GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 16, 2024

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

RE: License #: AH130405658
Investigation #: 2025A1028002
True Care Living

Dear Eliyahu 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

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

I. IDENTIFYING INFORMATION

License #:	AH130405658
Investigation #:	2025A1028002
Complaint Receipt Date:	10/03/2024
Investigation Initiation Date:	10/03/2024
Report Due Date:	12/02/2024
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
Facility Address:	565 General Ave. Springfield, MI 49037
Facility Telephone #:	(269) 968-3365
Original Issuance Date:	03/25/2021
License Status:	REGULAR
Effective Date:	09/25/2023
Expiration Date:	09/24/2024
Capacity:	147
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A incurred a fall and when emergency services arrived, Resident A was found unattended in the lobby.	Yes
Resident A was provided Lorazepam prior to emergency services arriving but it is not on Resident A's medication list.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/03/2024	Special Investigation Intake 2025A1028002
10/03/2024	Special Investigation Initiated - Letter
10/03/2024	APS Referral
10/03/2024	Contact - Face to Face Interviewed Employee A at the facility.
10/03/2024	Contact - Face to Face Interviewed Employee B at the facility.
10/03/2024	Contact - Face to Face Interviewed Employee C at the facility.
10/03/2024	Contact - Face to Face Interviewed Employee D at the facility.
10/03/2024	Contact - Document Received Received requested documentation from Employee A at the facility.

ALLEGATION:

Resident A incurred a fall and when emergency services arrived, Resident A was found unattended in the lobby.

INVESTIGATION:

On 10/3/2024, the Bureau received the allegations through the online complaint system.

On 10/3/2024, I interviewed Employee A at the facility who reported Resident A incurred a fall out of bed on 10/2/2024 with facility staff calling emergency services to transport Resident A to the hospital for further evaluation and treatment. Employee A reported to [their] knowledge, a staff member was sitting with Resident A in the lobby when emergency services arrived but [they] did not witness it. Employee A reported Resident A incurred a wrist injury from the fall and returned to the facility later with a soft cast on. I requested documentation from Employee A, but Employee A reported the staff on duty did not complete any documentation of the incident.

On 10/3/2024, I interviewed Employee B at the facility who reported [they] supervised staff during the shift Resident A fell. Employee B reported another staff member sat with Resident A in the lobby until emergency services arrived, but [they] were not present the entire time to confirm if Resident A was left unattended or not. Employee B reported to [their] knowledge, Resident A was not left unattended at any time prior to or when emergency services arrived.

On 10/3/2024, I interviewed Employee C at the facility whose statement was consistent with Employee A's statement and Employee B's statement.

On 10/3/2024, I interviewed Employee D at the facility who reported [they] were with Resident A when EMS services arrived and until EMS services took Resident A to the hospital. Employee D reported Resident A was not left unattended.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
	R 325.1901(17) - Definitions. **An incident or accident that results in a sudden adverse change in a resident's condition requiring unplanned hospitalization or treatment in a hospital emergency room is reportable.**

	An illness that results in hospitalization that is not part of a resident's natural progression of a disease is reportable.
ANALYSIS:	It was alleged Resident A incurred a fall and when EMS services arrived, Resident A was found unattended in the lobby. Interviews and on-site investigation reveal that while staff members interviewed had consistent statements pertaining to Resident A's fall, calling emergency services, and Resident A not being left unattended, there is no documentation to support the staff's statements. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was provided Lorazepam prior to emergency services arriving but it is not on Resident A's medication list.

INVESTIGATION:

On 10/3/2024, Employee A reported to [their] knowledge Resident A has a prescription for Lorazepam to be administered as needed and that Resident A was given Lorazepam in the morning of 10/2/2024, prior to Resident A's fall. Employee A reported the medication list provided to emergency services should match Resident A's medication administration record (MAR). Employee A provided me the requested documentation for my review.

On 10/3/2024, Employee B confirmed Resident A has a prescription for Lorazepam to take as needed and that Resident A was administered it on 10/2/2024 in the morning. Employee B reported that medication lists provided to emergency services does not always match the medication administration records because it does not update automatically, and staff are inconsistent with manually entering or correcting medication physician orders.

On 10/3/2024, Employee C's statement was consistent with Employee B's statement.

On 10/3/2024, I reviewed the requested documentation which revealed the following:

- Resident A is to take one tablet by mouth of 0.5mg of Lorazepam twice a day as needed.
- The medication administration record for 10/2/2024 is blank for Resident A's medication administration of Lorazepam.

- The medication administration record and the medication list provided to emergency services shows discrepancies, as Lorazepam is not listed on the medication list that was provided to emergency services.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged Resident A was provided Lorazepam prior to emergency services arriving but it is not on Resident A's medication list. Interviews and on-site investigation reveal staff were knowledgeable about Resident A being administered Lorazepam in the morning on 10/2/2024 prior to Resident A's fall. However, review of documentation reveals there are discrepancies between the medication list provided to emergency services when they arrived at the facility to address Resident A's fall and Resident A's medication administration record. The medication list does not reflect Resident A's as needed prescription for 0.5mg tablet of Lorazepam. The records do not match and therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

INVESTIGATION:

On 10/3/2024, when Resident A's medication administration record was reviewed, it was noted to be blank for 10/2/2024, despite staff interviews confirming Resident A has been administered Lorazepam in the morning of 10/2/2024.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.**

	(ii) The prescribed required dosage and the dosage that was administered. **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	During staff interviews, staff confirmed Resident A was administered Lorazepam the morning of 10/2/2024. However, review of the medication administration record revealed it was blank for this medication administration. Staff were not compliant with correctly documenting Resident A's medication administration in the record. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

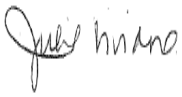
On 10/3/2024, on-site investigation revealed no documentation or incident report was recorded by staff pertaining to Resident A's fall with injury and subsequent visit to the hospital for evaluation and treatment.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(1) A home for the aged must implement and maintain a quality review program consistent with section 20175(8) of the act, MCL 333.20175, and the professional review function. The program is responsible for all of the following: **(a) Reviewing and evaluating incidents.** **(b) Identifying effective means to correct any deficient practice.** **(c) Ensuring resident safety and quality of care.** **(d) Improving procedures.**

ANALYSIS:	On-site investigation on 10/3/2024 revealed no documentation or incident report pertaining to Resident A's fall with injury and subsequent visit to the hospital for evaluation and treatment could be provided. Staff did not document the incident in the record. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



10/14/2024

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Julie Viviano Date
Licensing Staff

Approved By:

10/15/2024

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