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GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

May 26, 2022

Eliyahu Gabay True Care Living 565 General Ave. Springfield, MI 49037

> RE: License #: AH130405658 Investigation #: 2022A1028042 True Care Living

Dear Mr. Gabay:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff Bureau of Community and Health Systems Unit 13, 7th Floor 350 Ottawa, N.W. Grand Rapids, MI 49503 Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH130405658	
Investigation #:	2022A1028042	
Commission Descript Date:	05/40/0000	
Complaint Receipt Date:	05/12/2022	
Investigation Initiation Date:	05/12/2022	
Investigation Initiation Date:	05/12/2022	
Report Due Date:	07/11/2022	
Report Due Dute.	01/11/2022	
Licensee Name:	True Care Living Limited Liability Corporation	
Licensee Address:	16135 Stratford Drive	
	Southfield, MI 48075	
Licensee Telephone #:	(818) 288-0903	
Authorized		
Representative/Administrator:	Eliyahu Gabay	
Name of Facility:	True Care Living	
Name of Facility.	True Care Living	
Facility Address:	565 General Ave.	
r domey reduced:	Springfield, MI 49037	
	,	
Facility Telephone #:	(269) 968-3365	
Original Issuance Date:	03/25/2021	
License Status:	REGULAR	
Effective Deter	00/05/0004	
Effective Date:	09/25/2021	
Expiration Date:	09/24/2022	
Expiration Date.	03/27/2022	
Capacity:	69	
- apaony.		
Program Type:	AGED	
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II. ALLEGATION(S)

Violation Established?

The facility is not providing Resident A assistance with personal care.	No
The facility has bed bugs.	No
Additional Findings	Yes

III. METHODOLOGY

05/12/2022	Special Investigation Intake 2022A1028042
05/12/2022	Special Investigation Initiated - Letter
05/12/2022	APS Referral APS made referral to HFA.
05/18/2022	Contact - Face to Face Interviewed AR/Administrator, Eli Gabay, at the facility.
05/18/2022	Contact - Face to Face Interviewed Employee A at the facility.
05/18/2022	Contact - Face to Face 2022A1028042 – Interviewed Employee B at the facility.
05/18/2022	Contact - Face to Face 2022A1028042 - Interviewed Employee Cat the facility.
05/18/2022	Contact - Face to Face 2022A1028042 – Interviewed Employee D at the facility.
05/26/2022	Exit Interview

ALLEGATION:

The facility is not providing Resident A assistance with personal care.

INVESTIGATION:

On 5/12/2022, the Bureau received this complaint from online complaint system.

On 5/12/2022, a referral was made to APS through Centralized Intake.

On 5/12/2022, I interviewed facility authorized representative/administrator, Eli Gabay, at the facility. Mr. Gabay reported Resident A is modified independent with most care except for bathing. Mr. Gabay reported Resident A is currently in the hospital due to a recent incident and is expected to return to the facility and the service plan and level of care will be reevaluated upon Resident A's return.

On 5/18/2022, I interviewed Employee A at the facility. Employee A reported Resident A collapsed in [their] room on 5/11/2022 and was sent to the hospital. Resident A is their own guardian and does not require much personal assist, other than assist with bathing for safety. Resident A receives showers twice weekly but may request additional showers if needed. Resident A is modified independent with toileting and ambulation within the facility. Employee A reported Resident A is "very particular about hygiene" and usually has very good hygiene but due to a recent skilled nursing rehab stay between February 2022 to March 2022, Resident A has required intermittent reminders for hygiene. Employee A reported Resident A "hasn't really bounced back since the skilled rehab stay, but we are continuing to monitor [them]". Employee A reported Resident A was modified independent with toileting and was not soiled prior to leaving for the hospital in the emergency transport. Employee A provided me Resident A's service plan and chart notes for my review.

On 5/18/2022, I interviewed Employee B at the facility. Employee B reported Resident A is their own person and requires little to no assistance with care other than bathing. Resident A receives two showers weekly but may request additional showers as well. However, since a prior skilled nursing rehab stay, "[Resident A] can require reminders to change clothes or complete grooming". Due to requiring increased intermittent cuing, a request was submitted by the facility to Resident A's physician for a reevaluation of Resident A, but Resident A collapsed in [their] room on 5/112022 before it could be completed. To Employee B's knowledge, Resident A was not sent to the hospital with a soiled brief. Resident A "has not had any prior issues with toileting and the soiling could have occurred while in route to the hospital". Resident A is expected to return to the facility and will be subsequently reevaluated by [their] physician and the facility to determine the appropriate level of care.

On 5/18/2022, I interviewed Employee C at the facility. Employee C's statements are consistent with Mr. Gabay's, Employee A's, and Employee B's statements.

On 5/19/2022, I reviewed Resident A's service plan with chart notes, which revealed Resident A is independent with toileting and ambulation inside the facility. Resident A requires supervision for ambulation outside of the facility for safety. Resident A

requires intermittent cuing and/or reminders for dressing and grooming. The facility provides assist with setup for bathing and assistance with housekeeping, laundry, meals, and medications. Resident A receives at minimum showers twice weekly but may request additional showers. Facility staff also provides at minimum six checks daily on Resident A to ensure safety. The service plan was last updated 3/3/2022.

APPLICABLE RULE		
R 325.1933(2)	Personal care of residents.	
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.	
ANALYSIS:	On 5/11/2022, Resident A collapsed and was sent to the hospital. It is alleged that Resident A was not provided personal hygiene care by the facility and that Resident A arrived at the hospital with a soiled brief.	
	Interviews along with documentation review reveal it cannot be determined if Resident A soiled [their] brief due to [their] collapse at the facility or in route to the hospital. However, there is evidence the facility provided appropriate personal hygiene care in accordance with Resident A's service plan. The facility also demonstrates compliance with alerting physician to request reevaluation of Resident A due to noticeable change in behavior and/or condition concerning level of care.	
CONCLUSION:	VIOLATION NOT ESTABLISHED	

ALLEGATION:

The facility has bed bugs.

INVESTIGATION:

On 5/18/2022, Mr. Gabay reported there are two rooms that are continuing to require continuous treatment due to bed bugs. Mr. Gabay reported Resident A's room is one of the rooms that is still being treated and that he conferenced with the pest control company for the best course of action for Resident A. The pest control company advised Mr. Gabay to not move Resident A into another room due to the high risk of

spreading the bed bugs further into the facility. Resident A's room can be treated by the pest control company without compromising the health or safety of Resident A.

On 5/18/2022, Employee A reported the facility is still working on eliminating bed bugs and has been able to reduce the spread in the facility and limit it to only two rooms currently. Employee A reported the facility is treated by the pest control company monthly and there is a continuous treatment contract in place. Employee A reported it has been very difficult and costly to eliminate the bed bugs, but it is continually being addressed.

On 5/18/2022, Employee B's statements are consistent with Mr. Gabay's and Employee A's statements.

On 5/18/2022, I interviewed Employee D at the facility. Employee D reported the bed bug situation has been ongoing since the building was acquired in January 2021. Employee D reported bed bugs have been eliminated from the entire building except for two rooms. One of the rooms affected belongs to Resident A. Employee D reported the facility considered moving Resident A to another room, but the pest control company advised the facility against it to prevent further infestation. Resident A's room is being chemically safely and with heat to prevent compromising Resident A's health. Employee D reported it has been difficult to eliminate the bed bugs, but the facility has a routine contract in place with a local pest control company to continue to address it. Employee D provided me documentation of the pest control services routine services and contract.

On 5/18/2022, I reviewed the pest control service documentation which revealed multiple monthly treatments throughout the facility for bed bugs dating back to 4/15/2021.

APPLICABLE RULE		
R 325.1978	Insect and vermin control.	
	(1) A home shall be kept free from insects and vermin.(2) Pest control procedures shall comply with MCL 324.8301 et seq.	

ANALYSIS:	After the facility was purchased in January 2021, bed bugs were discovered in the facility. The facility management took immediate action in January 2021 to address the issue and to continue to ensure good care was provided to the residents.
	While the facility does currently have bed bugs, it is contained to two rooms on the first floor only. The facility continues to treat appropriately and is also enrolled in a continuous extermination program to address any further issues and to prevent any future outbreak occurrences.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

APPLICABLE RULE		
R 325.1924	Reporting of incidents, accidents, elopement.	
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.	
ANALYSIS:	Review of facility department file reveals no incident report was submitted for Resident A's recent hospitalization beginning 5/11/2022.	
	Resident A is own person and does not have an authorized representative. While there is evidence of facility charting for Resident A, it cannot be determined if Resident A's physician was notified of the recent hospitalization due to no incident report being submitted to the department.	
CONCLUSION:	VIOLATION ESTABLISHED	

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend the status of this license remain the same.

July horano

5/23/2022

Julie Viviano	Date
Licensing Staff	

Approved By:

05/25/2022

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