GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 10, 2019

Irina Dennert
21301 Kenosha Street
Oak Park, MI 48237

RE: License #: AS630380863
Investigation #: 2019A0993054
Arinas Senior Care

Dear Irina Dennert:

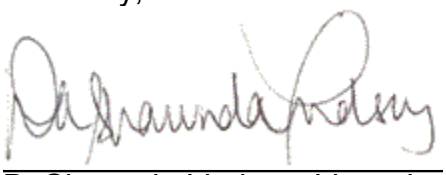
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630380863
Investigation #:	2019A0993054
Complaint Receipt Date:	09/23/2019
Investigation Initiation Date:	09/24/2019
Report Due Date:	11/22/2019
Licensee Name:	Irina Dennert
Licensee Address:	24574 Colin Kelly Centerline, MI 48015
Licensee Telephone #:	(248) 277-6889
Administrator:	Irina Dennert
Licensee Designee:	N/A
Name of Facility:	Arinas Senior Care
Facility Address:	21301 Kenosha Oak Park, MI 48237
Facility Telephone #:	(248) 277-6889
Original Issuance Date:	06/15/2017
License **Status:**	REGULAR
Effective Date:	08/15/2018
Expiration Date:	08/14/2020
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B was taken to the hospital on 09/19/2019 on a petition from licensee designee Irina Dennert. He did not meet criteria for hospitalization. Ms. Dennert is refusing to take Resident B back to the facility.	Yes

III. METHODOLOGY

09/23/2019	Special Investigation Intake 2019A0993054
09/23/2019	APS Referral Received allegations from adult protective services (APS)
09/24/2019	Special Investigation Initiated - Telephone Telephone call made to APS specialist Tiffany Pitts
09/24/2019	Contact - Telephone call made Telephone call made to Providence Hospital social worker Carl Grady. He stated he will call me back.
09/24/2019	Contact - Telephone call made Telephone call made to licensee designee Irina Dennert. Left a message.
09/24/2019	Contact - Document Sent Sent a text message to licensee designee Irina Dennert
09/24/2019	Contact - Document Sent Emailed licensee designee Irina Dennert
09/24/2019	Contact - Telephone call made Telephone call made to Resident B's guardian's case manager
09/24/2019	Contact - Telephone call made Telephone call made to Resident B's co-guardian (and brother). Left a message.
09/24/2019	Contact - Telephone call received Telephone call received from Providence Hospital social worker Carl Grady

09/24/2019	Contact - Face to Face Interviewed Resident B at Providence Hospital in Southfield
09/26/2019	Contact - Telephone call made Telephone call made to licensee designee Irina Dennert. Left a message.
09/26/2019	Contact - Document Sent Sent a text message to licensee designee Irina Dennert
09/26/2019	Contact - Document Sent Emailed licensee designee Irina Dennert
09/26/2019	Contact - Telephone call made Telephone call made to Resident B's co-guardian (and brother). Left a message.
09/26/2019	Contact - Telephone call made Telephone call made to Resident B's co-guardian (and brother)
09/27/2019	Contact - Telephone call made Telephone call made to licensee designee Irina Dennert. Left a message.
10/01/2019	Contact - Telephone call made Telephone call made to licensee designee Irina Dennert. Left a message.
10/01/2019	Contact - Document Sent Sent a text message to licensee designee Irina Dennert
10/01/2019	Contact - Document Sent Emailed licensee designee Irina Dennert
10/01/2019	Contact - Telephone call received Telephone call received from license designee Irina Dennert
10/01/2019	Exit Conference Exit conference with licensee designee Irina Dennert

ALLEGATION:

Resident B was taken to the hospital on 09/19/2019 on a petition from licensee designee Irina Dennert. He did not meet criteria for hospitalization. Ms. Dennert is refusing to take Resident B back to the facility.

INVESTIGATION:

On 09/23/2019, I received the allegations from adult protective services (APS).

On 09/24/2019, I conducted a telephone interview with APS specialist Tiffany Pitts. She confirmed she is investigating the allegations. Resident B was seen and cleared at Providence Hospital in Southfield and ready for discharged on 09/20/2019. Resident B is still at the hospital. The facility is refusing to pick him up due to his behaviors. Resident B's guardian and co-guardian (and brother) are currently trying to secure another facility for Resident B.

On 09/24/2019, I conducted a telephone interview with Resident B's guardian's case manager. She stated Resident B was admitted to the facility either on 09/13/2019 or 09/14/2019. Resident B was physically and verbally aggressive towards staff and other residents. Resident B was hitting and spitting on people. In addition, he attempted to set the facility on fire. Two days later, Resident B was taken another one of licensee designee Irina Dennet's unlicensed facilities. Resident B's guardian case manager did not know the name of the facility and/or the address. Ms. Dennert then transported Resident B to the hospital. When Resident B was cleared and ready for discharged, Ms. Dennert and the staff refused to pick him up. Resident B's guardian's case manager stated Ms. Dennert did not issue Resident B a discharge notice. In addition, she did not notify Resident B's guardian or co-guardian (and brother) that Resident B was being transferred to another facility.

On 09/24/2019, I conducted a telephone interview with Providence Hospital social worker Carl Grady. He stated Resident B was transported to the emergency room on 09/19/2019. Resident B was cleared and ready for discharged on 09/20/2019. Resident B has been an observation room since 09/20/2019 due to the facility refusing to pick him up. Resident B is still in the hospital. Mr. Grady stated he is working with Resident B's guardian, trying to get him placed in the Veteran Affairs (VA) Hospital.

On 09/24/2019, I interviewed Resident B at Providence Hospital in Southfield. I was only able to obtain limited information due to Resident B's cognitive state. Resident B confirmed he was living in a facility prior to being transported to the hospital. Resident B was unable to state the name of the facility and/or the address. In addition, he did not know the name of the individual who transported him to the hospital. Resident B stated he has been at the hospital for about one week.

On 09/26/2019, I conducted a telephone interview with Resident B's co-guardian (and brother). He verified Resident B was admitted to the facility for about two days. He was then taken another one of licensee designee Irina Dennet's unlicensed facilities. Resident B's co-guardian (and brother) did not know the name of the facility and/or the address. Resident B exhibited behavioral concerns and he was transported to the hospital. When Resident B was cleared and ready to be discharged, Ms. Dennert and the staff refused to pick him up. Resident B's co-guardian (and brother) stated Ms.

Dennert did not issue Resident B a discharge notice. In addition, she did not notify him that Resident B was being transferred to another facility.

On 10/01/2019, I conducted a telephone interview with licensee designee Irina Dennert. She confirmed Resident B was briefly admitted to the facility prior to her transporting him to the hospital. Ms. Dennert acknowledged she refused to pick him up when he was cleared and ready to be discharged. Ms. Dennert acknowledged she did not issue a discharge notice to Resident B and/or his guardians. Ms. Dennert denied Resident B was taken to one of her unlicensed facilities. According to Ms. Dennert, Resident B exhibited behavioral concerns while at the facility he was admitted to. When staff was unable to redirect him, she drove him around in her car. She later transported him to the hospital because she did not know what else to do.

On 10/01/2019, I conducted an exit conference with licensee designee Irina Dennert. I informed her of the findings. She disagreed with the findings, but she agreed to submit a corrective action plan.

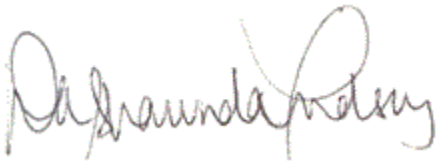
APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Resident B exhibited behavioral concerns after being admitted into the facility. Ms. Dennert did not issue him a discharge notice. Instead, she took him to another facility, and then transported him to the hospital. When he was cleared and ready to be discharged, she refused to pick him up.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(6) A licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible agency.
ANALYSIS:	Resident B exhibited behavioral concerns after being admitted into the facility. Ms. Dennert took him to another facility, and then transported him to the hospital. She did not notify Resident B's guardian and co-guardian (and brother) about this move.
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 B exhibited behavioral concerns after being admitted into the facility. Ms. Dennert did not issue him a discharge notice. Instead, she took him to another facility, and then transported him to the hospital. When he was cleared and ready to be discharged, she refused to pick him up.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

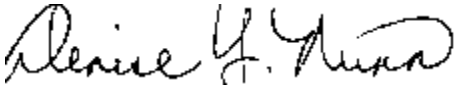
Contingent upon receipt of a corrective action plan, I recommend no change in the license status.



10/03/2019

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



10/10/2019

Denise Y. Nunn — Date
Area Manager