GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2021

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

RE: License #: AS630399606
Investigation #: 2021A0993016
Absolute 5

Dear Ms. Poberesky:

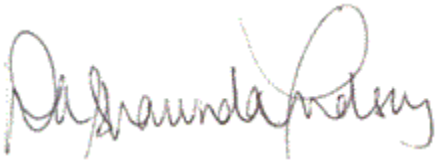
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



DaShawnda Lindsey, Licensing Consultant
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630399606
Investigation #:	2021A0993016
Complaint Receipt Date:	03/12/2021
Investigation Initiation Date:	03/15/2021
Report Due Date:	05/11/2021
Licensee Name:	Absolute Care, LLC
Licensee Address:	5847 Naneva Court - 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 - 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 MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A wandered away from the facility. Resident A was found unsupervised, knocking on a neighbor's door. Law enforcement was able to return Resident A to the facility after staff called and reported her missing.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/12/2021	Special Investigation Intake 2021A0993016
03/12/2021	APS Referral Allegations received from adult protective services (APS). The intake was denied.
03/12/2021	Contact - Document Received Received a copy of the incident report
03/15/2021	Special Investigation Initiated - Letter Requested a copy of the police report from West Bloomfield Police Department
03/15/2021	Contact - Document Received Received a copy of the police report from West Bloomfield Police Department
03/30/2021	Inspection Completed On-site Conducted an announced onsite investigation
03/30/2021	Contact - Document Received Received documentation
03/30/2021	Contact - Telephone call made Telephone call made to home manager Elina Sosnovskaya
03/30/2021	Contact - Telephone call made Telephone call made to Resident A's granddaughter. Left a message.
03/30/2021	Contact - Telephone call made Telephone call made to Resident A's daughter. Left a message.

03/30/2021	Contact - Telephone call made Telephone call made to staff Byambasuren Purejar
03/30/2021	Contact - Telephone call made Telephone call made to licensee designee Ruth Poberesky
03/30/2021	APS Referral Forwarded allegations to adult protective services (APS)
03/31/2021	Contact - Telephone call received Telephone call received from APS specialist Marcie Fincher
04/07/2021	Contact - Telephone call made Telephone call made to Resident A's daughter
04/07/2021	Contact - Telephone call made Telephone call made to Resident A's granddaughter
04/15/2021	Contact - Telephone call made Telephone call made to APS specialist Marcie Fincher
04/19/2021	Exit Conference Attempted to conduct an exit conference with licensee designee Ruth Poberesky with no success. I left a message.

ALLEGATION:

Resident A wandered away from the facility. Resident A was found unsupervised, knocking on a neighbor's door. Law enforcement was able to return Resident A to the facility after staff called and reported her missing.

INVESTIGATION:

On 03/12/2021, I received the allegations from adult protective services (APS). The intake was denied.

On 03/12/2021, I received a copy of the incident report (IR). Per the IR, written by home manager Elina Sosnovskaya, on 03/11/2021, she supervised five residents in the facility. While she was assisting Resident B in the bathroom, Resident A turned off the door alarm and walked out of the facility. When Ms. Sosnovskaya finished assisting Resident B, she checked on Resident A and noticed Resident A was missing. She called her boss (name not identified in the IR) and the police. She saw a police car driving down the street, called the police and asked them to bring Resident A back to the facility. The corrective measures were explaining to Resident A how dangerous it is

to leave out the facility unsupervised, keeping the bathroom door open, and placing a cover over the off button on the front door alarm.

On 03/15/2021, I received a copy of the police report from West Bloomfield Police Department. Per the report, police were dispatched to the neighbor's home on 03/11/2021 for a suspicious person. The neighbor observed Resident A's on her porch with her walker. Police made contact with Resident A "who was hard of hearing". When asked by police, Resident A did not state her name or where she lived. Police used the police system and were able to identify Resident A. Police attempted to contact Resident A's daughter and granddaughter with no success. While waiting for responses from Resident A's family, police made contact with neighboring departments. Police learned Ms. Sosnovskaya called the department concerning Resident A. The report documented Ms. Sosnovskaya stated she "was asked to fill in from 1400 hrs to 1700 hrs for [staff Byambasuren Purejav]". "According to [Ms. Sosnovskaya], [Resident A] was sitting on the front porch when [Ms. Purejav] left the residence but [Ms. Sosnovskaya] did not notice her when she arrived and was under the impression [Resident A] was napping in her room. It was after over 2 hours had passed that she went to check on Lena and realized she was missing."

On 03/30/2021, I conducted an unannounced onsite investigation. I interviewed staff Cheryl Loukinen. Ms. Loukinen stated she was not working in the facility when Resident A wandered away. She verified the incident occurred on 03/11/2021 while Ms. Sosnovskaya was working. According to Ms. Loukinen, Resident A has a history of wandering away. There is an alarm on Resident A's bedroom door, the front door as well as the garage door. Ms. Loukinen stated if the front door alarm is turned on and you open the front door, the alarm will sound until you either close the front door or turn it off.

I attempted to interview Resident A with no success. Resident A is verbal, but she has limited cognitive abilities.

During the onsite investigation, I observed an alarm on the front door, garage door as well as Resident A's bedroom. The alarms on the garage door and front door both sounded when those doors were open. The garage door alarm sounded, but the sound was not continuous. The front door alarm sounded, and the sound was continuous until either the door was closed, or the alarm was turned off. The alarm on Resident A's bedroom was turned off.

While at the facility, administrator Ella Maryakhin visited. Ms. Maryakhin verified Resident A has a history of wandering away, but she had never wandered off while living in the facility. Resident A moved into the facility about 1½ months ago.

On 03/30/2021, I received a copy of Resident A's assessment plan. Per the plan, Resident A cannot move independently in the community. Resident A is "confused, unable to go outside alone. Ambulates with walker but forgets to use, staff to remind to use walker and provide hands on assistance as needed". The plan did not document

that Resident A has a history of wandering away or document measures that are in place to prevent Resident A from wandering away.

On 03/30/2021, I conducted a telephone interview with home manager Elina Sosnovskaya. Ms. Sosnovskaya verified she worked in the facility on 03/11/2021 when Resident A wandered away. According to Ms. Sosnovskaya, she arrived at the facility around 2pm. She began assisting Resident B around 2:30pm. She realized Resident A was gone around 2:45pm. She looked around the facility, and then she remembered seeing a police car going up and down the street. She called police and informed them Resident A was missing. About 30 to 45 minutes later, police brought Resident A back to the facility. Ms. Sosnovskaya stated there is an alarm on the front door. The alarm was turned on, but Resident A turned it off prior to leaving out of the facility. As a result, the alarm did not sound when she left out of the facility.

On 03/31/2021, I conducted a telephone interview with APS specialist Marcie Fincher. She verified she is also investigating the allegations.

On 04/07/2021, I conducted a telephone interview with Resident A's daughter. Resident A's daughter stated she is Resident A's guardian as well. She stated Resident A has severe Dementia and a history of wandering away. When Resident A was admitted into the facility, she discussed Resident A's history of wandering away while at other facilities. Per Resident A's daughter, there is supposed to be an alarm on the door to notify staff if Resident A exit out of the facility. Resident A's daughter stated she cannot imagine Resident A being able to turn off the alarm prior to exiting the facility.

On 04/07/2021, I conducted a telephone interview with Resident A's granddaughter. She stated staff was informed Resident A has a history of wandering away when she moved into the facility. There is supposed to be an alarm on the front door to notify staff if Resident A exit out of the facility. She stated staff informed her of the incident on 03/11/2021 and she was told Resident A could not have been gone for more than a few minutes.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A has a history of wandering away. Resident A has Dementia. On 03/11/2021, Resident A wandered away from the

	facility. Per the assessment plan, Resident A cannot move independently in the community. Resident A is “confused, unable to go outside alone. Ambulates with walker but forgets to use, staff to remind to use walker and provide hands on assistance as needed”. The plan did not document that Resident A has a history of wandering away or document measures that are in place to prevent Resident A from wandering away.
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:	Resident A has a history of wandering away. Resident A has Dementia. On 03/11/2021, Resident A wandered away from the facility. Ms. Sosnovskaya stated there is an alarm on the front door. The alarm was turned on, but Resident A turned it off prior to leaving out of the facility. As a result, the alarm did not sound when she left out of the facility. According to Resident A’s daughter, Resident A has severe Dementia and she could not imagine Resident A being able to turn off the alarm prior to exiting the facility. It is plausible that the alarm was not turned on, allowing Resident A to wander away from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/30/2021, I conducted an unannounced onsite investigation. I interviewed staff Cheryl Loukinen. Ms. Loukinen stated she works from 8am to 8pm on Saturday, Sunday, Monday, and Tuesday. There is only one staff per shift.

While at the facility, administrator Ella Maryakhin visited. Ms. Maryakhin stated the shifts are 12 hours, and sometimes there are two staff per shift. When there is only one staff, staff uses a Hoyer lift to meet the residents’ needs.

On 03/30/2021, I received a copy of the residents' assessment plans. The following was documented in each plan:

Resident A:

- Cannot move independently in the community
- "Confused, unable to go outside alone. Ambulates with walker but forgets to use, staff to remind to use walker and provide hands on assistance as needed"
- Requires assistance with eating/feeding, toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility
- Uses a walker and has a hospital bed with full length rails

Resident B:

- Cannot move independently in the community
- Does not have any assistive devices and is a wander risk
- Requires assistance with eating/feeding, toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility

Resident C:

- Cannot move independently in the community
- Has a "wheelchair, staff to push, unable to assist with transfers, unable to sit without support"
- Requires assistance with eating/feeding, toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility
- Has a Hoyer lift and hospital bed with full length rails

Resident D:

- Cannot move independently in the community
- Has a walker and staff to provide hands on assistance with mobility
- Requires assistance with eating/feeding, toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility
- Has a hospital bed with full length rails

Resident E:

- Cannot move independently in the community
- Has a wheeled walker and staff to provide hands on assistance with mobility as needed.
- Requires assistance with eating/feeding, toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility

I also received a copy of the staff schedule from 03/01/2021 to 03/15/2021. I observed the following:

- On 03/01/2021, 03/02/2021, from 03/05/2021 to 03/10/2021, 03/12/2021, 03/13/2021, and 03/15/2021, there was one staff scheduled per shift (12-hour shifts).

- On 03/03/2021, except for the period from 1pm to 3pm, there was one staff scheduled per shift.
- On 03/04/2021, except for the period from 5pm to 7pm, there was one staff scheduled per shift.
- On 03/11/2021, except for the period from 9am to 11am, there was one staff scheduled per shift.
- On 03/14/2021, except for the periods from 9am to 11am, 12pm to 2pm, and 5pm to 7pm, there was one staff scheduled per shift.
- Ms. Purejar worked alone from 8pm to 8am on 03/03/2021, from 4pm to 5pm as well as as from 7pm to 8pm on 03/04/2021, from 8am to 9am as well as from 11am to 2pm on 03/11/2021, and from 8am to 9am, 11am to 12pm, 2pm to 5pm and 7pm to 8pm on 03/14/2021.

On 03/30/2021, I attempted to conduct a telephone interview with staff Byambasuren Purejar, but she stated her English is “not well” and she could not answer the any questions.

On 03/30/2021, I conducted a telephone interview with licensee designee Ruth Poberesky. Ms. Poberesky verified Ms. Purejar does not speak English well. She stated there is usually another staff scheduled with Ms. Purejar during parts of her shift.

On 04/15/2021, I conducted a telephone interview with APS specialist Marcie Fincher. She stated she interviewed licensee designee Ruth Poberesky. During the interview, Ms. Poberesky acknowledged there should be at least two staff per shift to meet the residents’ needs.

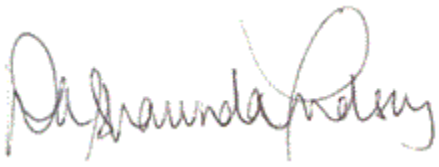
On 04/19/2021, I attempted to conduct an exit conference with licensee designee Ruth Poberesky with no success. I left a message.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qulaifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Ms. Purejar does not speak English well. Ms. Poberesky verified Ms. Purejar does not speak English well. There is usually another staff scheduled with Ms. Purejar during parts of her shift. From 03/01/2021 to 03/15/2021, there were periods of time Ms. Purejar worked alone in the facility. Due to not speaking English well, there is concern Ms. Purejar will be unable to effectively communicate during emergency situations.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident C uses a wheelchair, is unable to assist, and requires staff to push. Resident D uses a walker and requires staff to provide hands on assistance with mobility. All the residents require assistance with eating/feeding, toileting, bathing, grooming, dressing, personal hygiene, and walking/mobility. Ms. Poberesky acknowledged there should be at least two staff per shift to meet the residents' needs. However, there are sometimes only one staff per shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

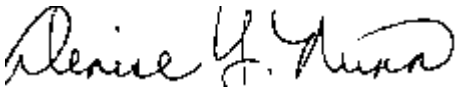
Contingent upon receipt of a corrective action plan, I recommend no change in the license status.



04/19/2021

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



04/19/2021

Denise Y. Nunn Date
Area Manager