additionally, LPN D said there were Arabic-speaking staff available that could interpret what R89 wanted. LPN D was accompanied to R89's room. R89 was awake and lying in bed. LPN D used the available communication board to interact with R89. Following this effort, LPN D said the communication board was not useful. On 9/23/25 at 11:51 AM, Registered Nurse/Unit Manager (RN/UM) E explained that a communication board was used to facilitate two-way communication between staff and residents, and it helps us to provide care and address what the resident needs. We assess communication needs for each resident upon admission. RN/UM E was informed of LPN D's earlier attempt to communicate with R89. RN/UM E said R89 was given a communication device that R89 couldn't use. RN/UM E added we have Arabic-speaking staff available to interpret for residents. On 9/23/25 at 12:01 PM, R89's RR informed RN/UM E that R89 can read Arabic and that R89 may be able to use a communication board that contains pictures and Arabic writing. A review of the clinical record for R89 documented an admission date of 9/19/25 with diagnoses that included chronic obstructive pulmonary disease, unspecified dementia, atrial fibrillation, and heart failure. R89's Risk for Impaired Communication care plan initiated on 9/21/25 documented the following interventions: Consult speech therapy per order; Evaluate the resident's ability to comprehend; and Provide resident with verbal feedback and updates on care. A progress note dated 9/22/25 documented a BIMS (Brief Interview for Mental Status: a tool used to assess a resident's current cognitive function) score of 4 which was indicative of severe cognitive impairment. On 9/23/25 at 12:13 PM, in the presence of the State Surveyor and RN/UM E, Speech Language Pathologist (SLP) F, an Arabic-speaker, interviewed R89. During this interview, R89 correctly stated her age, the number of children she has, and the name of the street and city in which she lives. R89 was unable to identify the current month and year. RN/UM E said she will assist in getting R89's (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BIMS reassessed. On 9/23/25 at 12:25 PM, Social Worker (SW) G said she completed R89's BIMS evaluation. SW G acknowledged she did not attempt to interview R89 because of the language barrier. SW G said she had a conversation with R89's RR for the BIMS assessment. SW G confirmed the availability of Arabic-speaking interpreters at the facility but acknowledged that she did not use them. On 9/23/25 at 1:42 PM, the Director of Nursing (DON) said that a resident's communication capabilities should be evaluated at the time of admission in order to provide quality care, ensure safety, and meet the resident's needs. If R89's communication board was not effective, staff should contact the family. If the family was unavailable, an Arabic-speaking staff member would provide assistance. The DON said they should have put a communication board in place upon admission. We should have assessed the language barrier and handled it upon admission because we cannot always ensure that family will be available to communicate for the resident. The facility provided a list of on-site Arabic-speaking staff from 9/19/25 to 9/21/25. During this period, Arabic-speaking staff were available only between 6:00 AM and 2:30 PM each day. On 9/24/25 at 10:29 AM, R89's RR expressed concern for R89 if R89 could not communicate with staff in his absence. R89's RR believes a communication board with both pictures and Arabic words would work well for R89. On 9/24/25 at 11:48 AM, SLP F assisted in a R89 interview. R89 was asked about her feelings when her son was not there to help communicate. R89 appeared frustrated and through interpreter SLP F said staff don't understand her when she's talking. SLP F stated, That creates a barrier to providing care. On 9/24/25 at 1:23 PM, the Nursing Home Administrator (NHA) said that a resident's communication ability is assessed upon admission. The admission communication assessment for R89, completed by SW G was reviewed and documented the following: Communication method: verbal. Makes self understood: Understood. Ability to understand others: Understands. List any barriers patient may have: none identified. The NHA said a language barrier should have been identified in the admission assessment. This would have triggered the need for a communication board, translation services, and a more thoughtful care plan. The NHA reviewed R89's clinical record and was unable to find a completed speech evaluation. The NHA indicated it was a big concern that R89's language barrier went unrecognized, given that residents must have the means to communicate effectively. The NHA acknowledged that R89's care plan did not address the language barrier nor establish effective communication methods. On 9/24/25 at 1:30 PM, Assistant Administrator C confirmed during the period of 9/19/25 to 9/21/25, that Arabic-speaking staff were only available between 6:00 AM and 2:30 PM each day. A review of a facility policy titled, Translation and/or Interpretation of Facility Services, dated 2020, was reviewed and revealed in part the following:- The facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility.- When encountering LEP individuals, staff members will conduct an initial language assessment.- It is understood that in order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual. On 9/24/25 at 3:30 PM during the exit conference, the NHA and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported all requested documents had been provided

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow standards of practice for one (R89) of five residents reviewed for Medication Administration resulting in R89 having medications held without a physician's orders and one medication order not being correctly transcribed on the Medication Administration Record.Findings include: On 9/23/2025 at 8:38 AM during observation of R89's medication administration, Licensed Practical Nurse (LPN) D said they were holding some medications because the resident's Blood Pressure (BP) was low at 109/58. (According to the American Heart Association 2017; Low blood pressure is considered less than 90/66 mm/Hg - millimeters of mercury.) LPN D withheld the following three medications from R89: 1) Isosorbide Mononitrate Extended Release (ER) 30 mg 24-hour release, 2) Metoprolol Succinate ER 50 mg, and 3) Amiodarone 100 mg. R89's Physician's orders and Medication Administration Record (MAR) were reviewed with LPN D. It was confirmed there were no Physician's orders to hold those medications. There were no blood pressure parameter orders for when those medications could be administered. LPN D was then asked why they held those medications when there were no orders to do so and replied, It's my nursing judgement. LPN D proceeded to hold the medications from R89. There was no attempt to notify the physician the medications were held. According to R89's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and dementia. The physician's medication orders were reviewed and included the following. Isosorbide Mononitrate ER 30 mg 24-hour release, for coronary artery disease with stable angina.Metoprolol Succinate ER 50 mg 24-hour tablet for Atrial Fibrillation.Amiodarone 100 mg for Atrial Fibrillation.There were no parameters (measurable factor or condition) prescribed to administering any of the medications. Continuation of R89's medication reconciliation revealed the following Physician's order on 9/19/25 was not transcribed onto the Medication Administration Record; Tiotropium 2.5 MCG (microgram)/ACT (breath actuated) inhaler, 2 Inhalations by inhalation daily. R89 did not receive that medication for three consecutive days 9/20/25, 9/21/25, and 9/22/25. On 9/23/25 at 9:45 AM during an interview with Director of Nursing (DON) Nurse Unit Manager Registered Nurse (RN) E regarding holding the medications for R89 the DON said, There are no parameters for those medications to be held. Those medications should have been given. A Blood Pressure of 109/59 isn't considered low. I can't explain why the nurse did not give those medications. The physician will be notified. During the interview regarding R89's transcription error RN E confirmed that R89 was prescribed two inhalers upon admission, but only one was transcribed on the MAR. RN E said, Yes the Tiotropium 2.5 MCG/ACT was missed and not put on the MAR. I think there was a discussion about that with the doctor, but I can't recall and there is no documentation about it. I will call the doctor for clarification. According to the facility's Administering Medications policy last revised 4/2019 in part reads: Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.According to the facility's Medication Holds policy last revised 4/2007 in part reads: A temporary medication hold may be ordered by the resident's attending physician.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have a medication error rate below 5%.Findings include:During the medication administration task nine errors were observed from 34 opportunities and subsequently a 26.47% medication error rate. R89 On 9/23/2025 at 8:38 AM during observation of R89's medication administration, Licensed Practical Nurse (LPN) D withheld the following three medications from R89 without an order to do so: 1) Isosorbide Mononitrate Extended Release (ER) 30 mg 24-hour release, 2) Metoprolol Succinate ER 50 mg, and 3) Amiodarone 100 mg. Continued observation of R89's medication administration revealed the following three medications were not given because LPN D said they were not available: 4) Vitamin B-12 oral tablet, 5) Omega-3 1000 mg capsule, 6) Ferrous Sulfate 325 mg tablet. There was no attempt to search the medication cart, go to the medication room or back-up box, notify the nurse unit manager, pharmacy, or resident's physician of the missing medications. LPN D marked the medications were not given on the R89's MAR and proceeded to the administer medication to the next resident. R89's Physician's orders and Medication Administration Record (MAR) were reviewed with LPN D. It was confirmed there were no Physician's orders to hold those medications. There were no blood pressure parameter orders for when those medications could be administered. LPN D was then asked why they held those medications when there were no orders to do so and replied, It's my nursing judgement. LPN D proceeded to hold the medications from R89. There was no attempt to notify the physician the medications were held. LPN D was asked about the missing medications and said, I'll have to see where they are. Most of them are floor stock and should be somewhere. LPN D confirmed the facility had a back-up box with medications but made no attempt to acquire the missing medications. According to R89's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and dementia. The physician's medication orders were reviewed and included the following. 1) Isosorbide Mononitrate ER 30 mg 24-hour release, for coronary artery disease with stable angina.2) Metoprolol Succinate ER 50 mg 24-hour tablet for Atrial Fibrillation.3) Amiodarone 100 mg for Atrial Fibrillation. There were no parameters (measurable factor or condition) prescribed to administering the above three medications.4) Aspirin 81 milligrams (mg) 1 tablet daily by mouth.5) Omega-3 1000 mg capsule 1 time a day by mouth6) Ferrous Sulfate 325 mg tablet 1 time a day by mouth. R48: On 9/23/2025 at 8:58 AM during observation of R48's medication administration, Licensed Practical Nurse (LPN) D did not administer the following three medications. LPN D said, There is no aspirin in the cart, and the Metformin and Losartan are missing. There was no attempt made by LPN D to locate the ordered medications. According to R48's EHR the resident admitted to the facility on [DATE] with multiple diagnoses that included A-fib and Diabetes, type 2. The physician's medication orders were reviewed and included the following. 7) Metformin HCL 500 mg 1 tablet by mouth 2 x day. 8) Losartan Potassium 100 MG Oral Tablet give 1 time a day by mouth. 9) Aspirin 81 mg 1 time a day by mouth. On 9/23/25 at 9:45 AM during an interview with Director of Nursing (DON) and Nurse Unit Manager Registered Nurse (RN) E R89's Electronic Health Record (EHR) was reviewed. The DON was queried about RN D holding the medications for R89. The DON said, There are no parameters for those medications to be held. Those medications should have been given. A Blood Pressure of 109/59 isn't considered low. I can't explain why the nurse did not give those medications. The physician will be notified. Further inquiry regarding R89's missing medications was reviewed with RN E. They said, Aspirin, Omega-3, and Iron (Ferrous Sulfate) are all floor stock. They are in the cart, or we can get them from our medication room. RN E inspected the medication cart, and all three medications (Aspirin 81 mg, Omega-3 1000 mg, and Ferrous Sulfate 325 mg) were observed in the medication cart. RN E could not explain why LPN D did not give those medications. RN E then proceeded to the medication room and obtained the following medications for R48 in the back-up box; Metformin 500 mg (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Losartan Potassium 100 mg. According to the facility's Administering Medications policy last revised 4/2019 in part reads: Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.According to the facility's Medication Holds policy last revised 4/2007 in part reads: A temporary medication hold may be ordered by the resident's attending physician.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one (R89) of four residents reviewed for Medication Administration was free from a significant medication error resulting in R89 missing three doses of a prescribed inhaler; Tiotropium 2.5 MCG (microgram)/ACT (breath actuated) inhaler.Findings include:On 9/23/2025 at 8:38 AM, R89 was selected for observation of medication administration with Licensed Practical Nurse (LPN) D. During R89's medication reconciliation review it was determined the following Physician's order on 9/19/25 was not transcribed onto the Medication Administration Record; Tiotropium 2.5 MCG (microgram)/ACT (breath actuated) inhaler, 2 Inhalations by inhalation daily. R89 did not receive that medication for three consecutive days 9/20/25, 9/21/25, and 9/22/25. According to R89's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and dementia. The hospital physician's admission orders on 9/19/25 were reviewed and included the following order: Tiotropium 2.5 MCG (microgram)/ACT (breath actuated) inhaler, 2 Inhalations by inhalation daily. There were no progress notes regarding the change in medication orders. There were no progress notes regarding the change in admission orders. The admission orders were documented by Unit Manager Registered Nurse (RN) E.On 9/23/25 at 9:45 AM during an interview with Director of Nursing (DON) and RN E, RN E confirmed that they completed the admission orders for R89 and had reviewed the medications with the physician. RN E confirmed that R89 was prescribed two inhalers upon admission, but only one was transcribed on the MAR. RN E said, Yes the Tiotropium 2.5 MCG/ACT was missed and not put on the MAR. I think there was a discussion about that with the doctor, but I can't recall and there is no documentation about it. I will call the doctor for clarification. The DON confirmed that R89 had missed three doses of the Tiotropium inhaler on 9/20/2025, 9/21/2025, and 9/22/2025.According to the facility's Administering Medications policy last revised 4/2019 in part reads: Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.