GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 18, 2022

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

RE: License #: AH130405658
Investigation #: 2022A1010077
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 (517) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH130405658
Investigation #:	2022A1010077
Complaint Receipt Date:	09/19/2022
Investigation Initiation Date:	09/21/2022
Report Due Date:	11/19/2022
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:	108
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not receiving their medications as prescribed.	Yes
Staff do not watch residents ingest their medications when they are administered.	Yes
Resident rooms are dirty and smell like urine and feces.	No

III. METHODOLOGY

09/19/2022	Special Investigation Intake 2022A1010077
09/21/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
09/21/2022	APS Referral APS referral emailed to Centralized Intake
09/26/2022	Comment Intake ID 190438 dismissed as allegations regarding resident medications already being investigated under this open SI
09/29/2022	Comment Intake ID 190589 dismissed as allegations regarding resident medications already being investigated under this open SI
10/05/2022	Inspection Completed On-site
10/05/2022	Contact - Document Received Received resident MARs
11/18/2022	Exit Conference Completed with licensee authorized representative Eli Gabay

ALLEGATION:

Residents are not receiving their medications as prescribed.

INVESTIGATION:

On 9/19/22, 9/26/22, and 9/29/22, the Bureau received allegations from the online complaint system. The complaints read residents are not received their prescribed medications. The complaints Resident B, Resident C, Resident D, Resident E, and Resident F have gone days without their medications. Resident F reportedly experienced three days of withdrawal symptoms as a result of not getting her medications.

On 9/21/22, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 10/5/22, I interviewed wellness director Malynda Sofia at the facility. Ms. Sofia reported resident medications are administered as prescribed. Ms. Sofia reported the facility recently changed its "in house pharmacy" and as a result some resident medications took a couple days to arrive and were not available.

Ms. Sofia reported Resident B no longer resides in the facility. Ms. Sofia stated when Resident B resided in the facility, she often changed physicians which caused issues with her medications. Ms. Sofia said because of Resident B's frequent physician changes, her medications changed often. Ms. Sofia reported Resident B's medications were administered as prescribed when she was at the facility. Ms. Sofia explained Resident B often left the facility, as she was able to be in the community unsupervised and could sign herself in and out. Ms. Sofia said Resident B moved out of the facility to reside with her boyfriend.

Ms. Sofia reported if Resident B had not moved out of the facility, she would have been given a 30-day discharge notice. Ms. Sofia stated Resident B was going to receive a discharge notice for brining medications, such as Tylenol, back into the facility and giving it to other residents. Ms. Sofia said there were also times when Resident B would not comply with the facility rules by not signing herself out when she would leave.

Ms. Sofia stated that to her knowledge, Resident C gets his medications administered as prescribed. Ms. Sofia reported there were some instances when Resident C refused to take his medications when staff attempted to administer them. Ms. Sofia provided me with a copy of Resident C's September MAR for my review. The MAR read Resident C's prescribed "MYRBETRIQ 25 MG TB24" was not administered from 9/1/22 through 9/22/22. The *Reason* section of the MAR read, "MEDICATION NOT AT FACILITY."

Resident C's September MAR read his prescribed "ESZOPICLONE 2MG PO TAB" was not administered from 9/1/22 through 9/7/22. The *Reason* section of the MAR read, "MEDICATION NOT AT FACILITY." Resident C's prescribed "DOCUSATE SODIUM 100 MG SOFTGEL" was not administered on 9/12/22 and 9/21/22 because "MEDICATION NOT AT FACILITY." Resident C refused this medication on 9/6/22, 9/7/22, 9/8/22, 9/10/22, 9/11/22, 9/16/22, 9/22/22, and 9/26/22 through 9/30/22.

Resident C's prescribed "CARVEDILOL 3.125 MG TABLET" was not administered on 9/21/22 and 9/22/22 because "MEDICATION NOT AT FACILITY."

Ms. Sofia reported to her knowledge Resident D's medications were administered as prescribed. Ms. Sofia provided me with a copy of Resident D's September MAR for my review. Resident D's MAR read her prescribed ONDANSETRON HCL 4 MG TABLET" was not administered from 9/1/22 through 9/23 because "MEDICATION NOT AT FACILITY." Resident D's prescribed "LEVOTHYROXINE 75 MCG TABLET" was not administered on 9/21/22 and 9/22/22 because "MEDICATION NOT AT FACILITY." Resident D's prescribed "ATORVASTATIN 40 MG TABLET" was not administered from 9/21/22 through 9/25/22 because "MEDICATION NOT AT FACILITY."

Ms. Sofia reported to her knowledge Resident E's medications were administered as prescribed. Ms. Sofia stated Resident E was given a 30 day discharge notice for excessive alcohol abuse. Ms. Sofia said Resident E goes out into the community and returns to the facility intoxicated. Ms. Sofia explained the facility has initiated alcohol rehabilitation services for Resident E, however he continues to return intoxicated and be disruptive to residents and staff.

Ms. Sofia provided me with a copy of Resident E's September MAR for my review. Resident E's MAR read his prescribed "METOPROLOL SUCC ER 25 MG TAB" was not administered from 9/1/22 through 9/22/22 because "MEDICATION NOT AT FACILITY. " The MAR read Resident E's prescribed "VITAMIN B-1 100 MG TABLET" was not administered from 9/2/22 through 9/22/22 and 9/27/22 because "MEDICATION NOT AT FACILITY." The MAR read Resident E's prescribed "ESCITALOPRAM 10 MG TABLET" was not administered 9/5/22, 9/6/22, 9/8/22, 9/9/22, 9/12/22, 9/13/22 through 9/21/22, 9/25/22 through 9/30/22 because "MEDICATION NOT AT FACILITY." The MAR read Resident E's prescribed "ATORVASTATIN 80 MG TABLET" was not administered 9/16/22 through 9/18/22 because "MEDICATION NOT AT FACILITY."

Ms. Sofia reported to her knowledge Resident F's medications were administered as prescribed. Ms. Sofia provided me with a copy of Resident F's September MAR for my review. Resident F's MAR read her prescribed "CALCIUM 600 MG TABS" was not administered from 9/18/22 through 9/30/22 because "MEDICATION NOT AT FACILITY." The MAR read Resident F's prescribed "DIVALPROEX SOD DR 250 MG TAB" was not administered 9/20/22 through 9/22/22 because "MEDICATION NOT AT FACILITY."

On 10/5/22, I interviewed medication technician (med tech) Staff Person 1 (SP1) at the facility. SP1 statements were consistent with Ms. Sofia.

On 10/5/22, I attempted to interview Resident C at the facility. Resident C was not in his room.

On 10/5/22, I interviewed Resident D at the facility. Resident D reported there were several days in which she did not “get most of her” medications. Resident D said she did not experience any withdrawal symptoms because of going several days without her medications. Resident D stated she was informed the facility changed its “in house” pharmacy approximately a week ago.

On 10/5/22, I interviewed Resident E at the facility. Resident E reported there were several instances when he did not get his prescribed medications. Resident E stated staff told him “they didn’t have” his medications multiple times, therefore they were not administered. Resident E said staff did not provide an explanation regarding why his medications were not at the facility.

On 10/5/22, I interviewed Resident F at the facility. Resident F’s statements were consistent with Resident E. Resident F stated since she moved into the facility several months ago, there were several times throughout her months of living at the facility when she did not get her prescribed medications. Resident F said she has experienced withdrawal symptoms because of going several days without her prescribed medications.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The interviews with residents, along with review of their September medication administration records, revealed some residents went several days without their prescribed medications. Resident F reported experiencing withdrawal symptoms because of going several days without her prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff do not watch residents ingest their medications when they are administered.

INVESTIGATION:

On 9/26/22, the additional allegations the Bureau received read, “[Resident E] reports that staff does not always hand him his medication, it is sometimes left in his

room for him. ASW viewed pills on his night stand next to a white paper cup that the facility dispenses medication in”

On 10/5/22, Ms. Sofia reported med techs were trained to watch residents ingest their medication when they administer it. Ms. Sofia denied knowledge regarding instances when staff did not watch residents ingest their medications when administered.

On 10/5/22, SP1 statements regarding med tech training was consistent with Ms. Sofia. SP1 reported the only time she found resident medication in their room was approximately one year ago. SP1 stated at that time, she observed a pill in a resident’s drawer. SP1 said to her knowledge, med techs are watching residents ingest their medications when they are administered.

On 10/5/22, Resident E reported staff do not watch him ingest his medications. Resident E stated staff hand him his medications in a small paper cup, then leave the room. Resident E showed me the small cup of medications staff gave him this morning. I observed several pills were in the cup sitting on Resident E’s nightstand. Resident E said he hasn’t taken any of the medications that were in the cup.

On 10/5/22, Resident F reported there are many times when staff give her her medications, then leave the room. Resident F stated often staff do not stay to watch whether she ingests her medications.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	The interviews with Resident E and Resident F, along with my observation of the pills left on Resident E’s nightstand, revealed staff often do not watch residents ingest their medications when they are administered. Ms. Sofia and SP1 reported staff were trained to watch residents ingest their medications when they are administered, however there is sufficient evidence to suggest staff are not acting as they were trained.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident rooms are dirty and smell like urine and feces.

INVESTIGATION:

On 9/19/22, the complaint read Resident B's roommate urinates and defecates on the floor of their bathroom. Resident B is no longer able to use the bathroom due to the smell and staff do not clean it.

On 10/5/22, I was unable to interview Resident B as she no longer resides in the facility.

On 10/5/22, I inspected several resident rooms and common areas of the facility. I did not observe any concerns regarding cleanliness of the facility. I did not observe urine or feces in resident bathrooms or detect any foul odors within the facility.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	My observation of resident rooms and common areas of the facility revealed no concerns regarding cleanliness.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with licensee authorized representative Eli Gabay by telephone on 11/18/22. Mr. Gabay reported a new wellness director was hired and the reordering of resident medications has been timely. Mr. Gabay stated staff were also re-educated to watch a resident ingest their medication and document any refusals.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

11/02/22

Lauren Wohlfert Date
Licensing Staff

Approved By:

11/17/2022

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