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

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)
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 (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.