GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 29, 2023

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

RE: License #: AH130405658
Investigation #: 2023A1028026
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 #:	2023A1028026
Complaint Receipt Date:	02/06/2023
Investigation Initiation Date:	02/08/2023
Report Due Date:	04/08/2023
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:	09/25/2022
Expiration Date:	09/24/2023
Capacity:	108
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff allowed Resident A to go into town unassisted and without supervision.	No
Additional Findings	Yes

III. METHODOLOGY

02/06/2023	Special Investigation Intake 2023A1028026
02/08/2023	Special Investigation Initiated - Letter
02/08/2023	APS Referral APS denied complaint and made referral to HFA.
02/21/2023	Contact - Face to Face Interviewed Employee A at the facility.
02/21/2023	Contact - Face to Face Interviewed Employee B at the facility.
02/21/2023	Contact - Face to Face Interviewed Employee C at the facility.
02/21/2023	Contact - Face to Face Interviewed Resident A at the facility.
02/21/2023	Contact - Face to Face Spoke with AR/Admin/Eli Gabay about additional findings.
02/21/2023	Inspection Completed On-site Completed on-site inspection due to special investigation.

ALLEGATION:

Staff allowed Resident A to go into town unassisted and without supervision.

INVESTIGATION:

On 2/06/2023, the Bureau received the allegations anonymously from the online complaint system.

On 2/06/2023, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 2/21/2023, I interviewed Employee A at the facility who reported Resident A is independent with care, ambulation, shopping, and making and keeping appointments. Resident A requires assistance with medication administration only and does not demonstrate any impairment with cognition, judgement, or decision making. Resident A is also oriented x 3. Resident A has a DPOA in place for finances only. Employee A reported Resident A routinely goes shopping in town by [their self] and signs in/out of the facility. Employee A reported staff monitor all residents who sign in and out to ensure safety. Employee A reported Resident A will either use public transportation or a private pay transportation when going shopping. Employee A reported Resident A has called the facility to request a ride back to the facility recently due to public transportation being full and/or unable to pick Resident A up at a particular location. The facility picked Resident A up at a local store due to public transportation being unavailable. Employee A reported there have been no issues with Resident A leaving the facility and Resident A is compliant with signing in/out of the facility. Employee A reported if Resident A were to demonstrate any change in cognition, then Resident A's independence with activities would be reassessed to ensure Resident A's care and safety. Employee A reported Resident A is "is very private and very independent". Employee A provided me copies of December 2022 to February 2022 resident sign in/out sheets and Resident A's service plan for my review.

On 2/21/2023, I interviewed Employee B at the facility who reported Resident A is independent and does not require any assistance other than medication administration. Employee B reported Resident A has a financial DPOA only and that Resident A is independent with all care, ambulation, shopping, decision making, and keeping appointments. Resident A does not and has not demonstrated any impairment with cognition, judgement, or decision making. Employee B reported Resident A is private person and leaves the facility to run errands or shop one to two times weekly. Resident A is compliant with signing in/out of the facility. Resident A uses public or private pay transportation when leaving the facility. However, Employee B reported Resident A recently requested a ride home from the facility because neither public or private pay transportation could provide transportation within the time requested by Resident A or within a timely manner. Facility staff picked up Resident A at a local store and returned Resident A to the facility. Employee B reported facility monitor all residents signing in/out of the facility to ensure safety.

On 2/21/2023, I interviewed Employee C at the facility whose statements were consistent with Employee A's statements and Employee B's statements.

On 2/21/2023, I interviewed Resident A at the facility who reported [they] regularly run errands and independently shop weekly. Resident A confirmed they are independent with care, ambulation, shopping, and making and keeping appointments. Resident A was also oriented x 3 during the interview and did not demonstrate any impairment with cognition, judgement, or decision making. Resident A confirmed they often use private pay or public transportation, but recently when [they] requested both forms of transportation while at a local store, it was unavailable due "to being full and not able to come get me at a decent time. I was not happy the bus couldn't get me and didn't want to wait all day, so I got ahold of the staff here for a ride". Resident A also confirmed they are a private person but always sign in/out of the facility.

On 2/21/2023, I reviewed the facility sign in/out sheets which revealed Resident A is compliant with signing in and out of the facility. The review also revealed evidence of staff monitoring the sign in/out sheets for safety.

I also reviewed Resident A's service plan which revealed the following:

- Resident A is independent with all care, ambulation, maintaining appointments, shopping, and managing healthcare services.
- The facility manages Resident A's medications per facility policy.
- Resident A does not demonstrate any impairment with memory, judgement, wandering, and/or sociability.
- Resident A does not demonstrate any wandering, depression, aggression, irritability, hallucinations, paranoia, and/or inappropriate/disruptive behaviors.
- Resident A does not demonstrate any verbal or hearing impairment.
- Resident A is independent with ambulation and use of walker.
- Resident A is appropriate and allowed to leave building without supervision. No history of elopement.
- Resident A is appropriately oriented to person, place, time, and self.

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.**

	(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.**
ANALYSIS:	It was alleged facility staff allowed Resident A to go into town unassisted and without supervision. Interviews, on-site investigation, review of documentation reveal Resident A is independent with all care and cognition and is appropriate and safe to leave the facility unassisted and without supervision. There is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 2/21/2023, I completed an on-site investigation due to this special investigation and it was revealed staff have completed multiple internal incident reports concerning resident care, hospitalizations, and medication errors but the reports were never submitted to the department for review.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**

	(2) The original incident/accident report shall be maintained in the home for not less than 2 years. **(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.** **(4) If an elopement occurs, then the home shall make a reasonable attempt to locate the resident and contact the resident's authorized representative, if any. If the resident is not located, the home shall do both of the following:** **(a) Contact the local police authority.** **(b) Notify the department within 24 hours of the elopement.**
ANALYSIS:	It was revealed through interviews and on-site inspection the facility has not submitted incident reports concerning hospitalizations, medication errors, and incidents involving resident care since December 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

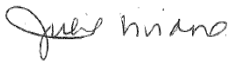
INVESTIGATION:

On 2/21/2023, during the onsite inspection, two bottles of industrial cleaners and one bottle of hydrogen peroxide were found in the second-floor dining room, easily accessible to anyone.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	Two bottles of industrial cleaners and one bottle of hydrogen peroxide were found in the second-floor dining room, easily accessible to anyone. This poses a serious risk of ingestion for individuals with impaired cognition.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

No additional licensure actions will be taken for these violations once an approved corrective action plan is received.



2/22/2023

Julie Viviano Date
Licensing Staff

Approved By:

03/24/2023

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