STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

May 10, 2022

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

RE: License #:	AH130405658
Investigation #:	2022A1021047 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 #:	2022A1021047
Complaint Receipt Date:	05/03/2022
Investigation Initiation Date:	05/05/2022
Report Due Date:	07/02/2022
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:	69
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	No

III. METHODOLOGY

05/03/2022	Special Investigation Intake 2022A1021047
05/05/2022	APS Referral complaint came from APS
05/05/2022	Inspection Completed On-site
08/10/2022	Exit Conference Exit Conference with authorized representative Eliyahu Gabay

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 5/3/22, the licensing department received an intake with allegations Resident A has history of eloping from the facility and has been unable to re-enter the facility. The complaint came from Adult Protective Services (APS).

On 5/5/22, I interviewed administrator Melinda Sophia at the facility. Ms. Sophia reported Resident A has a diagnosis of dementia. Ms. Sophia reported Resident A moved into the facility on 1/25/22 and resides with his wife in their apartment. Ms. Sophia reported Resident A is easily confused. Ms. Sophia reported Resident A walks around the facility, walks into other residents' rooms, and will go outside to smoke. Ms. Sophia reported earlier this month Resident A was found walking a few streets down the road and caregivers were able to bring Resident A back into the facility. Ms. Sophia reported no additional occurrences of Resident A leaving the facility unattended has occurred since that incident. Ms. Sophia reported when Resident A does leave the facility to smoke, he is able to follow other residents and re-enter the facility. Ms. Sophia reported residents are to sign out when they leave

the facility so that caregivers know where each resident is. Ms. Sophia reported the facility is not a locked facility. Ms. Sophia reported if a resident leaves the facility, the side doors are unsecured, but the front doors do require staff to unlock the door. Ms. Sophia reported the facility is working on training caregivers on dementia and how to work with residents with dementia.

On 5/5/22, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A does go outside to smoke but has always been able to re-enter the facility. SP1 reported Resident A wanders throughout the facility and at times into other residents' rooms. SP1 reported caregivers will attempt to re-direct Resident A by talking with him and changing the conversation subject when he is confused.

On 5/5/22, I interviewed SP2 at the facility. SP2 reported Resident A did leave the facility earlier this month. SP2 reported caregivers were able to locate Resident A and bring him back to the facility. SP2 reported Resident A has advanced dementia and wanders throughout the facility. SP2 reported when working with Resident A she will attempt to re-direct him. SP2 reported caregivers keep an extra eye on Resident A but there is no set schedule for Resident A.

On 5/5/22, I interviewed SP3 at the facility. SP3 reported Resident A does leave the facility to smoke but is able to re-enter the facility. SP3 reported Resident A does have dementia and is easily confused. SP3 reported caregivers will provide extra attention when Resident A is confused and lost.

I reviewed Resident A's service plan. The service plan omitted all information regarding elopement and cognition behaviors.

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

> *"2/3: I was informed by a female resident that (Resident A) has been mistakenly walking into her and other female's rooms looking for his wife. I placed a blue balloon on the door with RL name on it for identifying his room (Suggested by his wife). Unfortunately, it worked until he removed it from the door. I spoke with our Director of Care regarding some form of identification on the door so he will know that it is his room.*
> *2/4: Resident is very lost and making delusional stories.*
> *2/5: I spoke to resident on three separate occasions today about staying out of other residents' rooms. The third time I spoke to him he proceeded to tell me fine he will stay out and he will just kill himself.*
> *2/5: I found (Resident A) in a resident's room rummaging through her things. I asked him to leave and respect her privacy he left and went into other residents' room. I followed him in there and asked him to leave the residents room and then after he left that room he went into another sleeping residents room and proceeded to just stare at her.*
> *2/14: Resident was wandering up and down hallway last night, he was redirected to his room.*

2/22: Resident is walking into other female rooms, looking for wife. I redirected him and left his door open. Since he did not want to go into his own room. I explained that he should not go into other peoples' rooms.
2/24: Called VPA and left message for Barb regarding resident has been having increased memory issues and wandering. Also, he has been having conversations that don't make sense.
3/28: (Resident A) was very confused was walking up and down hallway most of the night and saying very strange things.
4/8/22: I witnessed (Resident A) go into another resident's room and start to go through her stuff, when she asked what he was doing he screamed at her and walked out her room, seems very agitated today, will keep an eye on him to see how he is throughout the day.
4/9/22: (Resident A) was walking around all night going into peoples rooms and taking their stuff, he left the facility around 9:10am and was notified by a resident he was walking in our northside parking lot Cody and I went walking around outside the facility and did not see him so we got in the car to find him and found him two streets away around 9:25 and brought him back to the facility, a little after getting back he was still wandering around going into peoples rooms even after we has asked him not to lots of times, around one o'clock he pulled our fire alarm while I was contacting 911."

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: **(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.**
For Reference: R 325.1901	**Definitions.**
	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Resident A was known to be confused and appear lost. Resident A exhibited these behaviors between 2/3-4/9. Resident A's plan was not updated during this period to reflect his increasing need for supervision. Specifically, it lacked the

	frequency of safety checks and level of one-to-one supervision he required due to his consistently demonstrated behaviors and his cognitive deficits. Due to this insufficiently developed plan, staff were not aware of his whereabouts allowing him to elope unnoticed and at risk of harm by leaving the facility unsupervised. The facility lacked an organized program of supervision and reasonable protective measures to keep him safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/10/22, I conducted an exit conference with authorized representative Eliyahu Gabay by telephone. Mr. Gabay reported Resident A always knows how to return to the building and gain access to the building.

IV. RECOMMENDATION

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

5/3/22

Kimberly Horst Date
Licensing Staff

Approved By:

08/08/2022

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