GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2020

Ruth Poberesky
Absolute Care, LLC
5847 Naneva Court
West Bloomfield, MI 48322

RE: License #: AS630394140
Investigation #: 2021A0605005
Absolute 4

Dear Ms. Poberesky:

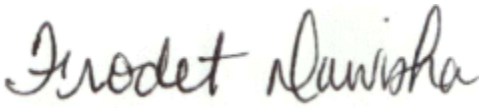
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630394140
Investigation #:	2021A0605005
Complaint Receipt Date:	11/02/2020
Investigation Initiation Date:	11/02/2020
Report Due Date:	01/01/2021
Licensee Name:	Absolute Care, LLC
Licensee Address:	5847 Naneva Court West Bloomfield, MI 48322
Licensee Telephone #:	(248) 252-6310
Administrator:	Ruth Poberesky
Licensee Designee:	Ella Maryakhin
Name of Facility:	Absolute 4
Facility Address:	5790 Farmington Rd West Bloomfield, MI 48322
Facility Telephone #:	(248) 252-6310
Original Issuance Date:	08/23/2018
License Status:	REGULAR
Effective Date:	02/23/2019
Expiration Date:	02/22/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Licensee designee Ruth Poberesky and administrator Ella Maryakhin have baskets of "as needed" medications that belong to residents that were either discharged from the home or deceased. They are administering these "as needed," medication to residents in the home who have not been prescribed these medications.	No
Discontinued medication is not being disposed by staff	Yes

III. METHODOLOGY

11/02/2020	Special Investigation Intake 2021A0605005
11/02/2020	Special Investigation Initiated - On Site I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) 1, observed Residents A, B and C and interviewed licensee designee Ruth Poberesky and administrator Ella Maryakhin. I also reviewed Resident A and B's medications and medication logs.
12/22/2020	APS Referral Adult Protective Services (APS) referral made
12/22/2020	Contact - Telephone call made Telephone calls made with Resident A's DPOA, Resident B's guardian #1 and Resident C's guardian #2 regarding allegations.
12/22/2020	Exit Conference Telephone call with licensee designee Ruth Poberesky. Left message.

ALLEGATION:

- **Licensee designee Ruth Poberesky and administrator Ella Maryakhin have baskets of "as needed" medications that belong to residents that were either discharged from the home or deceased. They are administering these "as needed," medication to residents in the home who have not been prescribed these medications.**
- **Discontinued medication is not being disposed by staff.**

INVESTIGATION:

On 11/02/2020, intake #175847 was assigned regarding licensee designee Ruth Poberesky and administrator Elle Maryakhin are administering medication to residents that are not prescribed to them. An Adult Protective Services (APS) referral was made.

On 11/02/2020, I conducted an unannounced on-site investigation. I was greeted by direct care staff (DCS) Svetlana Galai. Ms. Galai initially refused entry into the home, but then contacted licensee designee Ruth Poberesky for permission. Upon entering the home, I observed a basket of medications sitting on top of the medication cabinet. The medication cabinet was unlocked. I observed three residents at this home. I was unable to interview them as they do not speak English. I interviewed Ms. Galai regarding the allegations. Ms. Galai was very short with her responses. She stated, “I only give medication as prescribed.” She stated there is no medications in this home that do not belong to the residents that live here. Ms. Galai gave me permission to look around the home. I went into the laundry room and opened the cabinets. I observed medication in the cabinet that did not belong to Residents A, B or C. These medications were either ointments or inhalers that belong to Resident D who was discharged.

I observed Ms. Galai complete a medication pass to Resident B that was appropriate with no concerns noted. As I was speaking with Ms. Galai, Ms. Poberesky arrived at the home with the administrator Ms. Maryakhin. I discussed the allegations regarding medication sitting out on top of the medication cabinet and the medication cabinet was not locked. Ms. Poberesky stated they have not violated any rules as the medication cabinet is always locked and that medication usually is not left out in the open. Ms. Pobersky stated when a resident is discharged from the home, staff removes the old medication and put them aside and are then supposed to give these discarded medications back to the pharmacist. She stated, “sometimes staff forget, and they do not give it back to the pharmacist.” Ms. Poberesky stated the staff, nor she administers any medication to residents that are not prescribed to them.

I requested to review Resident A’s medication basket and medication logs and found the following errors:

- Resident A’s Symbicort inhaler was not in the original prescription package as it was just lying in the basket.
- Resident A’s Aripiprazole 5MG Tablet was discontinued on 10/23/2020, but the medication was not disposed of as it was still in the basket. Also, there was no discontinue script from the prescribing physician or pharmacist.
- Resident A’s Escitalopram 20MG Tablet was discontinued, but the medication was not disposed of as it was still in the basket. Also, there was no discontinue script from the prescribing physician or pharmacist.

Ms. Poberesky stated all communication from the physician Dr. Feinstein is via text messages and this home does not have any physician contacts and instructions on file for any of the residents. Ms. Poberesky stated that the physician sends the order to the pharmacist and the pharmacist then makes the changes on the website which connects to their medication system and staff know what to administer or not administer. She reported that the physician does not send them a discontinued script. I also observed in Resident A's basket, medication that belonged to Resident B. I reviewed Resident B's medication basket and all the medication in that basket belonged to Resident B.

Ms. Poberesky expressed her dissatisfaction with these allegations and stated, "We are doing an honorable job for no money. I believe we do follow the rules and we do more than anyone else. The medications in the cabinet in the laundry room belong to a resident who was discharged three years ago. The only thing we're guilty for is not throwing meds away." Ms. Poberesky reported that all DCS give medication to residents that are only prescribed to that resident and she has not violated any rules. I advised Ms. Poberesky that I will be contacting her later with my findings.

On 12/22/2020, I contacted Resident A's durable power of attorney (DPOA). The DPOA immediately began by saying, "I'm upset about the person who did that." I asked what person and he stated, "I'm not going to tell you." The DPOA stated that he visits Resident A daily as he resides a couple of miles from this group home and that he is extremely happy with Resident A's care. The DPOA stated that he has no concerns about Resident A's medication because Resident A only gets medications that are prescribed to her.

On 12/22/2020, I contacted Resident B's guardian #1 who stated that she is happy she placed Resident B at this home because they take care of her well. Guardian #1 stated that Resident B has dementia and anxiety and Resident B asked the home to give Resident B "something to calm her down," and Ms. Poberesky stated, "no." Guardian #1 stated the DCS only give Resident B medication that is prescribed to her.

On 12/22/2020, I contacted Resident C's guardian #2 who reported that she is happy that Resident C resides at this home as the DCS provide incredible level of care for Resident C. Guardian #2 stated when she visited the home before Covid-19, Resident C was well cared for and there were never any concerns. Regarding medication, guardian #2 stated, "I wanted the staff to give Resident C something to calm her down, but the staff said, no." Ms. Poberesky only administers Resident C medication that is prescribed by Resident C's physician.

On 12/22/2020, I left a voice mail message for licensee designee Ruth Poberesky with my findings.

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 {333.1101 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:	During my on-site investigation on 11/02/2020, I observed Resident A's medication basket sitting on top of the medication cabinet which was unlocked. In addition, Resident A's Symbicort Inhaler was not in the original pharmacy-supplied container for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my review of Resident A's medications and medication logs, Resident A's medications were given pursuant to label instructions. There was insufficient information to state that Resident A was given medication that was not prescribed to them.
CONCLUSION:	VIOLATION NOT ESTABLISHED

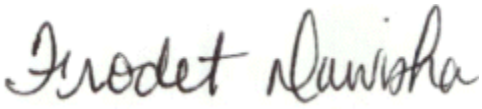
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the**

	resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	During my review of Resident A's medications and medication logs, Resident A's Aripiprazole 5MG and Escitalopram 20MG were discontinued by Resident A's physician. However, there was no discontinued script or instructions in writing regarding these medications being discontinued by the residents' physician in the resident file.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	During the on-site investigation on 11/02/2020, I observed medication in the cabinets located in the laundry room. These medications belong to Resident D who was discharged from this home three years ago.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend that this special investigation be closed and no change to the status of the license.



12/22/2020

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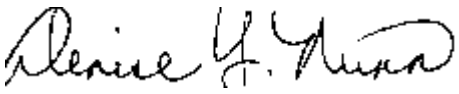
Frodet Dawisha Date
Licensing Consultant

Approved By:



12/22/2020

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Denise Y. Nunn Date
Area Manager