



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 23, 2020

Irina Dennert
21301 Kenosha Street
Oak Park, MI 48237

RE: License #: AS630380863
Investigation #: 2020A0611030
Arinas Senior Care

Dear Irina Dennert:

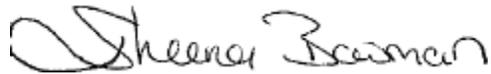
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in black ink that reads "Sheena Bowman". The signature is written in a cursive style with a large initial "S".

Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630380863
Investigation #:	2020A0611030
Complaint Receipt Date:	06/02/2020
Investigation Initiation Date:	06/03/2020
Report Due Date:	07/02/2020
Licensee Name:	Irina Dennert
Licensee Address:	24574 Colin Kelly Centerline, MI 48015
Licensee Telephone #:	(248) 277-6889
Administrator:	N/A
Licensee Designee:	Irina Dennert
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?
<ul style="list-style-type: none"> • The staff are not certified in CPR. • Resident R was missing multiple items from his belongings. • Family was not notified that resident was exposed to COVID from another resident. 	No
Additional Findings	Yes

III. METHODOLOGY

06/02/2020	Special Investigation Intake 2020A0611030
06/03/2020	Special Investigation Initiated - Telephone I left a voice message for the licensee requesting a call back.
06/10/2020	Contact - Telephone call made I left a voice message for the licensee designee requesting a call back.
06/12/2020	Contact - Telephone call made I made a telephone call to the licensee however; there was no answer. A message was not left because the mailbox is full.
06/12/2020	Contact - Telephone call made I left a voice message for the reporting source requesting a call back.
06/12/2020	Contact - Face to Face I made an unannounced onsite visit. I spoke to staff member, Sharnita Liggins outside of the AFC group home. I also spoke to the licensee designee, Irina Dennert via telephone.
06/16/2020	Contact - Telephone call made I made a return phone call to Florence Perry. The allegations were discussed.
06/16/2020	Contact - Telephone call made I made a telephone call to Resident R's daughter. Resident R's daughter was unable to speak. She stated she will call me back.

06/16/2020	Contact - Telephone call made I left a voice message for the licensee designee, Irina Dennert regarding the documents that I requested and a phone number for staff member Sabrina McClure.
06/16/2020	Contact - Document Sent I emailed a letter to the Oak Park police department requesting a copy of the police report filed by Ms. Dennert.
06/16/2020	Contact - Telephone call made I left a voice message for staff member, Sabrina McClure requesting a call back.
06/16/2020	Contact - Telephone call received I received a return phone call from Resident R's daughter. The allegations were discussed.
06/16/2020	Contact - Telephone call made I made a return phone call to Ted Kozlowski from Oak Park police department. Mr. Kozlowski findings were discussed.
06/17/2020	Contact - Telephone call made I made a telephone call to the licensee designee, Irina Dennert. There was no answer.
06/17/2020	Contact - Telephone call made I made a telephone call to Resident R's daughter. She provided the address to Ms. Dennert's other AFC group home.
06/17/2020	Contact - Telephone call made I left a voice message for the licensee designee, Irina Dennert regarding the requested documents.
06/17/2020	Contact - Telephone call made I made a telephone call to Florence Perry. Ms. Perry provided information regarding Ms. Dennert's AFC group homes.
06/17/2020	Contact - Document Received I received a copy of a police report from the Southfield Police Department.
06/17/2020	Contact - Face to Face I made an unannounced onsite to 24230 Berg. Rd. Southfield, MI. I spoke with staff member, Bessie Brown.

06/19/2020	Contact - Telephone call made I made a telephone call to the licensee designee, Irina Dennert regarding the documents I requested a week ago. There was no answer. A voice message was left.
06/21/2020	Contact - Document Received I received an email from Ms. Dennert. Ms. Dennert provided copies of Resident R's identification record, inventory of valuables, a picture of several small balls of different colors and copies of CPR certification cards for staff member, Barbara Shorky, Tamela McClure, Bessie Round, Sharnita Liggins, and Sabrina McClure.
06/23/2020	Exit Conference I conducted an exit conference with the licensee Irina Dennert, via email.

ALLEGATION:

- **The staff are not certified in CPR.**
- **Resident R was missing multiple items from his belongings.**
- **Family was not notified that resident was exposed to COVID from another resident.**

INVESTIGATION:

On 06/12/20, I made an unannounced onsite. I spoke to staff member, Sharnita Liggins outside of the AFC group home. Ms. Liggins stated today is her first day working at the AFC group home. Ms. Liggins is not aware of any of the residents in the home being sick. Ms. Liggins also stated she is not aware of any of the residents dying of COVID-19. Ms. Liggins contacted the licensee designee, Irina Dennert via telephone.

On 06/12/20, I interviewed Ms. Dennert over the telephone. Regarding the allegations, Ms. Dennert stated Resident D passed away in March 2020 due to respiratory issues. Resident D was on oxygen and she died in the hospital. Ms. Dennert stated Resident D tested negative for COVID-19. Ms. Dennert stated following Resident D's death, Resident R passed away in March 2020. Resident R passed away due to respiratory issues and he had issues with swallowing. Ms. Dennert stated EMS determined that Resident R died from respiratory issues and not COVID-19. Resident R was not tested for COVID-19. Ms. Dennert stated Resident R's daughter could have made a request for Resident R to be tested for COVID-19 following his death, but she decided not to.

Ms. Dennert stated Resident R's daughter called her and told her she was not worried about retrieving Resident R's clothing however, she only wanted Resident R's pictures for memories. Ms. Dennert stated after she spoke to Resident R's daughter, she sanitized and cleaned the whole house. Ms. Dennert stated she waited four weeks

before she threw away Resident R's clothing. Ms. Dennert stated Resident R's possessions consisted of a few clothing items and pictures. Ms. Dennert also stated Resident R would also urinate in his clothing. Ms. Dennert stated about two weeks ago, Resident R's daughter sent her a text message stating she was coming to the AFC group home that day to retrieve Resident R's belongings. Ms. Dennert responded to Resident R's daughter and stated her father's belongings were ready to be picked up.

Ms. Dennert was not present when Resident R's daughter arrived at the AFC group home. Ms. Dennert stated when Resident R's daughter came to the AFC group home, she became verbally aggressive towards staff member, Sabrina McClure. Resident R's daughter was upset because all of Resident R's belongings were thrown away. Ms. Dennert stated Resident R's daughter threatened and used verbal abusive language towards Ms. McClure. Ms. Dennert stated Resident R did have a squeezing ball and some games for his Alzheimer's. Ms. Dennert stated these items may be in the basement however, she will have to look for them. Ms. Dennert stated these items were not given to Resident R's daughter because she was running throughout the home screaming at Ms. McClure. Ms. Dennert stated she filed a police report with Oak Park Police Department. Ms. Dennert stated she did complete an inventory list for Resident R.

Ms. Dennert stated there are three employees at the AFC group home. Ms. Dennert stated all her staff members are trained in CPR. Resident R's file is at her office and not in the AFC group home. Ms. Dennert agreed to send me copies of Resident R's inventory list, identification record, and CPR trainings for all her staff members.

On 06/16/20, I made a return phone call to Florence Perry. Ms. Perry is a social worker and provides individual and group therapy for the residents. Ms. Perry has worked at the AFC group home since April 2019. Prior to COVID-19, Ms. Perry saw the resident on Monday's, Wednesday's, and Friday's. Ms. Perry is currently providing group therapy sessions through Telehealth. Regarding the allegations, Ms. Perry stated she was informed by Ms. Dennert that two residents passed away. Ms. Perry stated one of the residents that passed away was a male who was 100 years old and he was in hospice. Ms. Perry stated this resident's roommate was the second resident that passed away. Ms. Perry stated she does not know why the second resident passed away. Ms. Perry stated she thinks both residents passed away either at the end of March or at the beginning of April. Ms. Perry does not have any concerns regarding the residents not being properly cared for. Ms. Perry stated the home is always clean and the residents are always feed and well groomed.

On 06/16/20, I received a return phone call from Resident R's daughter. Regarding the allegations, Resident R's daughter stated Ms. Dennert lied to her when she asked her if Resident R had any symptoms of COVID-19. Resident R's daughter stated she was informed by a staff member that some of the residents in the home had symptoms of COVID-19. This staff member informed Ms. Dennert about some of the residents having symptoms however, Ms. Dennert ignored her. Resident R's daughter stated this staff member no longer works at the AFC group home because she did not like how things

were being handled at the AFC group home regarding COVID-19. Resident R's daughter mentioned that Ms. Dennert has several different homes.

Resident R's daughter stated Neptune Society funeral home came to the AFC group home to pick up Resident R's body. She was informed by Neptune Society that someone at the AFC group home died from COVID-19 five days prior to Resident R's death. Resident R passed away on 03/30/20. Resident R's daughter stated she asked the staff at the AFC group home if they are trained in CPR and they told her no. Initially Resident R's daughter told Ms. Dennert she only wanted Resident R's pictures and not his clothes. Resident R's daughter stated when she went to the AFC group home to retrieve Resident R's belongings, she received a small box of pictures, a wheelchair, a walker, and two coats. Resident R's daughter became upset because Ms. Dennert threw away Resident R's clothes even though she previously said she did not want them. Resident R's daughter bought Resident R three items for his Alzheimers that were worth a \$100. Resident R's daughter did not ask about the whereabouts of these three items when she was at the AFC group home. She stated that the caregiver called the police and said that she threatened her. Resident R's daughter denied threatening the caregiver.

On 06/16/20, I made a return phone call to Ted Kozlowski from Oak Park police department. Mr. Kozlowski stated there is no record of a police report being filed regarding the AFC group home in the month of May 2020. There was an EMS visit to the AFC group home on 03/28/20; which is the last record of contact from the police. Mr. Kozlowski stated the last police contact regarding Ms. Dennert was on 02/20/19 regarding her being a witness to an assault. Mr. Kozlowski stated there is no record of a phone call made by Ms. McClure. Mr. Kozlowski stated he may be able to locate a possible phone call from the AFC group home if a specific date of the phone call is provided.

On 06/16/20, I received a return phone call from staff member, Sabrina McClure. Regarding the allegations, Ms. McClure stated a total of three residents passed away at the AFC group home over the last few months. Ms. McClure thinks Resident R passed away first and does not know why. Ms. McClure stated another resident who was 100 years old and on hospice passed away. Ms. McClure stated during the month of March, she sent Resident T to the hospital because her blood sugar was low. Resident T was in the hospital for a week before she died. Ms. McClure stated Resident T may have had COVID-19 but she was not sure.

Ms. McClure stated prior to Resident R's daughter arriving to the AFC group home to pick up Resident R's belongings, she received a phone call from Ms. Dennert stating Resident R's daughter was on her way to the AFC group home. Ms. Dennert informed Ms. McClure that Resident R's belongings were in the garage. When Resident R's daughter arrived to the AFC group home, she appeared agitated. Resident R's daughter went to the garage to get Resident R's belongings. Ms. McClure stated Resident R's daughter came back into the house and said some things are missing. Ms. McClure proceeded to walk throughout the house including the basement and Resident R's

bedroom. Ms. McClure stated Resident R's daughter started making threats towards her and Ms. Dennert. Ms. McClure sent Ms. Dennert a text message about Resident R's daughter being upset because she could not find Resident R's belongings. Ms. McClure stated she did not know anything about Resident R's belongings because she had just returned to work after being off for several weeks. Resident R's daughter left the AFC group home very upset. Ms. McClure did not pay attention to what Resident R's daughter took with her because she was feeding the residents. Ms. McClure filed a police report with the Southfield police. Ms. McClure agreed to send me a copy of her police report.

Ms. McClure was asked why she filed a police report with the Southfield police department if the AFC group home is located in Oak Park, MI. Ms. McClure stated she does not work at Ms. Dennert AFC group home in Oak Park. Ms. Dennert has another AFC group home located in Southfield, where Resident R was residing. Ms. McClure stated there are five residents and foster care services are being provided at this AFC group home in Southfield. There is a total of three employees and they all provide supervision, personal care, and protection. Ms. McClure stated there is a social worker that provides services to the residents.

On 06/17/20, I made a telephone call to Resident R's daughter. She stated her father was residing at Ms. Dennert's AFC group home located at 24230 Berg Rd. Southfield, MI 48033. Resident R's daughter stated Resident R use to live at Ms. Dennert's AFC group home located in Oak Park, MI before he moved to the AFC group home in Southfield, MI.

On 06/17/20, I made a telephone call to Florence Perry. Ms. Perry was hesitant to tell me how many AFC group homes Ms. Dennert owns, as she told me I would need to ask Ms. Dennert. Ms. Perry stated Ms. Dennert has an AFC group home located on Berg Rd. in Southfield, MI, Kenosha Street in Oak Park, MI, and Coyle Street in Oak Park, MI. Ms. Perry did not know the complete addresses to these homes off hand. Ms. Perry stated some of the residents receive services from CNS, PACE, or Easter Seals.

On 06/17/20, I received a copy of a police report dated 06/03/20 from the Southfield Police Department. According to the police report, the occurrence date was 06/01/20 and the location was 24230 Berg Rd. Southfield, MI. The police report indicates that Ms. McClure is the victim of intimidation by Resident R's daughter. When Resident R's daughter arrived at the AFC group home to pick up Resident R's belongings, she became irate and told Ms. McClure "you better find my dad's things or I'm going to kick your ass". Resident R's daughter denied the allegations of the verbal assault however, she admitted to expressing herself about the manner of the care to her late father and his property to the staff members. The status of the case is closed.

On 06/17/20, I made an unannounced onsite to 24230 Berg Rd. Southfield, MI. I spoke with staff member, Bessie Brown. Ms. Brown stated she started working for the AFC group home on 05/09/20. Ms. Brown stated three residents reside in the AFC group

home and two out of the three residents receive therapy services. Ms. Brown agreed to ask Ms. Dennert to call me.

On 06/21/20, I received an email from Ms. Dennert. Ms. Dennert provided copies of Resident R's identification record, inventory of valuables, a picture of several small balls of different colors, and copies of CPR certification cards for staff member, Barbara Shorky, Tamela McClure, Bessie Round, Sharnita Liggins, and Sabrina McClure. All of the CPR certification cards were current. According to the identification record, Resident R's address included the AFC group home on Kenosha St. in Oak Park, MI and the AFC group home on Berg Rd. in Southfield, MI. However, the address for Kenosha St. was crossed out. Resident R was discharged on 03/28/20.

According to the inventory of valuables, Resident R's clothes, blanket, toothbrush, toothpaste, and soap were not picked up from the AFC group home within 30 days following his death. Resident R's jacket and pictures were picked up on 06/02/20. Resident R's Alzheimers toy is still at the AFC group home.

APPLICABLE RULE	
R 400.14204	Direct care staff; qualifications and training.
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (c) Cardiopulmonary resuscitation.
ANALYSIS:	On 06/21/20, Ms. Dennert provided copies of CPR certification cards for staff member, Barbara Shorky, Tamela McClure, Bessie Round, Sharnita Liggins and Sabrina McClure. All of the CPR certifications were current.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14315	Handling of resident funds and valuables.
	(15) Personal property and belongings that are left at the home after the death of a resident shall be inventoried and stored by the licensee. A licensee shall notify the resident's designated representative, by registered mail, of the existence of the property and belongings and request disposition. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the

	date that written notification is sent to the designated representative.
ANALYSIS:	<p>Following Resident R's death, Ms. Dennert spoke to Resident R's daughter over the telephone. Resident R's daughter told Ms. Dennert she was not worried about retrieving Resident R's clothing however, she only wanted Resident R's pictures for memories.</p> <p>On 06/16/20, Resident R's daughter initially told Ms. Dennert she only wanted Resident R's pictures and not his clothes. When Resident R's daughter went to the AFC group home to retrieve Resident R's belongings, she received a small box of pictures, a wheelchair, a walker and two coats. Resident R's daughter became upset because Ms. Dennert threw away Resident R's clothes even though she previously said she did not want them.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14315	Handling of resident funds and valuables.
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	<p>On 06/21/20, I received a copy of Resident R's inventory of valuables form. According to the inventory of valuables, Resident R's clothes, blanket, toothbrush, toothpaste, and soap were not picked up from the AFC group home within 30 days following his death. Resident R's jacket and pictures were picked up on 06/02/20. Resident R's Alzheimers toy is still at the AFC group home.</p> <p>Ms. Dennert waited four weeks after Resident R passed away before she threw away his clothing items. Resident R's daughter confirmed that she told Ms. Dennert that she only wanted Resident R's pictures.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

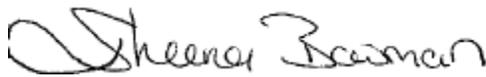
On 06/12/20, Ms. Dennert stated Resident R's file is at her office and not in the AFC group home. Ms. Dennert agreed to send me copies of Resident R's inventory list, identification record and CPR trainings for all her staff members.

On 06/23/20, I conducted an exit conference with the licensee designee, Irina Dennert via email. The findings and recommendations were provided. Ms. Dennert was advised a corrective action plan will be required.

APPLICABLE RULE	
R 400.14316	Resident records.
	(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.
ANALYSIS:	Resident R's records were not kept on file in the AFC group home following his death on 03/30/20.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

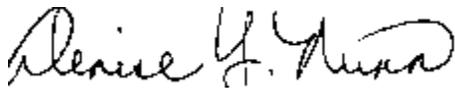
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Sheena Bowman
Licensing Consultant

06/23/20
Date

Approved By:



06/23/2020

Denise Y. Nunn
Area Manager

Date