GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 28, 2022

Shapoor Ansari
A.L.C.C. Inc.
1543 Island Lane
Bloomfield Hills, MI 48302

RE: License #: AL580015492
Investigation #: 2023A0116006
Alice Lorraine Care Center

Dear Mr. Ansari:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL580015492
Investigation #:	2023A0116006
Complaint Receipt Date:	11/02/2022
Investigation Initiation Date:	11/02/2022
Report Due Date:	01/01/2023
Licensee Name:	A.L.C.C. Inc.
Licensee Address:	1543 Island Lane Bloomfield Hills, MI 48302
Licensee Telephone #:	(734) 243-4000
Administrator:	Shapoor Ansari
Licensee Designee:	Shapoor Ansari
Name of Facility:	Alice Lorraine Care Center
Facility Address:	2590 N. Monroe Street Monroe, MI 48161
Facility Telephone #:	(734) 243-4000
Original Issuance Date:	05/05/1994
License Status:	REGULAR
Effective Date:	09/30/2022
Expiration Date:	09/29/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 11/01/22, it was reported that staff, Shalynda Tinkey forcefully grabbed Resident A's arm, flung her up from the toilet and stated, "She is fucking lazy." Resident A was alleged to have been combative with Ms. Tinkey causing her to become frustrated.	Yes

III. METHODOLOGY

11/02/2022	Special Investigation Intake 2023A0116006
11/02/2022	Special Investigation Initiated - Telephone Interviewed administrator, Starlyn Lay.
11/02/2022	APS Referral Referral made on 11/01/22 by administrator Starlyn Lay.
11/02/2022	Contact - Document Received Received incident report, written statements from staff, and corrective action Ms. Lay has already taken.
11/15/2022	Inspection Completed On-site Spoke with administrator, Starlyn Lay, interviewed Resident's A-C, interviewed Resident Care Coordinator, Krystle Stanifer.
11/15/2022	Contact - Telephone call made Interviewed staff, Debra McCoy.
11/15/2022	Inspection Completed-BCAL Sub. Compliance
11/22/2023	Exit Conference With licensee designee, Dr. Shapoor Ansari.

ALLEGATION:

On 11/01/22, it was reported that staff, Shalynda Tinkey forcefully grabbed Resident A's arm, flung her up from the toilet and stated, "She is fucking lazy." Resident A was alleged to have been combative with Ms. Tinkey causing her to become frustrated.

INVESTIGATION:

On 11/02/2022, I interviewed administrator, Starlyn Lay, who reported she is conducting an internal investigation into the matter. Ms. Lay reported she interviewed Resident A; however, due to her Alzheimer's she was unable to recall what occurred with her and staff, Shalynda Tinkey. Ms. Lay reported she has interviewed Ms. Tinkey and staff, Debra McCoy, who reported witnessing Ms. Tinkey aggressively grab Resident A under her arm, flung her up from the toilet seat, and said, "She is so fucking lazy," as she believed Resident A could assist staff during toileting, but she chooses not to. Ms. Lay reported she had both Ms. McCoy and Ms. Tinkey provide written statements about what occurred. Ms. Lay reported that she visually accessed Resident A and observed a purple dime sized bruise on the top portion of her left arm about two inches below the elbow and hand. Ms. Lay reported that the incident occurred on 10/31/22, she was made aware of it on 11/01/22. Ms. Lay reported she made an Adult Protective Services (APS) referral on 11/01/22 after observing the bruise on Resident A.

On 11/02/22, I reviewed the incident report and written statements by Ms. Tinkey and Ms. McCoy. In summation, Ms. Tinkey's statement documents that while she was assisting Resident A off the toilet, she stated that she could not stand, so Ms. Tinkey reported she placed her arm under Resident A's arm to assist with the transfer and reported Resident A became combative and started to swing on her and was very upset. Ms. Tinkey documents that Resident A was trying to scratch and hit her and ended up falling on the toilet. Ms. Tinkey documents that Resident A was cursing at her as she was attempting to pull her pants up. Ms. Tinkey's statement does not mention anything about another staff being in the bathroom assisting her, nor does it mention her at any time grabbing Resident A's arm.

I reviewed Ms. McCoy's written statement and in summation it documents that she witnessed Ms. Tinkey grab Resident A under the arm frustrated because Ms. Tinkey was saying out loud to Resident A "you can do this on your own." Ms. McCoy documented that Ms. Tinkey then flung Resident A up from the toilet causing her hand to slip off the grab bar, so she grabbed her arm and flung her up again and says, "I told you she could do it, she is just fucking lazy," to which Resident A replied, "Oh come on!"

On 11/15/22, I conducted a scheduled onsite inspection and spoke with Ms. Lay, interviewed Residents A-C, and Resident Care Coordinator (RCC) Krystle Stanifer. Ms. Lay reported that on 11/02/22, Ms. Tinkey was suspended pending the outcome of the investigation. Ms. Lay reported on 11/04/22, she contacted Ms. Tinkey for a face-to-face meeting to discuss the next steps as it relates to her employment. Ms. Lay reported that Ms. Tinkey refused to meet with her and then quit. Ms. Lay reported that she planned on terminating Ms. Tinkey on 11/04/22 at the meeting due to the incident.

Ms. Lay reported that APS investigator, Tywonda Millender, came to the facility on 11/04/22 and reported she has referred the matter to the local police department for further investigation. Ms. Lay reported that she contacted and informed Resident A's guardian of the matter and reported he was very upset but was satisfied at the actions Ms. Lay had taken to resolve the matter.

I interviewed Resident A and she reported that she was well and liked living in the facility. When asked about the incident Resident A reported that she did not remember what happened and could not remember Ms. Tinkey. Resident A is diagnosed with Alzheimer's disease.

I interviewed Residents B and C and they both reported that the staff treat them well and denied ever observing any of the staff mistreat the residents. Neither Resident B or C had any knowledge of the incident between Resident A and Ms. Tinkey. Resident B expressed his disappointment that he would be moving out of the facility in the coming days as his family cannot afford to keep him there. Resident B reported since being in the facility he had gained 20 lbs. and reported that this has been the best placed he has lived at.

I interviewed Ms. Stanifer and she reported that on 11/01/22, at the completion of her shift, she and Ms. Tinkey were walking to their vehicles and Ms. Tinkey told her about the incident with Resident A and how combative she was. Ms. Stanifer reported that Ms. Tinkey said Resident A "beat me up." Ms. Stanifer reported that she asked Ms. Tinkey did she document Resident A's behaviors in the progress notes, and she reported that she did not, but that she would. Ms. Stanifer reported that staff are supposed to always document in the progress notes aggressive, combative behaviors and other concerning things so that all staff are aware of what is going on with each resident on each shift. Ms. Stanifer reported that did not happen.

On 11/15/22, I interviewed Ms. McCoy and she confirmed that she had provided a written statement about the incident and that the entire ordeal was really unfortunate. Ms. McCoy reported that upon entering Resident A's room, she was not aware that Ms. Tinkey was already in there. Ms. McCoy reported that Ms. Tinkey was frustrated with Resident A and was grabbing her arm and flinging her around. Ms. McCoy reported that Resident A was not combative at all and denied that she was swinging, scratching or cursing at her or Ms. Tinkey. Ms. McCoy reported that Ms. Tinkey has a list of residents that she does not like or care for and Resident A is one of those residents. Ms. McCoy reported she assisted Resident A with toileting and then took her to the dining area for lunch. Ms. McCoy reported that the following day she was bothered by what she had observed and reported it to Ms. Lay.

On 11/22/22, I conducted the exit conference with licensee designee, Dr. Shapoor Ansari, and informed him of the findings of the investigation. Dr. Ansari reported he was aware of the incident and was satisfied with the actions Ms. Lay took to resolve

the matter. Dr. Ansari reported that the employee is no longer working in the facility and had not been there since 11/02/22.

APPLICABLE RULE	
R 400.15305	**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 findings of the investigation, which included interviews of Ms. Lay, written statements of Ms. Tinkey and Ms. McCoy, interviews of Residents A-C, and Ms. McCoy, I am able to corroborate the allegation. Ms. Lay reported after completion of the internal investigation, she determined that Resident A was not treated with dignity and respect and would be terminated, however, Ms. Tinkey quit. Ms. McCoy documented and verbally reported observing Resident A use unnecessary force with Resident A grabbing and flinging her off the toilet. Ms. McCoy reported Resident A was not combative during the incident. Resident A was unable to provide any details of the incident as she suffers with Alzheimer's disease. Residents B and C were not aware of the incident, however, reported the staff treat them good and they had no concerns. This violation is established as Resident A was not treated with dignity and her personal needs, including protection and safety were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

11/23/22

Pandrea Robinson
Licensing Consultant

Date

Approved By:

11/28/22

Ardra Hunter
Area Manager

Date