GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 2nd, 2023

Paul Carlson
Masonville Place
150 N. Shore Drive
Coldwater, MI 49036

RE: License #: AH120378302
Investigation #: 2023A1021056
Masonville Place

Dear Mr. Carlson:

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 authorized representative 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH120378302
Investigation #:	2023A1021056
Complaint Receipt Date:	04/21/2023
Investigation Initiation Date:	04/25/2023
Report Due Date:	06/21/2023
Licensee Name:	Masonville AID OPCO LLC
Licensee Address:	Ste 3700 330 N. Wabash Chicago, IL 60611
Licensee Telephone #:	(312) 725-7000
Administrator:	Tricia Weissmann
Authorized Representative:	Paul Carlson
Name of Facility:	Masonville Place
Facility Address:	150 N. Shore Drive Coldwater, MI 49036
Facility Telephone #:	(517) 278-6805
Original Issuance Date:	12/14/2016
License Status:	REGULAR
Effective Date:	06/14/2022
Expiration Date:	06/13/2023
Capacity:	89
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was discharged.	No
Additional Findings	Yes

III. METHODOLOGY

04/21/2023	Special Investigation Intake 2023A1021056
04/24/2023	Contact - Document Received received Resident A's documents
04/25/2023	Special Investigation Initiated - Telephone interviewed administrator
05/01/203	Contact-Telephone call made Interviewed Elara Caring aid Danielle Smith
05/02/2023	Exit Conference

ALLEGATION:

Resident A was discharged.

INVESTIGATION:

On 04/25/2023, the licensing department received a complaint with allegations Resident A was discharged from the facility. The complainant alleged Resident A was accused of inappropriate touching and using inappropriate language. The complainant alleged Resident A does not know the appropriate course of action and that Resident A was discharged.

On 04/25/2023 and 04/26/2023, I left voicemail messages with the complainant with no response received to date.

On 04/24/2023, I interviewed the administrator Tricia Weissmann by telephone. Ms. Weissmann reported Resident A was a resident at the facility since September 2022. Ms. Weissmann reported Resident A would talk to the female caregivers inappropriately, would request the caregivers to inappropriately wash him, and would masturbate in front of the female caregivers. Ms. Weissmann reported the facility

implemented a policy in which two caregivers had to be present when providing care to Resident A. Ms. Weissmann reported in September, Resident A asked a female care staff to scrub his “butt, cock, and balls.” Ms. Weissmann reported once the shower was completed Resident A requested the care staff to dry his “cock and balls.” Ms. Weissmann reported in December 2022, Resident A called for assistance and was found laying in bed and was undressed. Ms. Weissmann reported female care staff assisted in providing care, Resident A moaned and made other disturbing noises. Ms. Weissmann reported Resident A’s roommate was Resident B which is his wife. Ms. Weissmann reported Resident B’s hospice caregiver placed a formal complaint as Resident A was masturbating in front of her, and she felt very uncomfortable. Ms. Weissmann reported in March 2023, a care staff entered Resident A’s room and Resident A had his hands under the covers and was moaning over his private area and he was clearly pleasuring himself. Ms. Weissmann reported Resident A stopped and then grabbed the care staff arms and rubbed his hands up and down her arms. Ms. Weissmann reported later that day another staff person came into Resident A’s room to change a DVD for Resident A. Ms. Weissmann reported as the care staff bent over to do so, Resident A placed his foot between her buttocks. Ms. Weissman reported Resident B resided in the same room as Resident A. Ms. Weissman reported Resident B was upset with how Resident A acted towards care staff. Ms. Weissman reported Resident B’s home care agency and facility care staff were always uncomfortable providing care to Resident B due to Resident A’s behavior. Ms. Weissmann reported Resident A was issued a 30-day discharge notice for continued inappropriate and disruptive behavior towards staff. Ms. Weissmann reported these issues were addressed with Resident A multiple times, but the behaviors continued. Ms. Weissmann reported the facility implemented a policy that two care staff had to present when in Resident A’s room. Ms. Weissmann reported Resident A did admit to everything but did not understand why the behaviors were of concern. Ms. Weissmann reported since Resident A has been discharged, Resident B is now smiling and enjoying her time at the facility.

On 05/01/2023, I interviewed Elara Caring aid Danielle Smith by telephone. Ms. Smith reported she provided care to Resident B. Ms. Smith reported Resident B’s quality of care was impacted by Resident A’s behaviors. Ms. Smith reported two caregivers always had to be present when providing care to Resident B. Ms. Smith reported all caregivers were reluctant to go into their room due to Resident A’s behaviors.

I reviewed discharge notice for Resident A that was dated 04/14/2023. The letter read,

> *“In accordance with Section R 325.1922 of the Michigan Administrative Code and the provisions of the Residency Agreement, this letter serves as written notice of the Community’s intention to terminate your Residency Agreement, and in accordance with state law, transfer you to another facility or location. The intended termination/transfer date is May 14, 2023.*

You are being given thirty days advance notice of the discharge, however, if (a) a substantial risk to you arises due to our inability to meet your needs or to assure your safety and well-being or the safety and well-being of other residents, visitors, or staff or (b) there is destruction of propriety or a substantial risk of destruction of property exits. We will provide you with a notice of termination verbally and in writing as soon as practicable but not less than twenty-four (24) hours before termination.

The specific reason for your discharge, which has been documented in your record, is your continued inappropriate and disruptive behavior toward staff. For example, on March 31, 2023, when a staff member entered your room to help you get out of bed, you had your hands under the covers moving over your private area, clearly pleasuring yourself. You then stopped touching yourself and purposely reached out and grabbed the staff members hand and then rubbed your hand up and down her arm. You were asked not to do that, yet you did not reply and merely smiled.

Later that same day, a staff member came into your room, and you asked them to change the DVD that was currently in your DVD player. As the staff member bent over to change the DVD you placed your foot in between the staff members buttocks. Staff member asked you not to do that and then left you room.

This behavior has been ongoing for many months. On September 18, 2022, you told a female staff member who was helping you shower to "be good when you are scrubbing my cock and balls." The staff member asked you not to speak that way and you replied "what do you want me to call it?"

On September 21, 2022, you asked a female staff member to scrub your "butt, cock, and balls." The staff member calmly explained that you were capable of doing that yourself, however, once your shower was over you asked the staff member to dry your "cock and balls."

On December 27, 2022, you called for staff while lying in bed completely naked and uncovered. When staff came in to help clean you up in bed, you moaned and made disturbing noises as they cleaned around your groin area. This has happened more than once."

I reviewed Resident Administrative Notes. The note dated 09/22/2022 read,

"On 9/18 it was reported by staff member (1) in the 24 hour log that (Resident A) is making perverted comments. While giving him a shower, he asked them to "Be good when you are scrubbing my cock and balls." They asked him not to speak that way and he stated, "what do you want me to call it?" He continued to press his button several times and when the girls came in to ask him what he wanted, he was laying completely naked "spread eagle" on his bed and said he didn't meant to press his button.

On 09/21 it was again reported on the 24 hour log that he was asking (SP2) to scrub his "butt, cock, and balls." (SP2) explained to him that he was capable of doing it himself. After the shower, he then asked (SP2) to dry his "cock and balls." She encouraged him to dry them himself. He then said it felt irritated and said that she wouldn't know if it was irritated unless she looked very close.

On 09/22, I went in to have a discussion with (Resident A). I also called his family and discussed the situation; as it was decided that he will need to have 2 staff members in to do his showers because of his comments. (Relative A1) stated that he is "pervert" and has been like this his whole life but thinks he can get away with it because of "who he thinks he is."

I had a very firm conversation with (Resident A). I informed him that he was making staff uncomfortable, therefore, there would be 2 present when giving him showers. I also explained that he should not lay around naked when the girls are present and that it would be best that he slept in underwear. He laughed and said, "I don't see what is wrong with sleeping naked." I also asked him to please use different wording that "cock and balls." He laughed again and replied, "What would you like me to call it?" I told him "private area would be fine."

I reviewed Resident B's note left by Resident B's home care agency. The note read,

"(Resident A) is pleasuring himself while I am in the room. Monday I was in the bathroom with (Resident B) and the hallway door was wide open. He was saying profanity while his hand was in his pants and huffing and puffing. Today I was changing (Resident B) and he was laying in the bed next to her and playing with himself. It was obvious what was happening and I was right there! I do not feel comfortable approaching this with him. I can't imagine how embarrassing this is for (Resident B)."

I reviewed Resident Administrative Notes. The note dated 12/27/22 read,

"24 hour report reported that resident was "moaning and making funny noises" when staff was cleaning around his groin area. On 12/27/22, Tricia Weissmann and (SP3) met with (Resident A) and asked why was doing this. He replied, "it feels good to be clean" and laughed. Tricia explained this was making the girls uncomfortable. He said, "I guess I will try not to do that." I reminded him that we have had this discussion before. He stated, "well I don't know about that."

I reviewed Resident Administrative Notes. The note dated 3/31/2023 read,
On 3/30/23, I was notified in the evening that (SP4) wanted to speak with me the next morning. (SP4) approached me @ 9:10am to discuss what had happened with (Resident A) on 03/30/2023 during her shift.

On 03/11/2023, I received a note left in my office before I arrived @8:30am. The attached note was received from Danielle Smith (aide from Elara Hospice who cares for (Resident B)).

(Relative A1) was called by myself, Tricia Weissmann. I read him the note and also told him of the staff complaint. We discussed (Resident A) and how to approach the situation. It was decided that (Relative A1) would be on speaker phone, with (Resident B) present while I had the discussion; (SP6) was also present as a witness. This discussion occurred at 9:20am on 3/31/2023.

During this discussion, I read (Resident A) the accusations. I asked him if he did what was written in the note, and he said, "Well, I suppose I did." He then stated, "I didn't know there was a law that said I couldn't pleasure myself." He did not deny anything in the note. I explained to him that there is an issue when others are around and don't want to see or hear him doing those things. He began to laugh. His (relative A1) was upset on the phone and told him he knows exactly what he is doing. He continued to just sit there starring at me. I told (Resident A) that if he really didn't know what he was doing, then there is a serious issue and he should be sent for an evaluation. He then just starred at me and did not reply.

I also asked why he was touching himself and wiped his hand on (SP4)'s arm when she tried to get him up right after taking his hands out of his privates. He again replied, "well, I suppose, I didn't know that I couldn't do that." I then asked him why he asked (SP4) to start his DVD player for him and put his foot in between his buttocks. He again laughed but did not deny it.

(Resident B) stated that she was embarrassed and said "He is sick."

I again told (Resident A) that he is a very smart man and knows right from wrong and that he should realize this isn't something women would want to see or be around. He answered, "Well, I suppose not."

(Resident A) showed no remorse and acted as if we were making a big deal of what happened. It was explained to him that I would be contacting my corporate office and investigation the complaints further. I also explained to him that no one would be allowed alone in his room to care for him or (Resident B) until I have rectified the situation.

(Resident B) stated (after my conversation with (Resident A) earlier) to (SP1) that "(Resident A) is always yelling at her and she doesn't know why he is like that."

I reviewed 24 hour log. The log read,

"(Resident B) wanted to stay up and watch her program. (Resident A) throwing a fit about her wanting to stay up."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: **(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, except as provided by title XVIII or title XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. A nursing home patient or home for the aged resident is entitled to be given reasonable advance notice to ensure orderly transfer or discharge. Those actions shall be documented in the medical record.**
ANALYSIS:	Resident B's welfare was negatively impacted by Resident A's behavior as evidenced by outside agency workers and caregivers were hesitant to provide Resident B care while Resident A was present. Resident A was appropriately discharged from the facility due to the impact his behaviors had on Resident B's welfare.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's discharge letter read,

> *If you disagree with the Community's decision, you may file a complaint with the following agency:*
> *Michigan Department of Human Services*
> *PO Box 30037*
> *Lansing, MI 48909*

~~(517) 373-2035~~.
Provided:
Corp #
Ombudsman #
State #

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	Review of Resident A's discharge letter did not have a statement in the letter on the right to file a complaint with Licensing and Regulatory Affairs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/01/2023

Kimberly Horst — Date
Licensing Staff

Approved By:

05/02/2023

Andrea L. Moore, Manager — Date
Long-Term-Care State Licensing Section