GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2022

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

RE: License #: AS630399606
Investigation #: 2022A0991019
Absolute 5

Dear Ms. Poberesky:

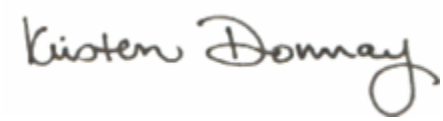
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630399606 |
| | |
| **Investigation #:** | 2022A0991019 |
| | |
| **Complaint Receipt Date:** | 03/11/2022 |
| | |
| **Investigation Initiation Date:** | 03/14/2022 |
| | |
| **Report Due Date:** | 05/10/2022 |
| | |
| **Licensee Name:** | Absolute Care, LLC |
| | |
| **Licensee Address:** | 5847 Naneva Court<br>West Bloomfield, MI 48322 |
| | |
| **Licensee Telephone #:** | (248) 252-6310 |
| | |
| **Administrator:** | Ella Maryakhin |
| | |
| **Licensee Designee:** | Ruth Poberesky |
| | |
| **Name of Facility:** | Absolute 5 |
| | |
| **Facility Address:** | 7405 Cornwall Ct<br>West Bloomfield, MI 48322 |
| | |
| **Facility Telephone #:** | (248) 252-6310 |
| | |
| **Original Issuance Date:** | 12/19/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 06/19/2020 |
| | |
| **Expiration Date:** | 06/18/2022 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>MENTALLY ILL<br>ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident B and Resident D are being neglected, with poor grooming and hygiene, and appear to be sedated. Resident B and Resident D have bruises on their bodies, as if they were hit with an object or a hand. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 03/11/2022 | Special Investigation Intake<br>2022A0991019 |
| 03/14/2022 | Special Investigation Initiated - Telephone<br>Call to visiting nurse |
| 03/14/2022 | APS Referral<br>Received from Adult Protective Services (APS) |
| 03/16/2022 | Inspection Completed On-site<br>Unannounced onsite inspection – I interviewed staff and residents |
| 03/17/2022 | Contact - Document Received<br>Copy of medication logs and orders |
| 03/25/2022 | Contact - Telephone call made<br>Left message for staff, Svitlana Galai |
| 04/06/2022 | Contact - Telephone call made<br>Left message for Dr. Feinstein |
| 04/15/2022 | Contact - Telephone call received<br>From APS worker, Tina Edens |
| 05/09/2022 | Contact - Telephone call made<br>Left message for Dr. Feinstein |
| 05/09/2022 | Contact - Telephone call made<br>Left message for staff, Svitlana Galai |
| 05/09/2022 | Exit Conference<br>Via telephone with licensee designee, Ruth Poberesky |

**ALLEGATION:**

- **Resident B and Resident D are being neglected, with poor grooming and hygiene, and appear to be sedated.**
- **Resident B and Resident D have bruises on their bodies, as if they were hit with an object or a hand.**

**INVESTIGATION:**

On 03/11/22, I received a complaint alleging that Resident B was found to be in poor condition on multiple visits to the home. She was in soiled clothing with poor grooming and appeared overmedicated. On 03/14/22, I received additional allegations from Adult Protective Services (APS) that Resident B and Resident D have bruises on their bodies, as if they were hit with an object or a hand. There were also concerns that Resident B and Resident D were not being changed regularly and were overmedicated. The allegations of physical abuse towards Resident B were previously investigated in SIR #: 2022A0993011, dated 03/14/22, and were not substantiated.

I initiated my investigation on 03/14/22, by contacting the visiting psychiatric nurse, Kathy Marshall, RN. Ms. Marshall indicated that she previously received a call from a licensing consultant regarding an investigation at Absolute 5. She stated that at the time, she had only been out to the home on two occasions and did not have much information to share. Since that time, she has been to the home several more times. Ms. Marshall indicated that during her visits to the home, she observed Resident B parked in her wheelchair alone in her room. She observed bruising on Resident B's arms. She could not determine the cause of the bruising. She stated that Resident B appeared to be sedated. Resident B fell asleep between the time that Ms. Marshall listened to her lungs and took her blood pressure. Ms. Marshall indicated that Resident B's primary care physician is Dr. Feinstein. Dr. Feinstein added a second anti-convulsant to Resident B's medications. Ms. Marshall stated that Resident B was prescribed the anti-convulsant medications, Keppra and Tegritol, which both have sedating effects. Ms. Marshall stated that the medication was prescribed by the doctor, but she was not aware of a clinical reason for it. She inquired with staff, Inna, and the owner of the home, Ruth Poberesky, but they were not aware of Resident B having any seizures and they did not seem knowledgeable about Resident B's medications or their side effects.

Ms. Marshall stated that on half of the occasions that she visited the home, Resident B's clothing was soiled from food and her skin was dry. Resident B previously had a hospice aide who came to the home to bathe her and provided a lot of care. The benefits for an aide were exhausted, so the home is now responsible for all of Resident B's care. There is typically one staff person on shift at the home. Ms. Marshall stated that Inna is the primary caregiver. Inna spends a lot of time in the kitchen and has a rough demeanor towards the residents. Ms. Marshall indicated that staff report that

Resident B is often combative and will yell and swear at them; however, she has never observed these behaviors from Resident B.

On 03/16/22, I conducted an unannounced onsite inspection at Absolute 5 with the assigned Adult Protective Services (APS) worker, Tina Edens. I interviewed direct care worker, Inna Koksharova. Ms. Koksharova stated that she has worked in the home for two years. Ms. Koksharova indicated that Resident B can be very abusive and aggressive towards staff. She calls staff names, yells, kicks, and hits staff. Resident B often refuses to take her medications and does not want to go to bed. Resident B will yell at staff to get out of her room. Ms. Koksharova indicated that she never hit Resident B and she never witnessed anyone being physically aggressive towards Resident B or any of the other residents in the home. Ms. Koksharova stated that Resident B frequently has bruises on her arms and legs, but she has very thin skin and bruises easily. Ms. Koksharova indicated that Resident B refuses to take baths, so staff give her a bed bath at least twice a week. Ms. Koksharova did not have any concerns about Resident B's grooming or appearance. Staff must put Resident B in her bed in order to change her. Sometimes Resident B cooperates and sometimes she refuses. If Resident B refuses to be changed, staff will wait and ask her later, or they will try to change her when the nurse is at the home and can help. Ms. Koksharova stated that every day is different, and they cannot force Resident B to be changed. Ms. Koksharova also stated that staff will call Resident B's daughter to help calm her down if she is refusing care or refusing to go to bed. Ms. Koshkarova indicated that Resident D uses the bathroom on her own, so she does not require staff to change her. She was not aware of Resident D having any bruises and never witnessed anyone being physically aggressive towards Resident D. Ms. Koksharova indicated that none of the residents in the home appear to be overmedicated. Staff only give medications as prescribed by the doctor. The residents are typically awake throughout the day. Resident D occasionally takes naps during the day. The residents wake up before 8:00am and go to bed around 7:30-8:00pm.

During the onsite inspection, I observed all of the residents sitting in the living room area of the home. The residents appeared to be alert and their grooming and hygiene was appropriate. Resident B and Resident D did not appear to be overmedicated or sedated. I attempted to interview Resident B, but she had difficulty answering questions due to limited cognitive abilities. Resident B stated that she felt safe in the home and indicated that nobody hits her or hurts her. I observed bruising on Resident B's left arm, but I noted that her skin appeared very thin and dry. Resident B could not say what happened to her arm.

During the onsite inspection, I attempted to interview Resident D. Resident D indicated that she has dementia and gets confused and forgets things. She stated that she is moving from the home soon. She indicated that the staff in the home are very good. She stated that Inna is a good, hard worker. Resident D stated that she feels safe in the home. She gets baths and showers regularly. Resident D did not have any bruises. She was well groomed and appeared to have good hygiene.

During the onsite inspection, the operational manager, Alina Latinsky, and the licensee designee, Ruth Poberesky, arrived at the home. They both indicated that the residents in the home are well cared for and denied the allegations of abuse, neglect, and overmedicating the residents. Ms. Poberesky indicated that they have been having issues with the relative of Resident B.

During the onsite inspection, I reviewed the medications and medication logs for Resident B and Resident D. All of the medications were prescribed by a physician. I attempted to contact the prescribing physician, Dr. Feinstein, but I did not receive a return phone call.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14305** | **Resident protection.** |
| | (3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act. |
| **ANALYSIS:** | Based on the information gathered through my investigation, there is insufficient information to conclude that the needs of the residents are not being attended to at all times. During the unannounced onsite inspection, the residents appeared alert, were well-groomed, and had good hygiene. Staff denied the allegations of neglect and indicated that Resident B and Resident D are bathed regularly. Staff change Resident B's brief regularly and Resident D uses the toilet on her own. Resident B and Resident D have limited cognitive abilities due to dementia, but they did not express any concerns about their care or the staff in the home. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | (2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:<br>(b) Use any form of physical force other than physical restraint as defined in these rules.<br>(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, |

| | |
|---|---|
| | material, or equipment for the purpose of immobilizing a resident. |
| **ANALYSIS:** | Based on the information gathered through my investigation, there is insufficient information to conclude that staff are being physically aggressive towards the residents or intentionally sedating them with medications. The residents were alert and sitting in the living room during the unannounced onsite inspection. All of the medications being administered were prescribed by a physician. Resident B had bruises on her arm, but her skin appeared very thin. Staff denied being physically aggressive towards Resident B and Resident B could not say what happened to her arm. Resident D did not have any bruises and reported that staff treat her well. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

During the unannounced onsite inspection on 03/16/22, I observed that the lock on the medication drawer was broken, and it was not locked. The licensee designee, Ruth Poberesky, indicated that she was aware the lock was broken, and it was scheduled to be fixed by maintenance.

| **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:** | Based on the information gathered through my investigation, there is sufficient information to conclude that the medications were not being stored in a locked cabinet or drawer at the time of the unannounced onsite inspection on 03/16/22 due to the lock being broken. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

During the onsite inspection, I reviewed the medications and medication administration records (MARs) for Resident B and Resident D. I noted the following:

The label instructions for Resident B's Alprazolam 0.25mg tab stated take 0.5 (half) tablet every morning and take 0.5 (half) tablet every 8 hours as needed for anxiety. Resident B's March 2022 MAR and the medication order stated Alprazolam 0.25mg tab - take one tablet every morning and take one tablet every 8 hours as needed for anxiety. Direct care worker, Inna Koksharova, indicated that she has been administering half a tablet per the label instructions, but the licensee designee, Ruth Poberesky, stated that staff should be following the orders on the MAR, as they are entered from the physician's orders.

The label instructions for Resident D's Rytary ER 23.75-95mg capsule indicated - Take 1 capsule by mouth in AM only, add another 1 capsule at lunch in 2 weeks. The label on the bottle indicates that the medication was filled on 02/14/22. Resident D's MAR shows that staff began passing the medication in the morning on 02/25/22. A second dose at lunch time should have been added in two weeks on 03/11/22. Staff did not begin passing the second dose until after the onsite inspection on 03/16/22.

The label instructions for Resident D's Donepezil 10mg stated - Take ½ tablet (5mg) at bedtime for a month and then 1 tablet (10mg) at bedtime. Resident D's MAR and medication order stated Donepezil Hydrochloride 10mg once a day - daily at bedtime. Staff began passing the medication on 02/28/22 and there is no indication that they were only passing ½ tablet as stated on the label instructions.

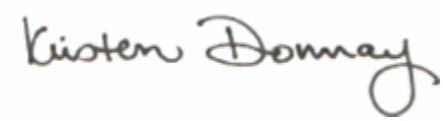
The label instructions for Resident D's Sertraline 25mg stated - Take 1 tablet by mouth for 2 weeks then 2 tablets daily as directed. Staff began passing the medication on 02/24/22. The dose should have been increased on 03/10/22, but there is no indication on the MAR that it was increased.

On 05/09/2022, I conducted an exit conference via telephone with the licensee designee, Ruth Poberesky. Ms. Poberesky indicated that the lock on the medication cabinet was repaired. She stated that she would work with the pharmacy to ensure that the MARs match the medication label instructions and are updated whenever there is a change in the dosage. She stated that they cannot make changes to the MAR, as it is an electronic system which can only be updated by the pharmacy.

| APPLICABLE RULE | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | (2) Medication shall be given, taken, or applied pursuant to label instructions. |
| **ANALYSIS:** | Based on the information gathered through my investigation, there is sufficient information to conclude that Resident B and Resident D's medications were not being given pursuant to label instructions. There were discrepancies in the dosages and label instructions for Resident B's Alprazolam, and Resident D's Rytery, Donezepil, and Sertraline. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



05/09/2022

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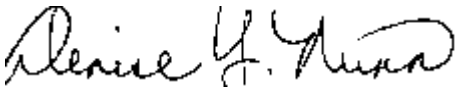
Kristen Donnay Date
Licensing Consultant

Approved By:



05/11/2022

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Denise Y. Nunn Date
Area Manager