GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 17, 2021

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

RE: License #: AH130405658
Investigation #: 2021A1028038
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 that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-01800.

Sincerely,

Julie Viviano

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 #:	2021A1028038
Complaint Receipt Date:	08/17/2021
Investigation Initiation Date:	08/18/2021
Report Due Date:	09/16/2021
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:**	TEMPORARY
Effective Date:	03/25/2021
Expiration Date:	09/24/2021
Capacity:	55
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not issue Resident a less than 30-day discharge in accordance with the rules.	Yes
Resident A was not a serious risk to self or others to warrant being issued a less than 30-day discharge.	No
The facility did not follow Resident A's service plan.	No

III. METHODOLOGY

08/17/2021	Special Investigation Intake 2021A1028038
08/18/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
08/18/2021	APS Referral APS referral emailed to Centralized Intake
09/08/2021	Contact - Face to Face Interviewed care staff: Malynda Sofia, Calina Vandermoore, Rannette Dilling, Judy Correnti and Sonya Jones at the facility
09/10/2021	Contact – Telephone call made Interviewed facility authorized representative/administrator, Eli Gabay, by telephone
09/10/2021	Contact – Telephone call made Made third attempt to contact the complainant
09/13/2021	Contact – Document received Received facility discharge documentation from Eli Gabay
9/17/2021	Exit Interview

ALLEGATION:

The facility did not issue Resident A a less than 30-day discharge in accordance with the rules.

INVESTIGATION:

On 8/17/21, the Bureau received the allegations from the online complaint system.

On 8/17/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 9/8/21, I interviewed care director Malynda Sofia at the facility. Ms. Sofia reported Resident A was admitted to the facility in July 2021 and Resident A was their own person and independent with decision making. Resident A signed the admission contract as their own representative and participated in development of their service plan. Ms. Sofia reported Resident A could complete some self-care and transferring without assistance. However, Ms. Sofia reported shortly after admission, Resident A began to refuse to complete any care for themselves and began demanding staff complete all care. Ms. Sofia reported Resident A would also leave the facility without letting anyone know and would return intoxicated, often disrupting other residents and was belligerent to staff. Ms. Sofia reported management met with Resident A multiple times to address the issue and warn Resident A that if the behavior continued, the facility would have to issue a discharge due to harm to self and for non-compliance. Ms. Sofia reported Resident A was issued the discharge notice on 7/29 and left the facility on 8/1. Ms. Sofia reported Resident A "went to live with family" with family helping Resident A move out of the facility. Ms. Sofia provided me a copy of Resident A's service plan, admission contract, and record notes.

I interviewed care staff manager Calina Vandermoore at the facility. Ms. Vandermoore's statement are consistent with Ms. Sofia's statements. Ms. Vandermoore reported Resident A did not comply with the facility rules, even though Resident A would promise to comply each time the behaviors were addressed by facility staff and management. Ms. Vandermoore reported discharge was discussed with Resident A due to demonstrated unsafe behaviors prior to being issued. Ms Vandermoore reported Resident A left with family the day after the discharge was issued.

I interviewed care staff person (CSP) Rannette Dilling at the facility. Ms. Dilling reported Resident A "didn't want to obey the rules and was unsafe." Ms. Dilling reported when Resident A first entered the facility, "[Resident A] completed most things with little to no assist, but as time went [Resident A] demanded staff help with everything". Ms. Dilling reported Resident A began to soil their garments often, requesting staff assistance. Staff would attempt to assist, and Resident A would then refuse staff help becoming belligerent with staff. Ms. Dilling reported "[Resident A]

would not help [themselves] and would not get up unless [they] wanted to". Ms. Dilling reported "[Resident A] was warned several times about being discharged for self-harm, for disrupting the other residents here, and for not following the rules". Ms. Dilling reported Resident A was discharged and went to live family.

I interviewed CSP Judy Correnti at the facility. Ms. Correnti's statements are consistent with Ms. Sofia's statements, Ms. Vandermoore's statements, and Ms. Dilling's statements. Ms. Correnti reported Resident A refused to comply with staff directions and "did not want to follow the rules". Ms. Correnti reported knowledge of Resident A being issued a discharge due to unsafe behaviors "after being spoken to several times by us and management."

I interviewed staff person Sonya Jones at the facility. Ms. Jones' statements are consistent with Ms. Sofia's statements, Ms. Vandermoore's statements, Ms. Dilling's statements, and Ms. Correnti's statements. Ms. Jones reported knowledge of an impending discharge for Resident A due to demonstrated unsafe behaviors.

On 9/10/21, I interviewed facility authorized representative/administrator Eli Gabay by telephone. Mr. Gabay's statements are consistent Ms. Sofia's statements, Ms. Vandermoore's statements, Ms. Dilling's statements, and Ms. Jones' statements. Mr. Gabay reported Resident A was his own representative upon entering the facility. Mr. Gabay reported Resident A refused to participate in self-care and often refused to participate in dialysis and diabatic treatments. The facility attempted to assist Resident A in meeting these scheduled treatments, but Resident A refused. Mr. Gabay reported he gave Resident A several wanrings before issuing a discharge about the escalating behaviors of returning to the facility intoxicated, disrupting other residents, for being belligerent to staff, and due to noncompliance of facility rules and staff requests to ensure safety. Mr. Gabay reported Resident A would not comply with the facility rules and continued demonstrate harmful behavior, despite agreeing to comply each time it was discussed with Resident A. Mr. Gabay reported he really tried to work with Resident A, but Resident A refused to comply with safety rules, staff directions, and facility rules. Mr. Gabay reported issuing the discharge notice on 7/29 with "[Resident A] packing up [their] things and leaving the facility on 8/1 with the [ex-spouse] and daughter helping [Resident A] move out. [Resident A] said [they] were going to live with their [ex-spouse] and daughter and they said [Resident A] was going to live with them because they could take better care of [Resident A]".

I reviewed Resident A's admission contract, service plan, and record notes which revealed the following:

- Resident A's admission contract is signed by Resident A. Resident signed as their own representative.
- Resident A's is independent with managing medications. Resident A is modified independent with transferring and use of mobility aids. Resident A requires assist with bathing, dressing, and grooming (specifically

toe/fingernail care due to diabetes diagnosis). Resident requires min assist with toileting and was not a on a toileting program. Resident A manages own finances and has emotional and physical support from family intermittently.

- Record notes reveal Resident A was oriented to person, place, and time upon enter the facility. Record notes also reveal Resident A's refusal of medical appointments/treatments and three separate events of soiling of self with refusal of staff assistance to clean up and refusal of overall assistance from staff. Resident A left the facility on 8/1 to live with ex-spouse and daughter.

On 9/13/21, I received facility discharge documentation from Mr. Gabay.
Review of discharge notice revealed a discharge notice was dated 7/19 for Resident A and Resident A signed acknowledgment of receipt of the discharge. The discharge read

"*The purpose of this letter is to notify you that you are being medically discharged from True Care Living. You must vacate the premises located at 565 General Ave. Springfield, MI 49037, Room 105S.*

1. *For Resident Safety*
   a. *Non Compliance with medication and dialysis treatment*
   b. *Residents are to have the cognitive and physical ability to be transported without assistance. This is to be verified by a physician statement. Otherwise, residents are not allowed to be transported without assistance.*
   c. *Should a resident require accompaniment/assistance of any kind, the family/guardian arranges such assistance prior to transportation of the resident.*
   d. *Alcohol use in facility and while driving on or off True Care Living property, poses a risk to both yourself and other residents. We have confirmed that you have driven while intoxicated multiple times."*

I have been unsuccessful in contacting the complainant, so I am currently unable to verify concerns or information.

I have been unsuccessful in contacting Resident A, so I am currently unable to verify concerns or information.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.**

ANALYSIS:	Interviews with the facility authorized representative, administrator and care staff reveal Resident A signed all facility documentation as their own representative. Resident A was issued a less than 30-day discharge dated 7/19/21 for noncompliance of facility rules, continued refusal of medical treatments, and for unsafe behaviors resulting from the consumption of alcohol. Resident A signed acknowledgement of the discharge notice. Review of facility documentation along with the discharge reveal evidence that supports Resident A demonstrated substantial risk of harm to self and others at the facility. However, the discharge issued to Resident is not consistent with the rules. The discharge does not contain the following: • Alternatives to discharge that have been implemented by the home, if any. • The location to which the resident will be discharged. • The right of the resident to file a complaint with the department. • That APS and the department were contacted upon issuance. • The right of the resident to return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plans if the department find the resident was improperly discharged.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was not a serious risk to self or others to warrant being issued a less than 30-day discharge.

INVESTIGATION:

On 9/8/21, Ms. Sofia reported Resident A would leave the facility without notice, "returning drunk and unable to care for self. [Resident A] would scream at staff and residents, even [their] roommate, demanding help and then refusing staff help. We tried to educate Resident A about the consequences of drinking because [they] also had health issues, but [they] would not listen". Ms. Sofia reported it was a difficult situation because "[Resident A] was their own person and could make their own decisions". Ms. Sofia reported staff did not see Resident A consume alcohol while at

the facility, but Resident A smelled heavily of alcohol and demonstrated intoxicated behaviors upon returning to the facility on several occasions.
Ms. Dilling reported Resident A would leave the facility, not notify anyone before leaving, and return intoxicated. Ms. Dilling reported to her knowledge this happened at minimum on four occasions. Resident A was often belligerent with staff upon returning intoxicated to the facility. Ms. Dilling reported Resident A "had [their] own vehicle and would drive [themselves] home drunk from wherever." Ms. Dilling reported she did not witness Resident A consume alcohol at the facility but Resident A would "return after a night out of drinking, reeking of alcohol." Ms. Dilling reported Resident A would then demonstrate impaired abilities and was unable complete any self-care upon returning to the facility. Ms. Dilling reported Resident A's roommate had to be relocated to another room due to Resident A disrupting the shared living space with Resident A being belligerent to the roommate as well. Ms. Dilling also reported Resident A began to refuse scheduled diabetic and dialysis treatments as well. Ms. Dilling reported staff would try to assist Resident A to meet the appointment obligations and the mobile dialysis unit came to see Resident A at the facility, but Resident A continued to refuse medical treatments.

Ms. Correnti's statements are consistent with Ms. Sofia's statements, and Ms. Dilling's statements. Ms. Correnti reported Resident A would leave the facility without notice sometimes and then return intoxicated, often disrupting other residents, "yelling and screaming at staff. [Resident A] would scream at staff for help and then refuse our help. [Resident A] also drove drunk and we and management all spoke with [them] about how unsafe this was, but [they] did not want to listen". Ms. Correnti reported Resident A would also refuse to participate in dialysis treatment even though the mobile dialysis unit would come to the facility to meet Resident A's needs.

Ms. Jones' statements are consistent with Ms. Sofia's statements, Ms. Vandermoore's statements, Ms. Dilling's statements, and Ms. Correnti's statements. Ms. Sofia's statements, Ms. Vandermoore's statements, and Ms. Dilling's statements. Ms. Jones reported she witnessed Resident A returning to the facility intoxicated a few times. Ms. Jones reported while she did not see Resident A drink alcohol, Resident A smelled heavily of alcohol and had slurred speech upon returning to the facility on several occasions. Ms. Jones also reported Resident A was unable to transfer from their vehicle and was unable to help propel wheelchair due to being intoxicated. Ms. Jones also reported Resident A would soil themselves when intoxicated, refusing staff help to clean up. Ms. Jones reported the last time she witnessed Resident A return intoxicated at the facility, "[Resident A] was out in the parking lot in [their] car, blaring on the horn screaming for people to come help." Ms. Jones reported she went out to assist resident and it took three staff members to assist Resident A safely back inside.

On 9/10/21, Mr. Gabay reported Resident A began to demonstrate increased behaviors shortly after admission to the facility. Mr. Gabay reported Resident A would leave the facility without letting anyone know and return intoxicated. Mr.

Gabay reported Resident A had own vehicle and would drive intoxicated to return to the facility. Mr. Gabay reported Resident A would be belligerent to staff, other residents, and roommate upon returning intoxicated disrupting the facility. Resident A would also lose control of their bodily functions when intoxicated and refuse staff assistance to clean up. Resident A also refused dialysis and diabetic treatments, despite the treatments being offered on-site at the facility. Mr. Gabay reported having several discussions with Resident A to rectify the unsafe behaviors so Resident A could remain safely in the facility, but Resident A would not comply or listen to management or staff.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(8) A home shall not retain a resident if the resident has harmed himself or herself or others or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others unless the home has the capacity to manage the resident's behavior.
AN/ALYSIS:	Interviews with the facility authorized representative, administrator and care staff along with review of facility documentation reveal Resident A would leave the facility without notice, consume alcohol outside the facility and then return to the facility intoxicated. Resident A's continued episodes of intoxication affected Resident A's ability to perform or participate with self-care. In addition, Resident A also refused medical treatments, demonstrated belligerence to staff, and disruption of other residents in the facility to include [Resident A's] roommate. Due to Resident A's demonstrated and documented behaviors, Resident A posed a serious risk to self and others by continuing to consume alcohol outside of the facility and returning intoxicated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not follow Resident A's service plan.

INVESTIGATION:

On 9/8/21, Ms. Sofia reported Resident A participated in the development of the service plan. Ms. Sofia reported Resident A was their own representative and could complete some self-care and transferring without assistance. However, Ms. Sofia reported shortly after admission, Resident A quit participating in any self-care and began to demand staff complete all care. Ms. Sofia reported Resident A would also refuse assist from staff and would soil themselves and choose to remain soiled, despite staff offering assistance. Ms. Sofia reported the facility was in the process of re-evaluating Resident A's service plan, but Resident A was non-compliant with participation. Ms. Sofia provided me a copy of Resident A's service plan and record notes for my review.

Ms. Vandermoore's statement are consistent with Ms. Sofia's statements. Ms. Vandermoore reported Resident A participate in self-care and demonstrated some modified independence with self-care upon admission. However, Ms. Vandermoore reported Resident "quit doing things for [themselves] and began to rely heavily on staff to complete all self-care." Ms. Vandermoore reported Resident A would then refuse any staff attempts to assist with self-care when staff attempted. Ms. Vandermoore reported the facility was re-evaluating Resident A's service plan due to the significant decrease in participation of self-care and demonstrated behaviors.

Ms. Dilling's statements are consistent with Ms. Sofia's statements. Ms. Dilling reported Resident A would "pee all over [self] and the bed and would sit in it, refusing to get up and refusing help to clean up." Ms. Dilling reported Resident A "gave up" on any self-care despite staff attempts and encouragement.

Ms. Correnti's statements are consistent with Ms. Sofia's statements, Ms, Vandermoore's statements, and Ms. Dilling's statements.

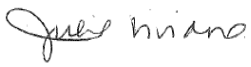
Mr. Gabay's statements are consistent Ms. Sofia's statements, Ms. Vandermoore's statements, and Ms. Dilling's statements. Mr. Gabay reported the facility was reassessing Resident A's service plan due to demonstrated behaviors before it was decided that a discharge needed to be issued.

On 9/13/21, I reviewed Resident A's service plan and records notes which revealed staff following the service plan appropriately. There is evidence of documented refusals by Resident A to participate in self-care and/or to allow staff to assist with care.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	Interviews with the facility authorized representative/administrator and care staff, along with review of the service plan and record notes, reveal Resident A participated in the development and planning of the service plan. There is evidence Resident A refused to participate in self-care and would refuse staff assistance as well. There is also evidence care staff continued to attempt to appropriately follow Resident A's service plan, despite Resident A's refusals of participation and staff assistance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION



9/13/21

_____

Julie Viviano Date
Licensing Staff

Approved By:

9/15/21

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Russell B. Misiak Date
Area Manager