GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2023

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

RE: License #: AS630399606
Investigation #: 2023A0602004
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 licensee designee and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan 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 (248) 975-5053.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630399606
Investigation #:	2023A0602004
Complaint Receipt Date:	10/18/2022
Investigation Initiation Date:	10/19/2022
Report Due Date:	12/17/2022
Licensee Name:	Absolute Care, LLC
Licensee Address:	5847 Naneva Court West Bloomfield, MI 48322
Licensee Telephone #:	(248) 252-6310
Administrator:	Ruth Poberesky
Licensee Designee:	Ruth Poberesky
Name of Facility:	Absolute 5
Facility Address:	7405 Cornwall Ct West Bloomfield, MI 48322
Facility Telephone #:	(248) 252-6310
Original Issuance Date:	12/19/2019
License Status:	REGULAR
Effective Date:	06/19/2022
Expiration Date:	06/18/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Layers of thick fecal matter was found in Resident A's sheets. The nurse could not perform a catheter change due to the amount of fecal matter around the area.	Yes
Resident A was in the home between October 1, 2022, through October 8, 2022, and was fed starchy food with little to no protein.	No
Additional Findings	Yes

III. METHODOLOGY

10/18/2022	Special Investigation Intake 2023A0602004
10/19/2022	Special Investigation Initiated - On Site Interviewed staff Member Inna Koksharova and the administrator, Ella Maryakhin.
10/19/2022	Contact – Document Received Received requested documents from licensee designee.
10/25/2022	Contact – Telephone call made Message left for complainant.
11/02/2022	Contact – Telephone call made Message left for Family Member 1.
11/02/2022	Contact – Telephone call made Message left for placing agency, Area Agency on Aging 1B (AAA)
12/06/2022	Contact – Telephone call made Message left for complainant.
12/20/2022	Contact – Telephone call made Spoke with Family Member 1.
01/09/2023	Contact – Telephone call made Call made to nurse practitioner, Shirley Castro.
01/23/2023	Contact – Telephone call made Spoke with social worker from AAA, Sara Richter

01/23/2023	Contact – Telephone call made Message left for Family Member 1.
01/23/2023	Contact – Telephone call made Spoke with Resident A.
01/23/2023	Contact – Telephone call made Spoke with Resident A's home care nurse, Melissa Gaglio.
01/23/2023	Exit Conference Held with the licensee designee, Ruth Poberesky by telephone.
02/01/2023	Contact – Telephone call made Message left for the complainant.
02/01/2023	Contact – Telephone call made Message left for Tiffany Newbeck who is a risk and safety manager with Star Emergency Medical Services.
02/01/2023	Exit Conference Held with the licensee designee, Ruth Poberesky by telephone.
02/02/2023	Contact – Telephone call received Spoke with Tiffany Newbeck.
02/02/2023	Contact – Telephone call made Message left for the licensee designee, Ruth Poberesky.

ALLEGATION:

Layers of thick fecal matter were found in Resident A's sheets. The nurse could not perform a catheter change due to the amount of fecal matter around the area.

INVESTIGATION:

On 10/18/2022, a complaint was received and assigned for investigation alleging that layers of thick fecal matter were found in Resident A's sheet, the nurse was unable to perform a catheter change due to the amount of fecal matter around the area. It was also alleged that Resident A was in the home between October 1, 2022, through October 8, 2022, and was fed starchy food with little to no protein.

On 10/19/2022, I conducted an unannounced on-site investigation at which time I spoke with staff Member Inna Koksharova. Ms. Koksharova stated she has worked in the home for over two years. She was able to recall Resident A's weeklong stay at the facility. Ms. Koksharova assisted Resident A with feeding, bathing, and changing her

clothing. She went on to state that Resident A was a large woman and required two people to lift her. Ms. Koksharova then contacted her manager, Ella Maryakhin to inform her that I was at the home. Ms. Maryakhin arrived shortly after the call was made.
On 10/19/2022, I interviewed Ella Maryakhin who identified herself as the administrator. Ms. Maryakhin stated Resident A was admitted to the facility on October 1, 2022, for a respite stay and was discharged on October 8, 2022. She described Resident A as being a large bedbound woman who required total care and two people to lift or reposition her. She stated it was impossible for one person to turn Resident A due to her size. Resident A was given sponge bathes daily and more often if she had a bowel movement. Ms. Maryakhin said Resident A would lay flat in bed on top of a sheet with one staff Member on each side of her bed. One staff Member would pull the sheet towards her (to move Resident A on her side) while the other staff Member washed Resident A's private area. According to Ms. Maryakhin, there was only one staff Member scheduled for each shift but when Resident A needed to be cleaned or changed, staff would contact either herself or the licensee designee, Ruth Poberesky as they live less than two miles from the home. Ms. Maryakhin said Resident A had a visiting nurse to change her catheter once a week. The nurse came to the home on 10/04/2022 and made no complaint about being unable to change Resident A's catheter for any reason.

On 10/19/2022, I received and reviewed a copy of Resident A's health care appraisal, assessment plan and staff schedule dated 10/01/2022 through 10/08/2022. The health care appraisal documented that Resident A is obese, bedbound, and unable to reposition herself. The assessment plan documented that Resident A is bedbound, able to use upper extremities only, staff to reposition every two hours, staff to change depends after each bowel movement, sponge bath daily by staff, total care with dressing and personal hygiene provided by staff as needed.

On 12/20/2022, I interviewed Family Member 1 by telephone. Family Member 1 stated Resident A was referred to Absolute 5 by Area Agency on Aging for respite care as she was going out of town for a week. Family Member 1 made a visit to the home prior to Resident A being admitted, spoke with Ms. Maryakhin and Ms. Poberesky and toured the home. It was explained to Ms. Poberesky that Resident A was bedbound, required total care, and needed two people to manage her care. Ms. Poberesky assured her that the staff were capable of caring for Resident A. On 10/01/2022, Resident A was transported to the facility by ambulance and Family Member 1 met them at the facility. Upon arrival, the emergency medical technicians (EMT) transferred Resident A from the stretcher onto the bed with a mega mover (a sheet with handles). Family Member 1 left the mega mover, several gowns and several briefs with staff to be used for Resident A.

Family Member 1 stated on 10/08/2022, she arranged for an ambulance to pick up Resident A from the group home and transport her back to her own home. Once at the facility, it was observed that Resident A's catheter bag was full of urine and the EMT's had to ask the staff member (name unknown) to empty the bag before they could transport her. When Resident A was transferred from the bed and onto the stretcher, it was observed that she was still laying on the mega mover she was transported to the

facility on. Staff were using blue bed pads rather than Resident A's briefs as none of her briefs or gowns had been used. Family Member 1 was informed by the EMT's that Resident A was not wearing a brief, the blue bed pad she was laying on was saturated with fecal matter and fecal matter was caked on her buttocks. Family Member 1 stated it took her almost three hours to clean Resident A after getting her back home. Resident A has a visiting nurse once each week to change her catheter. Family Member 1 was informed by the visiting nurse that when she arrived at the facility on 10/04/2022, there was a staff member (name unknown) in the room with Resident A but left out once she entered the room and did not return the entire time she was there. Resident A was full of feces and needed to be cleaned. The nurse was unable to change Resident A's catheter during her visit because she spent her entire time bathing her.

On 01/09/2023, I spoke with Shirley Castro who is the nurse practitioner for Resident A's primary care physician. Ms. Castro stated Resident A's catheter care nurse was not referred from their office. She had no information regarding any care Resident A receives from the visiting nurse.

On 1/23/2023, I spoke with Sara Richter, a social worker at AAA. Ms. Richter provided a contact number for Resident A and Resident A's home care nurse.

On 01/23/2023, I interviewed Resident A by telephone. Resident A stated the only time staff cleaned her was when she had a bowel movement. Staff would only wipe off some of the feces and leave her laying in the rest. She said she never received a complete bed bath during her week-long stay because staff told her she was too large. Resident A stated that her home care nurse, Melissa Gaglio did come to the home to change her catheter but was only able to irrigate it due to the area being unclean.

On 1/23/2023, I spoke with Resident A's home care nurse, Melissa Gaglio by telephone. Ms. Gaglio stated she has been providing catheter care to Resident A in her home once a week for the past three years. She made a visit to the group home to change Resident A's catheter (exact date unknown) and found her laying in feces (on her backside) from the top of her shoulders down to her calves. Family Member 1 left enough briefs large enough to fit her but she was not wearing one at the time of the visit and her sheets were filthy. A staff member (name unknown) asked her if she was there to take care of Resident A and she informed her that she was only there to change her catheter. Ms. Gaglio informed the staff member that Resident A had a bowel movement and needed to be cleaned before she could change her catheter. The staff refused to clean Resident A.

Ms. Gaglio stated she could not leave Resident A in that condition. Staff brought her soapy water and she proceeded to clean Resident A as best she could. It took her an hour and a half to complete the job. She had to push Resident A's body to the side and hold it up with one hand while cleaning her with her other hand. Once she was able to push Resident A to her side, she observed several sanitary pads stuck all over her buttocks to absorb the feces. When the staff member was questioned about this, she pretended not to speak English and walked out of the room. Ms. Gaglio was unable to

change Resident A's catheter as she needed someone to hold Resident A's legs apart and staff refused to assist her. Ms. Gaglio stated that she has never seen Resident A in that condition in all the years she has been assisting her. She is always neat, clean and wearing a brief.

On 02/02/2023 I spoke with Tiffany Newbeck, the risk and safety manager with Star Emergency Medical Services (EMS). Star EMS is the ambulance company that transported Resident A from the group home and back to her home on 10/08/2022. Ms. Newbeck pulled the report that was written by the EMT's who transported Resident A on 10/08/2022. According to the report, EMT's met Family Member 1 at the group home and found Resident A lying in bed on top of a mega mover that contained a large amount of feces. Bedsores were observed on her back and buttocks. Her vitals were taken and found to be good. Resident A informed the EMT's that she had a family member bring her some fruit during her stay at the group home, but staff told her it would cause her to have diarrhea and took it away from her. Resident A also reported that she was given Imodium to prevent her from having diarrhea.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.
ANALYSIS:	Based on the information obtained from Ms. Maryakhin, Family Member 1, Ms. Poberesky, Resident A and Ms. Gaglio, Resident A is bedbound, obese, and requires a two person assist with personal care. According to the staff schedule dated 10/01/2022 - 10/08/2022, there was only one staff member scheduled on each shift with the following statement noted at the bottom of the schedule, "In case of help required with bed bath, call Ella/Ruth (whoever is available). According to Ms. Maryakhin, when Resident A had a bowel movement or required bathing, the staff member on shift was instructed to contact her or the licensee designee and one of them would come to the home to assist.

	Resident A stated she was never given a bed bath during her stay in the home. When she had a bowel movement, staff would wipe some of the feces off and left her laying in the rest. Ms. Gaglio found Resident A laying in feces and staff refused to clean her or assist Ms. Gaglio with cleaning her. According to Ms. Poberesky, Resident A received bed baths daily, but this was not documented on the bath schedule. According to the weekly bath schedule, Resident A was scheduled for a bed bath on Wednesday and Sunday. On Monday, Tuesday, Thursday, Friday and Saturday it was provided on an as needed basis. Based on this information, I determined that the licensee accepted Resident A into the facility without adequate staffing to meet all her needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 obtained from Family Member 1, Ms. Gaglio and Resident A, there is sufficient information to determine that Resident A was not treated with dignity and her personal needs were not met. Family Member 1 was informed by the EMT's that Resident A was not wearing a brief, the blue bed pad she was laying on was saturated with fecal matter and fecal matter was caked on her buttocks. Family Member 1 stated it took her almost three hours to clean Resident A after getting her back home. Ms. Gaglio found Resident A laying in feces and staff refused to clean her or assist Ms. Gaglio with cleaning her. Resident A stated she was never given a bed bath during her stay in the home. When she had a bowel movement, staff would wipe some of the feces off and left her laying in the rest.

CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was in the home between October 1, 2022, through October 8, 2022, and was fed starchy food with little to no protein.

INVESTIGATION:

According to Family Member 1 there was concern about the meals Resident A were provided during her respite stay. Resident A is a diabetic and should not eat a lot of starchy foods, but they were served to her while at the facility.

On 10/19/2022, I received and reviewed menus from Ms. Maryakhin dated 10/01/2022 through 10/14/2022. According to the menus reviewed, potatoes, rice, noodles, or pasta was served during 10 lunch mealtimes and 11 dinner mealtimes. There were substitute meals provided but some of them also included starchy foods. There were fruits and/or vegetables documented at every mealtime.

On 10/19/2022, I also received and reviewed a copy of Resident A's health care appraisal and assessment plan dated 10/08/2022. The health care appraisal documents Resident A as being diagnosed with spinal stenosis, GERD, multiple sclerosis, neurogenic bladder and obesity. Resident A was on a regular diet but required blood glucose checks every morning. There was no documentation of diabetes listed on either form. However, the following medications were listed:

- Basaglar 100 units/ml 50 units – 9 am
- Basaglar 100 units/ml 55 units – 9 pm
- Januvia 100 mg – 9 am
- Furosemide 40 mg – 9 am
- Furosemide 20 mg – 9 pm
- Risperidone 1 mg – 9 am and 9 pm
- Citalopram 20 mg – 9 am
- Eliquis 5 mg – 9 am and 9 pm
- Atorvastatin Calcium 10 mg – 9 pm
- Hydromorphone 2 mg – 1 am, 5 am, 9 am, 1 pm, 5 pm, and 9 pm
- Baclofen 20 mg (take two 10 mg tabs) – 9 am and 9 pm
- Protonix 40 mg – 9am and 9 pm
- Oxybutynin chloride 15 mg – 9 am and 9 pm
- Lactobacillus (one cap) – 9am
- Centrum Vitamin D 500 mg – 9 am
- Ferrous Sulfate 325 mg – 1 pm
- Liquid Potassium CL ER – 9 am
- Cranberry CAP 450 mg – 9 am and 9 pm

- Clobetasol Cream (apply to right foot) – 9 am and 9 pm
- Melatonin 10 mg – 9 pm

On 01/23/2023, I interviewed Resident A by telephone. Resident A stated she did not like all the meals served as there were a lot of starchy foods provided. She had a family member who visited her and brought her some food.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine that the licensee provided meals to Resident A that were not consistent with a regular diet. According to the menus dated 10/01/2022 through 10/14/2022, there were starchy foods served at several mealtimes. However, Resident A's health care appraisal and assessment plan documented that she was on a regular diet.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/19/2022, I received and reviewed the staff schedule for the month of October 2022, as well as Resident A's health care appraisal and assessment plan. According to the staff schedule, there was one staff member scheduled on each shift with the following statement noted at the bottom of the schedule, "In case of help required with bed bath, call Ella/Ruth (whoever is available).

On 01/23/2023, I spoke with the licensee designee, Ruth Poberesky. Ms. Poberesky stated although there is only one staff member scheduled on each shift, Ms. Maryakhin or herself will go to the home three days daily (8 am, 3 pm and 9 pm) to assist with resident care. She stated that she did not feel the need to put herself or Ms. Maryakhin on the schedule since they are the owner/operator of the home.

On 02/01/2023 I conducted a second exit conference with the licensee designee, Ruth Poberesky by telephone. I informed Ms. Poberesky that after speaking with my area manager, my recommendation has changed to 1st provisional. Ms. Poberesky stated I

did not take into consideration that there was a 45-minute window where there were two staff members on shift (8 am - 8:15pm, 7:30 pm - 8:15 am, and 7:30 am – 8:15 pm) and she and Ms. Maryakhin were also in the home.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that the licensee did not have sufficient direct care staff on duty at all times to meet the needs of Resident A. On 10/19/2022, I reviewed the staff schedule for the month of October 2022, Resident A's health care appraisal, and assessment plan. The staff schedule documented one staff member is scheduled on each shift with the following statement noted at the bottom of the schedule, "In case of help required with bed bath, call Ella/Ruth (whoever is available). The health care appraisal documented that Resident A is obese, bedbound, and unable to reposition herself. The assessment plan documented that Resident A was bedbound, staff to reposition every two hours, staff to change depends after each bowel movement, sponge bath daily by staff, total care with dressing and personal hygiene provided by staff as needed. According to Ms. Maryakhin, there was only one staff member scheduled for each shift but when Resident A needed to be cleaned or changed, staff would contact either herself or the licensee designee, Ruth Poberesky as they live less than two miles from the home. According to Ms. Poberesky, she or Ms. Maryakhin went to the home three times daily (8 am, 3 pm and 9 pm) to ensure Resident A's needs were met. However, Resident A's assessment plan documented that staff would reposition her every two hours. This could not have occurred even if Ms. Poberesky or Ms. Maryakhin came to the home at 8 am, 3 pm and 9 pm with only one staff on shift.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2021A0993016; CAP dated 4/25/2021**

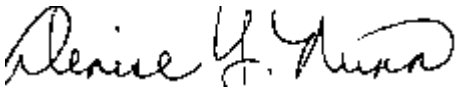
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, a 1st provisional license is recommended.

02/02/2023

Cindy Berry — Date
Licensing Consultant

Approved By:



02/02/2023

Denise Y. Nunn — Date
Area Manager