GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2022

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

RE: License #: AH130405658
Investigation #: 2022A1028045
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 #:	2022A1028045
Complaint Receipt Date:	05/17/2022
Investigation Initiation Date:	05/18/2022
Report Due Date:	07/16/2022
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
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:	69
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was found wandering the streets on 5/13/2022.	Yes
Additional Findings.	Yes

III. METHODOLOGY

05/17/2022	Special Investigation Intake 2022A1028045
05/18/2022	Special Investigation Initiated - Letter APS referral sent to Centralized Intake
05/18/2022	APS Referral APS referral sent to Centralized Intake
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 Interviewed staff Employee B at the facility.
05/18/2022	Contact - Face to Face Interviewed Employee C at the facility.
08/11/2022	Exit Interview Exited with AR/Admin/Eli Gabay.

ALLEGATION:

Resident A was found wandering the streets on 5/13/2022 by a passerby.

INVESTIGATION:

On 5/17/2022, the Bureau received this complaint anonymously from online complaint system.

On 5/17/2022, a referral was made to APS through Centralized Intake.

On 5/18/2022, I interviewed facility authorized representative/administrator, Eli Gabay, at the facility. Mr. Gabay reported Resident A entered the facility in February 2022 from a hospital stay. Resident A did not initially have a diagnosis of dementia or wandering behaviors, but later presented with both. Resident A initially was allowed to leave the facility in the beginning of [their] residence but Resident A was required to wear a GPS location watch and later wore an alert bracelet with demographic information as well. Resident A's authorized representative agreed with Resident A wearing the GPS location watch and alert demographic bracelet, Mr. Gabay reported due to the facility not being a lock down facility and/or secured memory care unit and due to concerns for safety along with Resident A's inconsistent signing out of the facility per policy protocol, Resident A was placed on routine hourly checks, which were later increased. Mr. Gabay reported Resident A often turned the GPS location watch off and would exit the facility without notifying staff. Mr. Gabay reported the facility consistently reminded Resident A to not turn the GPS location watch off and was in good communication with Resident A's authorized representative about Resident A leaving the facility and concerns for Resident A's safety. Mr. Gabay reported the facility also contacted APS, Resident A's physician, and Resident A's authorized representative to assist in obtaining Resident A a more appropriate placement due to Resident A continually leaving the facility and concerns for safety. Mr. Gabay reported the facility has currently been unsuccessful in finding Resident A an alternative place despite numerous attempts to and despite multiple attempted collaborations with APS and Resident A's authorized representative. Mr. Gabay reported a discharge was issued to Resident A, but Resident A is still at the facility due to the facility being unsuccessful at finding an alternative placement that can provide more appropriate supervision.

On 5/18/2022, I interviewed Employee A at the facility. Employee A reported upon initial admittance to the facility in February 2022, Resident A did not present with dementia or wandering behaviors. However, it was later determined by the facility that Resident A did have a physician diagnosis of dementia as Resident A began presenting with wandering behaviors. Once Resident A began to wander outside the facility, the facility communicated with Resident A's authorized representative to implement safety protocols for Resident A such as the use of a GPS location watch, increased staff monitoring, and use of an alert bracelet with demographic information. Despite increased safety measures and consistent communication with Resident A's authorized representative, Resident A would turn off the GPS location watch and leave the facility. Employee A reported the facility has been in continual communication with Resident A's authorized representative, but the authorized representative has not been helpful in finding alternatives to keep Resident A safe or with obtaining an alternative placement that is more appropriate for Resident A. Employee A reported Resident A's service plan was updated to reflect safety measures. Employee A provided me a copy of Resident A's service plan, record

notes, and communication record with Resident A's authorized representative for my review.

On 5/18/2022, I interviewed Employee B at the facility. Employee B reported when Resident A initially entered the facility, there were no issues with wandering, but once Resident A began to demonstrate wandering behaviors, safety protocols were implemented, and Resident A's authorized representative was contacted on multiple occasions about Resident A's behaviors. Employee B reported Resident A often turned off the GPS location watch and left the facility without notifying facility staff. Despite safety protocols in place, Resident A was able to often leave the facility unnoticed. Employee B reported Resident A was never combative with facility staff requests to sign out or to wear the GPS location watch, but Resident A was not compliant with facility staff requests either. Employee B reported the facility updated the service plan with safety protocols and reached out multiple times to APS, Resident A's physician, and Resident A's authorized representative due to safety concerns, but the facility has been unsuccessful in deterring Resident A's wandering behaviors and in obtaining a more appropriate placement.

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

On 6/9/2022, I reviewed Resident A's service plan dated 2/25/22 but it was not signed. The review revealed Resident A has several co-morbidities and a diagnosis of dementia with behavioral disturbance. The review also revealed:

- Resident A requires assistance with keeping appointments, housekeeping, laundry, meals, shopping, and medication administration.
- Resident A requires cuing for bathing, and grooming. Resident A is independent with ambulation, transfers, dressing, and toileting.
- Resident A "*is capable of responding to properly in an emergency. No assistance needed".*
- Resident A requires 6 safety checks daily. *"Staff will check on the resident's whereabouts and safety regularly throughout the day, around the clock."*

I reviewed Resident A's record notes which revealed Resident A began demonstrating wandering behaviors on 2/27/22. Resident A was found outside the facility on seven more occasions with the last documented occasion occurring on 5/13/2022. The record notes also revealed the facility was in communication with the local police, APS, Resident A's authorized representative, and Summit Pointe for mental health treatment.

I reviewed the communication record between the facility and Resident A's authorized representative, which revealed the following:

- Communication beginning between the facility and Resident A's authorized representative on 2/3/2022 for the initial placement.

- The facility again reached out on 2/28/22 informing the authorized representative that Resident A demonstrated wandering and increased confusion but questioned if it was due to the transition to the facility.
- The facility contacted the authorized representative on 3/4/2022 about the implementation of the GPS location watch and phone application to track Resident A. The authorized representative acknowledged the information but reported [they] had not installed the application on [their] phone yet.
- The facility contacted the authorized representative on 3/15/2022 about issuing Resident A a 30-day discharge. The authorized representative acknowledged the receipt and reported an alternative placement for Resident A was still being sought.
- The authorized representative contacted the facility on 3/16/2022 inquiring if referral packets could be sent to two possible other placement facilities.
- The facility contacted the authorized representative on 5/13/2022 requesting psychiatric services be set up for Resident A.

APPLICABLE RULE	
R 325.1921(1)	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: (a) Assume full legal responsibility for the overall conduct and operation of the home. (b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents. (c) Assure the availability of emergency medical care required by a resident. (d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.
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:	Interviews along with review of Resident A's service plan and record notes, and other documentation reveal Resident A has a diagnosis of dementia with behavior disturbance resulting in eight documented occasions in which Resident A left the facility unsupervised and/or unbeknownst to facility staff. While the facility demonstrated the implementation of safety protocols and communication with Resident A's authorized representative to increase Resident A's safety, Resident A's safety and protection were compromised due to inappropriate supervision not being provided by the facility to ensure Resident A's safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

On 6/9/2022, I reviewed Resident A's service plan dated 2/25/22 but it was not signed. The review revealed Resident A has several co-morbidities and a diagnosis of dementia with behavioral disturbance with six required safety checks by facility staff daily.

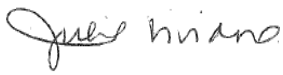
Review of record notes revealed Resident A began demonstrating wandering behaviors on 2/27/22 and incurred seven more occurrences outside of the facility with the last documented occurrence on 5/13/2022. The record notes also revealed the facility was in communication with the local police, APS, Resident A's authorized representative, and Summit Pointe for mental health treatment; and that Resident A wore a GPS location watch and an alert demographic bracelet.

APPLICABLE RULE	
R 325.1922(5)	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Resident A demonstrated a change in behavior and increased wandering beginning 2/27/22. Resident A incurred seven additional occurrences of significant wandering outside of the facility resulting in compromised safety with the most recent occurring on 5/13/2022. Despite safety protocols being implemented, Resident A's service plan was not updated to reflect the change in Resident A's care needs or the safety protocols that were implemented to increase Resident A's safety. The service plan was also not signed by Resident A or Resident A's authorized representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved correction plan, I recommend the status of this license remain unchanged.



6/13/2022

_____

Julie Viviano Date
Licensing Staff

Approved By:

06/14/2022

_____

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