GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 2, 2025

Irina Barsan
Dayag Care LLC
8350 Pine St
Taylor, MI 48180

RE: License #: AS820415684
Investigation #: 2025A0116032
Dayag Care

Dear Ms. Barsan:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820415684
Investigation #:	2025A0116032
Complaint Receipt Date:	06/11/2025
Investigation Initiation Date:	06/11/2025
Report Due Date:	07/11/2025
Licensee Name:	Dayag Care LLC
Licensee Address:	8350 Pine St Taylor, MI 48180
Licensee Telephone #:	(248) 826-3380
Administrator:	Irina Barsan
Licensee Designee:	Irina Barsan
Name of Facility:	Dayag Care
Facility Address:	8350 Pine St Taylor, MI 48180
Facility Telephone #:	(313) 633-1270
Original Issuance Date:	11/30/2023
License Status:	REGULAR
Effective Date:	05/31/2024
Expiration Date:	05/30/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Licensee designee, Irina Barsan, gave morphine without POA consent, despite being told no and that she was administering it more than Resident A needed it.	Yes
All allegations reported were not investigated as they were not rule related.	

III. METHODOLOGY

06/11/2025	Special Investigation Intake 2025A0116032
06/11/2025	APS Referral Not required at the resident is deceased.
06/11/2025	Special Investigation Initiated - Telephone Interviewed complainant.
06/16/2025	Inspection Completed On-site No one home. a card was left.
06/16/2025	Contact - Telephone call made Licensee designee, Irinia Barsan.
06/16/2025	Contact - Document Received Hospice prescriptions and Resident A's medication administration record.
06/17/2025	Contact - Telephone call made Hospice Branch Director, Jenny Dreuth, RN.
06/26/2025	Exit Conference Licensee designee, Irina Barsan.
06/30/2025	Inspection Completed-BCAL Sub. Compliance
06/30/2025	Exit Conference Licensee designee, Irinia Barsan.

ALLEGATION:

Licensee designee, Irina Barsan, gave morphine without POA consent, despite being told no and that she was administering it more than Resident A needed it.

INVESTIGATION:

On 06/11/25, I interviewed the complainant, and he reported that Resident A was admitted into the home in the beginning of May 2025. Resident A was there for about 2 1/2 days before he had her sent out to the hospital. Complainant was not happy with licensee designee, Irinia Barsan, and reported she felt like she could do whatever she wanted. Resident A was assessed by hospice on the evening of her admission into the home and was prescribed morphine for pain. Complainant requested that Ms. Barsan not administer another dose of Morphine to Resident A as she appeared to be doing fine based on her non-verbal cues. Ms. Barsan administered another dose of morphine anyway. Complainant contacted the hospice provider, terminated their services and had Resident A sent out to the hospital. Resident A did not return to the home and passed away on May 27, 2025.

On 06/16/25, I conducted an unscheduled on-site, no one was home. I left my business card.

On 06/16/25, I interviewed licensee designee, Irinia Barsan, and she reported that at the present she does not have any residents in the home. With regard to the allegations Ms. Barsan reported that Resident A was admitted into the home on the evening of 05/02/25 and was sent out to the hospital on the morning of 05/05/25, at the request of her POA. Resident A was assessed by and under the care of Harmony Hospice. Resident A was prescribed morphine every two hours as needed for pain as she was in a tremendous amount of pain. On 05/04/25 Resident A's POA was at the home and requested that she not administer her next dose of morphine. Ms. Barsan administered it anyway as Resident A was showing signs of pain and discomfort. Resident A's POA was upset and the following morning had Resident A sent to the hospital. Resident A never returned. Ms. Barsan was following the hospice orders and wanted to keep Resident A comfortable.

On 06/16/2025, I received and reviewed the hospice doctor prescription orders and Resident A's medication administration record (MAR). The initial order (05/02/25) for morphine was 0.75 ml every two hours as needed for pain. The order was changed on 05/04/25 increasing the dose to 1ml every 2 hours as needed for pain. The MAR shows that on 05/03/25 Ms. Barsan administered 0.75ml of morphine at 9:00 a.m., 10:00 a.m., 1:00 p.m., 5:00 p.m., 9:30 p.m., and 12:00 a.m. On 05/04/25, Ms. Barsan administered the 1ml dose of morphine to Resident A at 1:00 p.m., 4:30 p.m., 5:30 p.m., 9:30 p.m. and 12:00 a.m. On both 05/03/25 and 05/04/25 Ms.

Barsan did not follow the written order and administered one dose of morphine each day, sooner than the 2-hour required time frame between doses.

On 06/17/25, I interviewed Hospice Branch Director, Jenny Dreuth, RN. Nurse Dreuth reported that Resident A was under their care and was assessed on the evening of 05/02/25 in the group home. Resident A's pain level was assessed at 10/10 as she was in an enormous amount of pain and was prescribed morphine every two hours as needed. Resident A was in so much pain that it was difficult for the nurses to put a blood pressure cuff on her.

On 06/26/25 and 06/30/25, I conducted the exit conference with licensee designee, Irina Barsan, and informed her of the findings of the investigation. Ms. Barsan was not happy and did not agree with the findings. I explained to Ms. Barsan, that although the morphine order was a prn, the order was specific in that it could not be given before the 2-hour timeframe.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the findings of the investigation, which included interviews of the complainant, licensee designee, Irina Barsan, and review of Resident A's MAR and prescription order, there is a preponderance of evidence to establish this violation. On 05/03/25 and 05/04/25, Ms. Barsan did not give Resident A's morphine medication as prescribed. On both days Ms. Barsan gave one dose of the medication before the 2-hour required time frame between doses. On 05/03/25, Ms. Barsan gave the medication at 9:00 a.m. and again at 10:00 a.m. On 05/04/25, Ms. Barsan gave the medication at 4:30 p.m. and 5:30 p.m.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/01/25

Pandrea Robinson
Licensing Consultant

Date

Approved By:

07/02/25

Ardra Hunter
Area Manager

Date