GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 17, 2021

Irina Dennert
21301 Kenosha Street
Oak Park, MI 48237

RE: License #: AS630380863
Investigation #: 2021A0605016
Arinas Senior Care

Dear Ms. Dennert:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Frodet Dawisha

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630380863
Investigation #:	2021A0605016
Complaint Receipt Date:	03/10/2021
Investigation Initiation Date:	03/10/2021
Report Due Date:	05/09/2021
Licensee Name:	Irina Dennert
Licensee Address:	24574 Colin Kelly Centerline, MI 48015
Licensee Telephone #:	(248) 277-6889
Administrator/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:	08/15/2020
Expiration Date:	08/14/2022
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS/AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was observed in her room tied down to the bed. There was no linen on the bed, and she was tied down with a restraint vest through her legs. The rails of the bed were pulled up.	Yes
Three weeks ago, Resident A had a bruise on her lip and forehead and she also lost three teeth. The facility advised that she fell.	Yes
Resident A has also lost almost 15 pounds since her admission in November 2020.	Yes
Resident A's diaper was also soaking wet. There were no covers on Resident A's bed, and she had on street clothes from the day before (yesterday).	Yes
Additional Findings	Yes

III. METHODOLOGY

03/10/2021	Special Investigation Intake 2021A0605016
03/10/2021	APS Referral Adult Protective Services Referral (APS) made.
03/10/2021	Special Investigation Initiated - Telephone Telephone call with Resident A's daughter.
03/10/2021	Inspection Completed On-site An unannounced on-site investigation was conducted. I interviewed Residents B, C and D. I also interviewed direct care staff (DCS) Rayonda Williams.
03/10/2021	Contact - Telephone call made Telephone call made with Resident A's daughter.
03/11/2021	Contact - Document Sent Email sent to licensee designee Irina Dennert requesting Residents A, B, C, and D's assessment plans, weight records and guardian's information. I also requested staff schedule and staff's contact information.

03/11/2021	Contact - Telephone call made I left a voice mail message for Irina Dennert requesting a return call to discuss allegations.
03/11/2021	Contact – Telephone call made I attempted to all DCS Adrienne Turner on the telephone number provided by Resident A's daughter, but the number is no longer in service.
03/16/2021	Contact - Telephone call made I left another voice mail message for Irina Dennert.
03/16/2021	Contact - Telephone call made I left a voice mail message for APS worker Gene Evans.
03/16/2021	Contact - Telephone call made Telephone call made with Resident A's daughter.
03/16/2021	Contact – Telephone call received Telephone call received from APS worker Gene Evans.
03/16/2021	Contact – Telephone call received Telephone call received from Irina Dennert. The allegations were discussed.
03/17/2021	Exit Conference I left a message for licensee Irina Dennert advising her of my findings and recommendation.

ALLEGATION:

- **Resident A was observed in her room tied down to the bed. There was no linen on the bed, and she was tied down with a restraint vest through her legs. The rails of the bed were pulled up.**
- **Three weeks ago, Resident A had a bruise on her lip and forehead and she also lost three teeth. The facility advised that she fell.**

INVESTIGATION:

On 03/10/2021, intake # 178152 was assigned for investigation regarding Resident A being tied down to her bed using a restraint harness. The bed had no linens, or blanket and Resident A was soiled. Resident A lost weight while residing at this home.

On 03/10/2021, I contacted via telephone Resident A's daughter. The daughter stated that she went to visit with Resident A at Arina's Senior Care and found Resident A tied

up to her bed. The daughter was at work so I told the daughter I would call her back after I conducted the on-site investigation at Arina's Senior Care. She acknowledged.

On 03/10/2021, I conducted an unannounced on-site investigation. I was greeted by the direct care staff (DCS) Rayonda Williams. Ms. Williams stated she had been working for licensee designee Irina Dennert for over five years, but then left and returned on 02/01/2021. She stated she works Mondays-Thursdays from 9AM-9PM and there is only one DCS per shift. Ms. Williams stated there is no staff awake during the midnight shift but that "she rarely sleeps." Ms. Williams stated she sleeps in the living room.

The allegations were discussed. Ms. Williams stated she arrived at work on 03/08/2021 and Resident A's daughter told her she was going to take Resident A out, but then never returned with Resident A. She is not sure where Resident A was moved to. Ms. Williams stated Adrienne Turner was the staff that works Saturdays/Sundays and was working last weekend. Ms. Williams stated, "Resident A is a fall risk, then maybe someone tied her up because they were trying to get work done." Ms. Williams stated that Resident A is very active, keeps getting up from bed, has unsteady gait and very fragile. She stated Resident A requires a DCS "to be right beside her whenever she gets up." Ms. Williams has never witnessed Resident A tied up and stated she has never tied up Resident A. Resident A has never fallen during her shift; however, stated that Adrienne told her that Resident A fell to her knees while Adrienne was escorting Resident A to the bathroom. Ms. Williams stated that Resident A's daughter pointed out the bruising to Resident A's lip on 03/08/2021, but Ms. Williams does not know how Resident A sustained the bruise. Ms. Williams stated that about two weeks ago, DCS Tammy (last name unknown) told her that Resident A was getting weak and was having increased falls. Last week, Resident A's legs were weak, and she was becoming more confused. Resident A was getting up in the middle of the night and would not remain in bed. Ms. Williams stated, "I'm a light sleeper so I would get up and help her." Ms. Williams denied tying Resident A to the bed at night while she was sleeping.

Ms. Williams did not know where any of the residents' records were or the resident register for the residents' information. She pulled out the residents' medication logs and provided me with Resident B, Resident C and Resident D's names. I observed Resident B's medications to be in a pill organizer and not in their own prescription bottles. Ms. Williams stated Resident B was admitted into this home on 03/06/2021, with his medications in the pill organizer.

I reviewed the staff log that was documented by DCS Adrienne Turner on 03/07/2021 and 03/08/2021. Adrienne documented on 03/07/2021 that Resident A fell in the kitchen while her daughter was present. Adrienne documented on 03/08/2021, that Resident A's daughter arrived at the home in the morning upset that Resident A was still in bed and tied to the bed. Adrienne wrote she tried explaining to Resident A's daughter why Resident A was tied to the bed and that it was because Resident A was a fall risk.

I interviewed Resident B in his bedroom. Resident B was sitting in his recliner and covered up with a blanket. He stated he has not lived here long, but he does not like it

here at all. He said, “it’s like they don’t want me here.” Resident B stated he has never been tied to his bed and he does not know anything about Resident A. Resident B appeared to be clean and had good hygiene. While I was speaking with Resident B, Ms. Williams came into the room and stated that licensee designee Irina Dennert was on the telephone. I informed Ms. Williams to ask Ms. Dennert where were all the resident records and resident register. Ms. Williams stated that Ms. Dennert told her that all resident records were not at this home and that Ms. Dennert removed them all yesterday “to review them.” Ms. Williams informed Ms. Dennert that I will call her afterwards.

I interviewed Resident C in her bedroom. Resident C was lying in bed. She stated, “it’s alright,” living here. She gets enough food to eat and denied being tied to her bed. Resident C stated she is fully ambulatory and does not know anything about Resident A because, “I don’t go in anybody’s room.” Resident C appeared to be clean and had good hygiene.

I attempted to interview Resident D while she was sitting in her wheelchair watching TV in the living room but was unsuccessful. Resident D has dementia and was repeating my questions back to me. She appeared to be clean and had good hygiene.

On 03/11/2021, Resident A’s daughter sent me the following email summarizing her contact with Arina’s Senior Care:

> “I moved my mother (Resident A) into Arina’s Senior Care on November 15, 2020. I took pictures of my mother on this date. She was happy to carry on a conversation on the phone with friends and family and comfortably wearing a size 10 pants. Due to the COVID-19 pandemic restrictions that were placed on families, which limited the visitations, I was not allowed to see mom as frequently as desired. I was alerted by Ben Arcenal her visiting nurse that mom was losing weight since her stay in the home. During this time, I was able to receive two doses of the Pfizer COVID-19 vaccine and I immediately increased my visitations with mom. I noted on February 8, 2021, that mom had a deep ruby red bruise on her lower right lip a significant bruise on her upper forehead left side and later notice that the teeth on her right side were missing. I was told by the owner Irina Dennert that the caregiver said mom had fell but no further explanation was offered or given of how or when or why. I expressed my concerns about the bruises to Irina Dennert. I suspected abuse. Pictures have been provided.
>
> On Monday, March 8, 2021, I entered the home at 8 o’clock am to bring mom breakfast which I had started doing daily. She was still losing weight which Ben Arcenal had confirmed to me one week prior. I had several conversations with the owner regarding mom’s weight loss and the need to make sure that she was being provided proper nutrition. Please see before and after pictures. I had also had prior conversations with the owner not to have mom restraint in the chair in the living room, which I have seen routinely used on several occasions. Irina Dennert promised me at that time that she would not be using restraints for mom.

Note: this is the same restraint vest that I found mom strapped to the bed in on March 8, 2021.

On March 8, 2021, I entered my mom's room to find her strapped to the bed with the restraining vest, street clothes on, a soaking wet diaper and side rails up and her feet were hanging between the bed rails and she was struggling to get loose from the restraints. Her fresh clean new bed linen was in a chair, but she had not been provided them instead she was left to sleep on a cold plastic mattress in the winter because they said they did not want to be bothered cleaning her sheets. This is clearly elder abuse. I promptly told them this was inhumane. The caregiver told me she was just about to get her up and that she had to restrained her to get her to go to bed. I asked her to leave the room. I will take care of her there was no confrontation argument or raising of the voice. I took pictures of the situation I try to remove the restraint. I was unable to. I had to cut my mother loose because the knots were so severe. I cleaned my mother up checked her body for any additional abuse fed her breakfast and left with her in my care no exchange had with the caregiver. I drove directly to the Oak Park Police Department with my mom in the car and spoke to Detective Anthony Carognan. Then I contacted LARA as well as APS adult protective services per Detective Anthony Carognan's request. I have since talked to Gene Evans of adult protective services as well."

On 03/11/2021, Resident A's daughter emailed me pictures she took of Resident A on the day of 03/08/2021 when she found her tied to her bed. The pictures show a white strap tied around Resident A onto the bed rails. A restraint harness was used to tie Resident A down onto her bed. There were no linens or blanket on the bed. Resident A appeared disheveled in the picture.

On 03/11/2021, I contacted Resident A's daughter via telephone. The daughter stated the DCS that tied her mother to the bed was Adrienne Turner. She provided me with her contact number. Resident A is currently in a facility located in Livonia.

On 03/11/2021, I left a voice mail message for licensee Irina Dennert and sent her an email requesting Resident A's, Resident B's, Resident C's, and Resident D's assessment plans. I also requested weight records and Resident B's, Resident C's, and Resident D's guardian information. I received no return call or email response from Ms. Dennert.

On 03/11/2021, I contacted Detective Anthony Carignan with Oak Park Police Department. Detective Carignan stated he spoke briefly with Resident A's daughter who was very upset about this situation. He told Resident A's daughter to call APS and to have APS make a referral to law enforcement or to return to speak with him and file a complaint. He stated he gave the daughter his business card.

On 03/11/2021, I contacted Resident A's daughter and advised her to call Detective Carignan and file a police report regarding this incident. She agreed.

On 03/16/2021, Mr. Arcenal stated one time he received a telephone call from Resident A's daughter about Resident A having a red/purplish bruise on her right lip and a bruise on her left temple. Mr. Arcenal conducted an unannounced visit to Arina's the next day and observed these injuries. He spoke with Adrienne who told him that Resident A fell. He asked Adrienne for an explanation as to how Resident A fell, but Adrienne was unable to provide an explanation or describe how Resident A fell. Mr. Arcenal stated that a fall was not consistent with the injury because the injuries were on opposite sides, right lip and left temple. Mr. Arcenal again educated Adrienne on the importance of reporting all falls to Resident A's daughter immediately. He talked to Ms. Dennert about Adrienne not reporting to Resident A's daughter immediately after the fall and Ms. Dennert stated, "Adrienne is dumb."

On 03/16/2021, I contacted Resident A's daughter to obtain a copy of Resident A's assessment plan. The daughter stated she never completed an assessment plan at admission and that she only completed one document which was the amount paid for cost of care. The daughter emailed the resident care agreement which was not completed on the department's form.

On 03/16/2021, I received a telephone call from licensee designee Irina Dennert. The allegations were discussed. Ms. Dennert stated she received a telephone call from DCS Adrienne Turner on 03/08/2021, crying on the phone asking if she is getting fired. Ms. Dennert asked her, "What happened?" Adrienne stated, "Resident A's daughter is upset with me because I used the gait belt." Ms. Dennert stated she asked Adrienne how she used the gait belt and that is when Adrienne told Ms. Dennert that she tied Resident A to her bed with the gait belt. Adrienne told Ms. Dennert she tied Resident A to the bed because "Resident A was trying to get up." Ms. Dennert stated she told Adrienne that was unacceptable and she would speak with Resident A's daughter. Ms. Dennert stated she fired Adrienne. Ms. Dennert reported the gait belt was prescribed by Resident A's therapist due to unsteady gait but does not have a prescription from the physical therapist. She stated the gait belt is only to be used to assist Resident A while walking. Ms. Dennert stated Resident A's daughter never told her that Resident A was being tied to her chair with the gait belt. She stated the daughter told Ms. Dennert that "she did not want the gait belt used." Ms. Dennert was unable to state why the daughter said she did not want the gait belt used by staff on her mother.

On 03/16/2021, I received a telephone call from APS worker, Gene Evans. Mr. Evans is currently investigating these allegations and stated he will be substantiating his case for abuse/neglect of Resident A.

Ms. Dennert stated the bruise on Resident A's right side of her lip and left temple were caused on 03/07/2021 when Resident A was walking in the kitchen with her daughter and her daughter fell on top of her. Ms. Dennert was advised that according to the home health care nurse, these injuries were observed before 03/07/2021. Ms. Dennert then stated the injuries were because Resident A fell in the bathroom while Adrienne was assisting her in there. Ms. Dennert stated Adrienne told her that Resident A fell on the

floor, hitting the door causing the right lip and left temple injuries. Ms. Dennert was unable to explain how the fall caused the injuries on both sides of Resident A's face. She stated this fall was documented and she will forward the documentation to me via email. Ms. Dennert stated she does not believe Adrienne or any of her other staff caused physical harm to Resident A. She stated, "I know Adrienne was not abusing her. She would not put a finger on her because she's religious." Ms. Dennert stated she does not hire staff that are abusive to her residents and all her residents are cared for. She stated it was unacceptable of what Adrienne did to Resident A, but that Resident A was not abused.

Ms. Dennert stated that Resident A was eating three meals a day plus snacks. She knows this because she is at the home and sees Resident A finish her meals. Ms. Dennert stated Resident A has lost weight, but not sure how much. She stated that Resident A was difficult to weigh so she had a home health care come monthly to weigh Resident A on a chair scale. Ms. Dennert stated she will send me Resident A's weight records via email. Ms. Dennert stated she offers nutritional meals and that her residents never go hungry. Resident A's daughter was also bringing food for Resident A, but she is not sure why Resident A was losing weight.

Ms. Dennert stated she removed all the resident records from the home because Resident B was admitted into the home this past Saturday and she wanted to audit all the records. She will send me all the residents' assessment plans and their guardians' contact information as well as her staff's contact information within a couple of hours. Note: As of 03/17/2021, Ms. Dennert has not provided any of the documents she stated she would be sending for review.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation and information gathered, DCS Adrienne Turner was not suitable to meet the physical, emotional, and intellectual, and social needs of Resident A. Adrienne tied Resident A to her bed with a gait belt that was only supposed to be used to assist Resident A while walking due to Resident A's unsteady gait.
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:	Based on my investigation, Resident A has had numerous falls that resulted in serious injuries. DCS Rayonda Williams stated that Resident A requires constant supervision because she is a fall risk and consistently gets up at night. Therefore, there is insufficient DCS on duty for the supervision, personal care, and protection of residents. According to DCS Rayonda Williams, she works Mondays-Thursdays from 9AM-9PM and is asleep during the midnight shift.
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 my investigation and information gathered, Resident A's personal needs, including protection and safety were not attended to at all times by DCS Adrienne Turner. Resident A was tied down to her bed by Adrienne and had fallen numerous times that resulted in unexplained injuries to her face. Resident A sustained a bruise on the right side of her lip, left temple and three of her teeth were knocked out. The explanation provided by Adrienne to Resident A's nurse, Ben Arcenal was not consistent with the injuries. According to Mr. Arcenal, Adrienne was unable to provide details regarding Resident A's fall and how Resident A sustained injuries on opposite sides of each other during the same fall.
CONCLUSION:	**VIOLATION 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: **(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 my investigation and information gathered, Resident A was restrained by DCS Adrienne Turner who tied Resident A with a gait belt onto Resident A's bed. Resident A's daughter found Resident A tied to her bed on 03/08/2021. According to the daughter, the straps were tied tightly around Resident A onto the bedrails. The daughter had to cut the straps to untie Resident A. Adrienne documented in the staff log that she tied Resident A to the bed because Resident A is a "fall risk."
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A has also lost almost 15 pounds since her admission in November 2020.

INVESTIGATION:

On 03/10/2021, DCS Ms. Williams stated Resident A was getting three meals a day and snacks. She stated she does not know anything about Resident A's weight loss because Resident A was eating all her meals. I observed the refrigerator and freezer and there was plenty of nutritious food in this home.

On 03/16/2021, I contacted via telephone registered nurse, Ben Arcenal with Corporsano Home Health Care. Mr. Arcenal has been Resident A's nurse since she was at a previous facility. Resident A weighed 144 pounds when she left that facility and was admitted into Arina's Senior Care. Mr. Arcenal stated that one of the caregivers (name unknown) mentioned to him that Resident A was losing weight about six weeks ago. This caregiver told him that Resident A had a good appetite and was eating all her meals but continued to lose weight. He does not know how much weight she had lost, but stated he last saw her a week before her leaving Arina's and she appeared to have lost weight. Mr. Arcenal told the caregiver and Irina Dennert to begin giving Resident A Ensure drink twice daily about three weeks prior to his last visit. He is not sure if the caregivers were following his recommendation or not. Mr. Arcenal stated the caregivers

were complaining about Resident A being agitated at night. Mr. Arcenal would visit weekly unannounced and she would always be sitting on the recliner and was calm, quiet, and pleasant. Mr. Arcenal would educate the staff on how to approach Resident A who had a strong personality but would continue to be told by the caregivers that Resident A was agitated. Mr. Arcenal stated he had several conversations with Irina Dennert about educating her staff on Resident A's weight loss and how to approach Resident A.

On 03/16/2021, Resident A's daughter emailed me the form Arina's Senior Care utilized to record Resident A's monthly weight. According to the document, Resident A's weight was not recorded on 11/19/2020, 01/09/2021, and 03/02/2021. There is no date on the form for December 2020 and February 2020.

APPLICABLE RULE	
R400.14316	**Resident records.**
	(1)A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information. **(g) Weight record.**
ANALYSIS:	During the on-site investigation on 03/16/2021, Resident A's weight records were not maintained in the home or available for my review.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on the weight record form used by Arina's Senior Care, Resident A was not weighed monthly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's diaper was soaking wet. There were no covers on Resident A's bed, and she had on street clothes from the day before (yesterday).

INVESTIGATION:

On 03/11/2021, Resident A's daughter emailed pictures of Resident A's condition she was found by the daughter on 03/08/2021. I reviewed the pictures and Resident A appeared disheveled as her top was falling off her shoulder and her hair was not combed. I also observed no linens or a blanket or a pillow on her bed. Resident A appeared to have been tied on top of the bare mattress.

APPLICABLE RULE	
R400.14314	**Resident hygiene.**
	(3) A licensee shall afford a resident opportunities, and instructions when necessary, to obtain haircuts, hair sets, or other grooming processes.
ANALYSIS:	Based on my review of Resident A's pictures of how she was found on 03/08/2021, Resident A's personal hygiene was not attended to by DCS. Resident A's hair was not combed, and she appeared disheveled as her top was falling off her shoulder.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	Base on my review of the pictures of Resident A, there were no sheets, pillowcase, or blanket on her mattress when Resident A's daughter found her tied to the bed on 03/08/2021. The daughter took pictures of the linens sitting on a chair next to Resident A's bed.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R400.14411	**Linens**
	(2) A licensee shall provide at least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident bed.
ANALYSIS:	Based on my review of the pictures of Resident A on 03/08/2021, she did not have a pillow on her bed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 03/11/2021, I sent the following email to licensee Irina Dennert: I'm currently conducting a special investigation regarding allegations pertaining to Resident A. I will need the following documents emailed to me to assist with my investigation:

- Resident A's: Assessment plan and weight records
- Resident B's: Assessment plan, weight records and guardian's information
- Resident C's: Assessment plan, weight records and guardian's information
- Resident D's: Assessment plan, weight records and guardian's information
- Staff schedule for March 2021 including Adrian's and Tammy's last names and contact numbers.

To date, none of the above requested documents have been received.

Note: On 09/03/2020, a renewal on-site inspection was conducted with Irina Dennert. A statement of correction was requested on 09/16/2020 and 02/17/2021. To date, Ms. Dennert has not submitted the statement of correction.

APPLICABLE RULE	
R400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.
ANALYSIS:	Licensee Irina Dennert failed to cooperate with this investigation as she has not submitted required documents requested on 03/11/2021 and 03/16/2021. I requested Resident A's assessment plan and weight records, Resident B's, Resident

	C's, and Resident D's assessment plans, weight records and guardian's contact information. I also requested the staff schedule and staff's contact information. In addition, Ms. Dennert has not submitted her statement of correction for the on-site renewal inspection that was completed on 09/03/2020. Follow-up requests for the statement of correction were made on 9/16/2020 and 2/17/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 03/10/2021, I requested to review the resident register and the residents' records, but they were not available in the home. Irina Dennert had removed all records from this home.

APPLICABLE RULE	
R 400.14209	**Home records; generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(d) Resident records.**
ANALYSIS:	During the on-site investigation on 03/10/2021, I requested to review Resident A, Resident B, Resident C, and Resident D resident records including their assessment plans and weight records, but according to DCS Rayonda Williams, they were not available. Ms. Williams contacted licensee Irina Dennert on the telephone who said she had all the residents' records in her possession and not available in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**

ANALYSIS:	During the on-site investigation, I requested to review the resident register to obtain residents' names and admission dates, but the register was not available in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/16/2021, Resident A's guardian emailed me a copy of the resident care agreement she signed at admission. The resident care agreement was not completed on the department's form.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(7) A department resident care agreement form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department. A resident shall be provided the care and services as stated in the written resident care agreement.
ANALYSIS:	During my review of Resident A's resident care agreement on 03/16/2021, the resident care agreement was not completed on the department's form. There is no prior authorization for a substitute form to be used.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my investigation, Resident A's daughter and the home health care nurse, Ben Arcenal stated that the DCS at Arina's Senior Care were not immediately notifying Resident A's daughter of Resident A's falls. The daughter stated she visited with her mother (Resident A) and noticed bruising on her mother's right lip and left temple. She also found that her mother was missing three teeth. The daughter stated she was never informed by anyone at Arina's Senior Care of her mother falling or how her mother sustained these injuries. Mr. Arcenal stated he educated both DCS and Ms. Dennert on the importance of informing Resident A's daughter immediately after a fall, but they continued to not report it to the daughter.

APPLICABLE RULE	
R400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.
ANALYSIS:	During my investigation, Resident A had numerous falls that resulted in injuries and an immediate investigation of the cause was not completed by the licensee. In addition, an accident/ incident report was not provided to Resident A's daughter.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 03/10/2021, Resident B's medications were in a pill organizer and not in the original prescription containers. DCS Ms. Williams stated Resident B was admitted into the home with these medications in a pill organizer and they do not have any of the original prescription bottles.

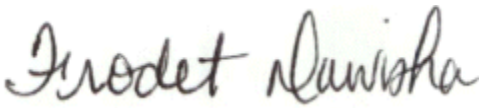
On 03/17/2021, I attempted to conduct the exit conference with licensee Irina Dennert. I left a voice mail message for Ms. Dennert with my findings and recommendation for revocation.

APPLICABLE RULE	
R400.14312	**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 S333.1101 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:	During my on-site investigation on 03/10/2021, Resident B's medications were not in their original prescription containers. Resident B's medications were in a pill organizer.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

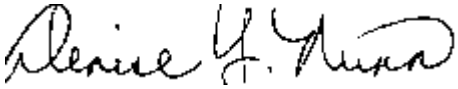
I recommend a summary suspension and revocation of the license.



03/17/2021

Frodet Dawisha — Date
Licensing Consultant

Approved By:



03/17/2021

Denise Y. Nunn — Date
Area Manager