GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 19, 2022

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

RE: License #: AH130405658
Investigation #: 2022A1028067
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 #:	2022A1028067
Complaint Receipt Date:	07/20/2022
Investigation Initiation Date:	07/20/2022
Report Due Date:	09/19/2022
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:	91
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Care staff did not follow Resident A's service plan.	No
Care staff did not give Resident A medication in accordance with physician orders.	Yes
Additional Findings	No

III. METHODOLOGY

07/20/2022	Special Investigation Intake 2022A1028067
07/20/2022	Special Investigation Initiated – Letter 2022A1028067
07/20/2022	APS Referral APS made complaint made referral to HFA through Centralized Intake.
08/04/2022	Contact - Face to Face Interviewed Eli Gabay at the facility on 8/4/22.
08/04/2022	Contact - Face to Face Interviewed Employee A at the facility.
08/04/2022	Contact - Face to Face Interviewed Employee B at the facility.
08/04/2022	Contact - Face to Face Interviewed Employee C at the facility.
08/04/2022	Contact - Document Received Received Resident A's service plan, record notes, June 2022 to July 2022 MAR, and physician orders and notes from Employee A.
08/08/2022	Contact – Telephone Call Made Interviewed Resident A's case manager by telephone.
10/19/20022	Exit – Report sent to AR/Admin/Eli Gabay (out of office due to personal holiday), ED/Calina VanderMoere, and RD/Malynda Sofia.

ALLEGATION:

Care staff did not follow Resident A's service plan.

INVESTIGATION:

On 7/20/2022, the Bureau received the allegations from Adult Protective Services (APS) through the online complaint system.

On 7/20/2022, APS made referral to Centralized Intake for referral to HFA.

On 8/4/2022, I interviewed the facility administrator, Eli Gabay, at the facility. Mr. Gabay reported care staff carefully review and follow all residents service plans. Mr. Gabay reported Resident A has been at the facility for almost a year and has caseworker through an outside agency that assists Resident A with care decisions, transportation, and appointments. Mr. Gabay reported Resident A "has been in and out of the hospital and to the doctor recently due to a rash, a misdiagnosis of the subsequent rash, and due to a UTI". Mr. Gabay reported Resident A is currently at the hospital due to exhibiting further symptoms of a stroke.

On 8/4/2022, I interviewed Employee A at the facility who reported Resident A's service plan is followed by care and is routinely updated due to health concerns. Employee A reported Resident A requires reminders and/or assist with bathing and grooming. Resident A can dress self and toilet self but has difficulty swallowing during mealtimes. The facility manages Resident A's medications, laundry, meals, and housekeeping. Resident A is independent with transfers and ambulation using walker. Employee A reported "[Resident A] has cognitive delays but can make needs known. Resident A has had some behaviors since being here but can be redirected". However, Employee A reported Resident A has refused care from staff before and it was documented in the chart notes. Employee A confirmed Resident A is currently in the hospital due to exhibiting symptoms of stroke. Employee A provided me Resident A's service plan, medication administration record (MAR) from June 2022 to July 2022, record notes, and physician orders with physician notes for my review.

On 8/4/2022, I interviewed Employee B at the facility who reported Resident A requires some cuing, supervision, and assist with bathing and grooming due to cognitive delays. Employee B reported Resident A has refused care intermittently when staff have attempted to remind and/or assist Resident A with bathing and grooming. Employee B reported the facility handles Resident A's laundry, meals, housekeeping, and medication administration. Resident A is independent with dressing, toileting, transfers, and ambulation using walker. Employee B reported Resident A can require supervision during mealtimes for safety due to difficulty swallowing. Employee A reported Resident A "has had some behaviors but can be

redirected. [Resident A] has refused to shower a few times". Employee B reported care staff review resident service plans often to ensure appropriate levels of care.

On 8/4/2022, I interviewed Employee C at the facility who reported Resident A requires some assist or reminders for bathing and grooming and Resident A has refused intermittently to participate in these cares despite care staff attempts to assist. Employee C reported Resident A can dress, toilet, transfer, and ambulate with use of walker independently, but the facility manages laundry, medications, meals, and housekeeping. Resident A requires supervision for safety during meals due to difficulty swallowing. Employee C reported care staff routinely review resident service plans to ensure appropriate care and/or if the resident was sent to the hospital or physician for a change in condition. Employee C reported despite Resident A's intermittent refusals of care and demonstrated behaviors, Resident A can be redirected.

On 8/4/2022, I completed an inspection of the facility which revealed the facility was clean. Residents observed were clean, groomed, content, and/or being assisted by care staff.

On 8/8/2022, I reviewed Resident A's service plan which revealed the following:

- Resident A has a diagnosis of cognitive delay, diabetes mellitus, neuropathy, CHF, and COPD.
- Resident A is independent with transfers, ambulation with use of walker, dressing, toileting, and does not have a special diet, but has difficulty swallowing.
- The facility assists and/or manages Resident A's medications, laundry, housekeeping, meals, and bathing.
- The facility checks Resident A's safety routinely throughout the day.

I also reviewed Resident A's record notes which revealed the following:

- The facility coordinates with Grace Health for Resident A and Resident A is also assigned a case manager through Summit Point for case coordination.
- History of Resident A being up and anxious during the night with Resident A being seen by the hospital and/or physician on 11/17/2022, 1/31/202, 4/24/2022, 5/25/2022, 6/15/2022, 6/24/2022, 7/19/2022, 7/27/2022 and 8/3/2022 for change in condition to include UTI and/or medication review.
- On 1/3/2022, 2/3/2022, and 3/14/2022 Resident A refused showers.
- On 5/25/2022, Resident A attempted to refuse morning medication administration from care staff, but care staff was able to reapproach and administer medication.

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:	It was alleged care staff were not following Resident A's care plan. Interviews, on-site inspection, and review of documentation reveal no evidence to support this allegation. Care staff are providing care consistent with Resident A's service plan. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Care staff did not give Resident A medication in accordance with physician orders.

INVESTIGATION:

On 8/4/2022, Mr. Gabay reported Resident A was originally diagnosed with scabies and prescribed treatment. Care staff followed physician orders and were in communication with Resident A's physician and case manager. However, at a follow-up appointment, the physician reported Resident A was mistakenly diagnosed with scabies. Resident A did not have scabies as originally thought, instead Resident A was diagnosed with cellulitis and prescribed treatment. Mr. Gabay reported care staff followed all physician orders concerning Resident A's condition(s).

On 8/4/2022, Employee A reported Resident A developed a rash and was sent to the physician in April 2022. Resident A was diagnosed with scabies at this time and received medication to treat. However, the rash was still present despite treatment and on 4/21/2022 a new medication was prescribed and used. Employee A reported the diagnosis of scabies was questionable because no other resident in the facility was diagnosed with scabies to include Resident A's roommate. There was no outbreak of scabies in the facility either. Despite questioning the scabies diagnosis, Employee A reported the new medication was used in accordance with physician orders. On 7/19/2022. Resident A refused the topical treatment cream and later complained [their] skin was burning from the topical treatment. At this time, care staff noticed Resident A's feet were very swollen as well and called emergency services and notified Resident A's case manager. Upon admission to the hospital, Resident A was diagnosed with cellulitis and the diagnosing physician reported Resident A was incorrectly diagnosed with scabies. Employee A reported care staff followed

physician orders and will continue to follow all physician orders once Resident A returns to the facility.

On 8/4/022, Employee B reported Resident A developed a rash that was originally diagnosed as scabies by the hospital physician with subsequent treatment prescribed. Employee B reported this diagnosis was questioned later by facility care staff because no other resident in the facility was diagnosed with scabies and there was no outbreak of scabies in the facility. Care staff followed physician orders regardless of suspicions concerning diagnosis. Employee B reported Resident A was eventually prescribed a different medication for the rash in April 2022 due to the rash still being present. Care staff continued to follow all physician orders and were in communication with Grace Health and Resident A's case manager. On 7/19/2022, Resident A refused the topical treatment cream for the persistent rash due to burning [their] skin, with Resident A being sent to the hospital. At the hospital Resident A was diagnosed with cellulitis. Employee B reported the hospital staff stated Resident was incorrectly diagnosed with scabies.

On 8/4/2022, Employee C's statements were consistent with Mr. Gabay's, Employee A's and Employee B's statements.

On 8/4/2022, I reviewed Resident A's chart notes which revealed the following:

- On 4/7/2022, Resident A had a follow up appointment at Grace Health where the rash was still present. Grace Health inquired about the prescription for scabies.
- On 4/21/2022, Resident A returned with new medication of Ferrous Sulfate and Eucerine Cream to treat rash. Medications to be applied as needed.
- On 4/24/2022, Resident A's chest x-ray was positive for pneumonia. Prescription called into Walgreen's 24-hour pharmacy.
- On 5/25/2022, physician medication review was scheduled to take place due to Resident A's documented behaviors at the facility but was rescheduled to 6/9/2022.
- On 7/19/2022, Resident A refused topical cream treatment and later complained the cream burned her skin. Care staff observed Resident A had very swollen feet. Resident A sent to hospital for evaluation and treatment.
- On 7/20/2022 from 9:49am to 11:00am Resident A returned to facility with diagnosis of cellulitis. Upon return to facility, Resident A requested treatment, but pharmacy had not filled prescription yet due to it being a new diagnosis and prescription. Care staff explained to Resident A the facility is waiting on the pharmacy to fill the prescription and they will pick up and treat Resident A immediately once the prescription is filled. Resident A became angry and used vulgar language with care staff but care staff were able to calm and redirect Resident A.
- On 7/20/2022 at 4:00pm, Resident A refused to use prescribed inhaler. Staff observed Resident A's legs and feet were again very swollen. Resident A sent to hospital again for evaluation and treatment, returning later that evening.

- On 7/27/2022, Resident A complained of pain in hands and requested to go to hospital. Care staff offered Resident A PRN medication and emergency services were called. Emergency services arrived and determined it was not an emergency and would not transport Resident A to the hospital but informed Resident A and care staff that Resident A could go to the hospital independently to be seen. Resident A accepted PRN medication instead.
- On 8/3/2022 at 12:53pm, care staff noted Resident A was demonstrating odd behavior and suspected UTI. Care staff spoke with case manager and case manager added Resident A to [their] schedule to be seen if behavior continues. Resident A denied need for emergency services.
- On 8/3/2022 at 3:09pm, care staff observed Resident A with stroke like symptoms and sent Resident A to hospital. Resident A's case manager notified.
- Evidence of communication with Resident A's case manage and physician concerning Resident A's medications, diagnoses, and changes in condition.

I also reviewed Resident A's MAR from June 2022 to July 2022 which revealed the following:

- Medication administration for June 2022 was completed in accordance with the physician's orders and there is evidence of Resident A's refusals of medications.
- On 7/16/2022, Resident A was to receive 1 tablet of Lorazepam 1mg three times daily at 8:00am, 2:00pm, and 8:00pm. The 2:00pm time is blank. It cannot be determined if Resident A received the medication at this time or not, as there is no documentation of it being administered.
- On 7/16/2022, Resident A was to receive 1 tablet of Nateglinide 60mg PO three times daily at 8:00am, 2:00pm, and 8:00pm. The 2:00pm time is blank. It cannot be determined if Resident A received the medication at this time or not, as there is no documentation of it being administered.

I reviewed Resident A's physician orders and physician notes which revealed the following:

- On 7/19/2022, Resident A was seen for scabies, skin infection, and suspected cellulitis with subsequent treatment being prescribed by Bronson Urgent Care physician. Resident A also seen for possible UTI.
- On 7/20/2022, Resident A was diagnosed with cellulitis by Bronson Emergency Department physician. Appropriate medication change made, and new medication prescribed.
- On 8/1/2022, Resident A seen for follow up appointment by Grace Health physician with no new concerns noted.

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:	Interviews, on-site inspection, and review of documentation reveal facility care staff followed physician orders for Resident A's diagnoses of scabies, cellulitis, and UTI. However, review of Resident A's July 2022 MAR revealed: • On 7/16/2022, Resident A was to receive 1 tablet of Lorazepam 1mg at 2:00pm. This time slot is blank on the record. • On 7/16/2022, Resident A was to receive 1 tablet of Nateglinide 60mg at 2:00pm. This time slot is blank on the record. It cannot be determined if Resident A received the medications at that time or not, as there is no documentation of it being administered and/or no documentation of it being refused by Resident A either. Violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

8/9/2022

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L Moore

10/05/2022

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