GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2021

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

RE: License #:	AH130405658
Investigation #:	2022A1021015
	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 authorized representative 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH130405658
Investigation #:	2022A1021015
Complaint Receipt Date:	12/08/2021
Investigation Initiation Date:	12/08/2021
Report Due Date:	02/07/2022
Licensee Name:	True Care Living Limited Liability Corporation
Licensee Address:	16135 Stratford Drive Southfield, MI 48075
Licensee Telephone #:	(818) 288-0903
Administrator/ Authorized Representative:	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:	09/25/2021
Expiration Date:	09/24/2022
Capacity:	55
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive medical services.	Yes
Resident A observed to be dirty.	No
Additional Findings	Yes

III. METHODOLOGY

12/08/2021	Special Investigation Intake 2022A1021015
12/08/2021	Special Investigation Initiated - Telephone message left with complainant
12/08/2021	APS Referral APS denied the complaint
12/14/2021	Inspection Completed On-site
12/22/2021	Exit Conference Exit Conference with authorized representative Eliyahu Gabay

ALLEGATION:

Resident A did not receive medical services.

INVESTIGATION:

On 12/8/21, the licensing department received a complaint with allegations Resident A was not receiving physical and occupational home health services. The complainant alleged Resident A's catheter had not been changed in over one month.

On 12/8/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 12/8/21, I called and left a message with the complainant. The complainant did not contact me back and therefore I was unable to obtain additional information.

On 12/14/21, I interviewed Resident A at the facility. Resident A reported he was to have physical and occupational therapy at the facility. Resident A reported this has not been arranged for him. Resident A reported he has a catheter and no one at the facility is trained to change the catheter. Resident A reported he went to the hospital in early December and at the hospital, the staff changed the catheter bag to an overnight bag which has helped with the catheter bag not overfilling. Resident A reported he is responsible for emptying the catheter bag which he can do but he cannot change the catheter. Resident A reported when he was discharged from the hospital, he was to follow up with his urologist. Resident A reported this has not been arranged.

On 12/14/21, I interviewed assistant Calina Vandermoere at the facility. Ms. Vandermoere reported she is not aware Resident A was to have home health services. Ms. Vandermoere reported the facility is not responsible for catheter maintenance. Ms. Vandermoere reported Resident A was recently admitted to the hospital and the hospital staff changed the catheter. Ms. Vandermoere reported she is not aware of any follow up needed from the hospital.

On 12/14/21, I interviewed caregiver Tara L'Esperance at the facility. Ms. L'Esperance reported the urologist office contacted the facility inquiring about home nursing for Resident A. Ms. L'Esperance reported the facility does not have a preferred company for home nursing services. Ms. L'Esperance reported the urologist office was to send the order to the facility.

I reviewed Resident A's service plan. The service plan revealed Resident A has a catheter.

I reviewed chart notes for Resident A. The chart notes read,

"10/4: Resident referred to Urology for transfer of care. Resident will see Dr. Spencer.
11/3: Dr. Spencer called and said he was going to put an order in for a home nurse to come once a month to redo the bag and tubing."

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.**

For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Resident A was to have visiting nurse services to assist with catheter care and to support the wellbeing of Resident A. The facility did not appropriately follow up with the physician office to ensure Resident A received this medical care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A observed dirty.

INVESTIGATION:

The complainant alleged Resident A was observed dirty and smelt like urine.

On 12/14/21, I interviewed Resident A at the facility. Resident A reported he moved into the facility in September 2021. Resident A reported he has a catheter and it had not been changed in over a month. Resident A reported when he was in the hospital, the hospital staff changed the catheter. Resident A reported he has a leg bag for the catheter and now he has an overnight bag. Resident A reported there is no one trained at the facility to change the catheter. Resident A reported he receives a shower once weekly but does wish to receive a shower more frequently.

I observed Resident A at the facility. Resident A was in clean clothes and appeared to be clean. I did not smell any urine on Resident A or in his room.

Ms. Vandermoere reported Resident A admitted to the facility in September. Ms. Vandermoere reported Resident A has issues with his catheter such as it leaks, and Resident A does not empty the bag in a timely manner. Ms. Vandermoere reported Resident A has let the urine leak and spill out. Ms. Vandermoere reported the facility

is not responsible for any catheter care. Ms. Vandermoere reported often Resident A will refuse a shower. Ms. Vandermoere reported Resident A is depressed and is not motivated to care for himself. Ms. Vandermoere reported caregivers will offer Resident A a shower, but he will decline.

On 12/14/21, I interviewed caregiver Ranette Dilling at the facility. Ms. Dilling reported she can get Resident A to take a shower. Ms. Dilling reported she ensures Resident A receives a shower at least once a week. Ms. Dilling reported Resident A can empty his catheter himself. Ms. Dilling reported Resident A is depressed and sometimes requires extra encouragement to complete self-care tasks.

I reviewed Resident A's service plan. The service plan revealed Resident A required minimal assistance with bathing and preferred a shower.

I reviewed chart notes for Resident A. The chart notes read,

> *"10/2: At 6:30am resident was in the dining room soaked with urine, a full urine bag, and a puddle of urine under him. When asked to go to his room to get cleaned up resident tried to move to a different chair instead of going to room. After about 10 minutes he went to his room. Then at 9:30 when checking on resident he was laying in bed-soaked again with urine refusing to get up to get cleaned up. I kept going back every 5 to 10 minutes for a hour. Resident told me that I was hitting him and then another resident told him that no one him. (Resident A) looked at me and said he was going to hit me.*
> *10/10: Resident refused to change clothes and refused to empty bag when asked by staff.*

APPLICABLE RULE	
R 325.1933	**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:	Interviews with Resident A and caregivers at the facility revealed Resident A is bathed once a week, but at times Resident A will refuse the shower. There is lack of evidence to support the allegation Resident A is not bathed at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

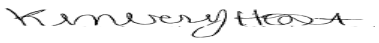
Resident A's service plan read,
"Toileting Aids: Catheter"

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.
Reference: R325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
Review of Resident A's service plan revealed lack of detail regarding his specific care needs. His care plan identified he was not on a toileting program and that he did have a catheter. However, it is not known if Resident A requires staff assistance with the catheter or if he is independent with catheter care. In addition, there is lack of detail for staff members to know actions to take if there is an issue with the catheter.	

On 12/22/21, I conducted an exit conference with authorized representative Eliyahu Gabay. Mr. Gabay had no questions regarding the findings in this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



12/22/2021

Kimberly Horst — Date
Licensing Staff

Approved By:

12/22/2021

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