GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 28, 2022

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

RE: License #: AL580015492
Investigation #: 2022A0116019
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 EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AL580015492
Investigation #:	2022A0116019
Complaint Receipt Date:	02/25/2022
Investigation Initiation Date:	02/25/2022
Report Due Date:	04/26/2022
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:	Starlyn Lay
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:	09/30/2020
Expiration Date:	09/29/2022
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff Bailey Heath was making inappropriate comments to a resident and other staff.	Yes

III. METHODOLOGY

02/25/2022	Special Investigation Intake 2022A0116019
02/25/2022	Special Investigation Initiated - Telephone Interviewed administrator, Starlyn Lay.
02/25/2022	Contact - Document Received Received written statements completed by staff, Ashley Tinsley and Shaelyn Blevins.
03/02/2022	Contact - Telephone call made Spoke with Ms. Lay.
03/08/2022	Inspection Completed-BCAL Sub. Compliance Visually observed Resident A and B, interviewed Resident's C-E.
03/14/2022	Contact - Telephone call made Interviewed staff, Bailey Heath.
03/15/2022	Contact - Telephone call made Interviewed assigned Adult Protective Services (APS) investigator, Samantha Garcia.
03/21/2022	Exit Conference Licensee Designee, Dr. Shapoor Ansari.

ALLEGATION:

Staff Bailey Heath was making inappropriate comments to a resident and other staff.

INVESTIGATION:

On 02/25/22, I interviewed administrator, Starlyn Lay. Ms. Lay reported that this is the incident that prompted her to call and speak with me on 02/10/22. Ms. Lay reported that it was not until yesterday and earlier today that she received the written statements from staff Ashley Tinsley and Shaelynn Blevins that she learned that the inappropriate statements were said to the residents. Ms. Lay reported that she will forward copies of those written statements to me for review.

Ms. Lay reported that she will be conducting an internal investigation and will be speaking with Mr. Heath directly.

On 02/25/22, I received written statements from Ashley Tinsley and Shaelynn Blevins (copies in file). In summation, Ms. Tinsley's statement documents that in January of '22 Mr. Heath made sexual comments to Resident A. The letter documents that while Ms. Tinsley was providing peri-care to Resident A, Mr. Heath asked Resident A if Ms. Tinsley was "making her feel good." The statement also documents an incident that occurred in February of '22 when Ms. Tinsley was providing care to a male resident and Mr. Heath told her to stop "jacking off" the residents. The written statement further documents an incident where Mr. Heath was telling a co-worker, in front of residents, how he used to "eat out" his ex-girlfriend.

Ms. Blevins written statement documents that on 02/08/22 she and Mr. Heath worked from 10:00 p. m. to 6:00 a.m. and reported while she was changing Resident A, Mr. Heath said, "That pussy stank." The statement also documents that later the same night Mr. Heath walked past Resident B who was holding her stuffed cat and he asked her if she "liked that pussy cat." Ms. Blevins documented that she was caught off guard by Mr. Health's inappropriate comments and she couldn't imagine how the residents would feel if they were able to understand what Mr. Heath was saying.

On 03/02/22, I spoke with Ms. Lay and she reported that she interviewed Mr. Heath today and reported that he denied the allegations. Ms. Lay reported that Mr. Heath did admit to asking Resident B if she likes that "pussy cat" but denied implying anything sexual by the question. Ms. Lay reported that she terminated Mr. Heath because she believed that he had made the inappropriate comments and did not feel comfortable with him continuing to work with the residents.

Ms. Lay reported that both Resident A and B, based on their diagnosis and stage of Alzheimer's were unable to be interviewed.

On 03/08/22, I conducted a scheduled onsite inspection and visually observed Residents A and B. Both appeared neatly dressed and nicely groomed.

I interviewed Residents C and D and neither remembered a male staff by the name of Bailey. Resident C reported that he must be new as she does not recall having any interaction with a male staff. Residents C and D both reported that the staff is nice and treat them good.

I interviewed Resident E and she reported that Mr. Heath assisted her a few times and reported that he did not make any inappropriate or concerning comments to her. Resident E denied hearing Mr. Heath make any inappropriate comments to any of the other residents.

On 03/14/22, I interviewed Baily Heath. Mr. Heath denied the allegations as reported and stated that the staff who reported these alleged incidents don't like him and wanted him fired. Mr. Heath reported that while assisting one of the female staff, he did say that Resident A stinks because she had not been showered and needed to be. Mr. Heath reported that the comment was taken out of context. Mr. Heath reported that he was glad he was fired as he was going to quit anyway. Mr. Heath reported that the staff is "messy" and don't do their job.

On 03/15/22, I interviewed assigned APS investigator, Samantha Garcia. Ms. Garcia reported that her case is closed. Ms. Garcia reported that the incident did not rise to the level of sexual abuse, but admits that Mr. Heath's comments, if said, were totally inappropriate. Ms. Garcia reported that when she interviewed Mr. Heath, he denied the allegations.

On 03/21/22, I conducted the exit conference with Dr. Ansari and informed him of the findings of the investigation. Dr. Ansari reported an understanding and stated that once aware of the situation, Ms. Lay conducted an internal investigation which resulted in Mr. Heath's termination.

APPLICABLE RULE	
R 400.15204	**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 the findings of the investigation, which included interviews of Ms. Lay, Mr. Heath, and Ms. Garcia, written statements authored by Ms. Tinsley, and Ms. Blevins, I am able to corroborate the allegations. Ms. Lay reported that at the conclusion of her internal investigation, she terminated Mr. Heath as she believed that he did make inappropriate comments to and about the residents. Ms. Tinsley and Ms. Blevins' written statements document that while working with Mr. Heath, he made inappropriate comments to them and to Residents A and B. Mr. Heath admitted that he said Resident A stinks; however, reported that his comment was taken out of context and that the staff don't like him and wanted him to get fired. Ms. Garcia reported that although the APS investigation was unsubstantiated for sexual abuse, she reported that the comments alleged to have been made by Mr. Heath were inappropriate. This violation is established as Mr. Heath is not suitable to meet the emotional, intellectual or social needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____03/21/22
Pandrea Robinson Date
Licensing Consultant

Approved By:

_____03/28/22
Ardra Hunter Date
Area Manager