



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

July 1<sup>st</sup>, 2025

Kari Conn  
Michigan Masonic Home  
1200 Wright Avenue  
Alma, MI 48801

RE: License #: AH290278031  
Investigation #: 2025A1021058  
Michigan Masonic Home

Dear Kari Conn:

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) 335-5985.

Sincerely,

*Kimberly Horst*

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**

<b>License #:</b>	AH290278031
<b>Investigation #:</b>	2025A1021058
<b>Complaint Receipt Date:</b>	06/02/2025
<b>Investigation Initiation Date:</b>	06/05/2025
<b>Report Due Date:</b>	08/02/2025
<b>Licensee Name:</b>	Michigan Masonic Home, Inc.
<b>Licensee Address:</b>	1200 Wright Ave Alma, MI 48801
<b>Licensee Telephone #:</b>	(989) 466-3801
<b>Administrator/ Authorized Representative:</b>	Kari Conn
<b>Name of Facility:</b>	Michigan Masonic Home
<b>Facility Address:</b>	1200 Wright Avenue Alma, MI 48801
<b>Facility Telephone #:</b>	(989) 463-3141
<b>Original Issuance Date:</b>	09/19/2005
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2024
<b>Expiration Date:</b>	07/31/2025
<b>Capacity:</b>	138
<b>Program Type:</b>	AGED

## II. ALLEGATION(S)

	Violation Established?
Care staff are rude to Resident A.	No
Resident A's care needs are not met.	Yes
Resident A's room has not been cleaned.	No
Additional Findings	No

## III. METHODOLOGY

06/02/2025	Special Investigation Intake 2025A1021058
06/05/2025	Special Investigation Initiated - On Site
06/10/2025	Contact-Telephone Call Made Interviewed SP2
06/11/2025	Inspection completed on site
07/01/2025	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

### ALLEGATION:

**Care staff are rude to Resident A.**

### INVESTIGATION:

On 06/02/2025, the licensing department received a complaint with allegations care staff have been rude and abusive to Resident A. The complainant alleged staff person 2 (SP2) was rude during morning care with Resident A.

On 06/05/2025, I interviewed the administrator Kari Conn at the facility. The administrator reported Resident A has a history of being rude to care staff. The administrator reported Resident A can be more independent but prefers for care staff to provide all care. The administrator reported the facility is working with Resident A

and Resident A's family on encouraging Resident A to be more independent. The administrator reported SP2 is a good employee, and she has not received any complaints regarding SP2's behavior with residents. The administrator reported if a care staff was rude to Resident A, Resident A would inform management staff of this behavior.

On 06/05/2025, I interviewed SP1 at the facility. SP1 reported he conducted a care conference on 06/04/2025 with Resident A and the family. SP1 reported none of these concerns were brought to his attention. SP1 reported at times Resident A has yelled at care staff and have kicked the care staff out of her room. SP1 reported he has spoken multiple times with Resident A on appropriate behavior towards care staff. SP1 reported Resident A would inform management of this behavior.

On 06/05/2025, I interviewed SP3 at the facility. SP3 reported Resident A has yelled at her and has refused care. SP3 reported she has never seen any employee be rude to Resident A. SP3 reported some care staff do encourage Resident A to be more independent which does frustrate Resident A.

On 06/05/2025, I interviewed SP4 and SP5 at the facility. SP4 and SP5 statements were consistent with those made by SP3.

On 06/10/2025, I interviewed SP2 by telephone. SP2 reported at times Resident A has been very rude to her and refused care. SP2 reported Resident A can be more independent and care staff are to encourage this independence. SP2 reported during a shower, Resident A does need assistance with washing lower body and back. SP2 reported she will encourage Resident A to complete the rest of her shower. SP2 reported Resident A can find appropriate clothing and she will encourage Resident A to complete dressing activities. SP2 reported that when Resident A's family is on site, Resident A will be less likely to complete care tasks herself even though she has the capacity to do so. SP2 reported she has always treated Resident A respectfully.

On 06/05/2025, I did observe many interactions between residents and staff members. The interactions were positive as evidenced by the staff members who were actively engaged and participating in the care of the residents.

On 06/11/2025, I interviewed Resident A at the facility. Resident A reported at times she loses her temper, will yell at the care staff, and care staff yell at her back. Resident A reported this has only occurred a few times. Resident A was unable to report what care staff yell to her. Resident A reported care staff have always been kind to her during showers. Resident A reported she feels safe at the facility and does not want to leave the facility.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.</b>
<b>ANALYSIS:</b>	While Resident A did report that, at times, care staff have yelled at her, there is lack of evidence to support the allegation that Resident A has constantly been treated disrespectfully at the facility.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Resident A's care needs are not met.**

**INVESTIGATION:**

The complainant alleged Resident A's care needs are not met. The complainant alleged Resident A's trash bags have not been replaced after the trash was removed. The complainant alleged Resident A has not received a shower for three weeks. The complainant alleged care staff have left Resident A to sit in urine and feces. The complainant alleged care staff have not accurately documented what Resident A has done.

The administrator reported Resident A's room is cleaned weekly and is tidied up daily. The administrator reported Resident A is to receive a shower per her request. The administrator reported Resident A can be incontinent at times and has refused for care staff to change her. The administrator reported no knowledge of false documentation in Resident A's record.

SP1 reported at times Resident A will sit in her chair and be incontinent. SP1 reported Resident A can take herself to the bathroom but at times refuses to do so. SP1 reported when care staff become aware that Resident A has been incontinent, the care staff will change Resident A. SP1 reported Resident A can and will request showers but at times Resident A has refused showers. SP1 reported Resident A is a PACE participant and does go to the center Monday, Wednesday, and Friday.

SP4 reported Resident A will sit in her chair and soil herself. SP4 reported that when this occurs, care staff will attempt to clean and change Resident A. SP4 reported Resident A is to receive a shower twice weekly on Sunday and Wednesday on the first shift and after 7:30am. SP4 reported Resident A uses a wheelchair and staff are to encourage Resident A to be more independent. SP4 reported Resident A does

not use the walker. SP4 reported care staff are to encourage Resident A to be more independent.

SP3 reported she can usually get Resident A to be agreeable to care. SP3 reported care staff are not to enter Resident A's room before 7:30am and Resident A is on a shower schedule. SP3 reported Resident A uses the wheelchair to get around the community. SP3 reported Resident A can do more than she does, and care staff are to encourage her independence.

On 06/05/2025, I interviewed SP5 at the facility. SP5 reported one day the facility was short staffed and she forgot to put a trash bag in Resident A's room when the trash was taken out. SP5 reported she went back into Resident A's room and told her that she could put the bag in the trash can to encourage Resident A's independence.

Resident A reported she does receive showers at the facility. Resident A reported on one occasion; care staff told her that she needed to put the trash bag in the trash can.

I observed Resident A with a continuous glucose monitor (CGM). It was found Resident A has a Libre monitoring system that displays blood glucose numbers. If the device is to fall off, employees are to contact PACE and PACE will put the device back on the next time Resident A is at the center.

I reviewed shower documentation for Resident A. The shower documentation revealed that Resident A received a shower on 05/25, 05/26, 05/28, 06/01, and 06/04. The documentation revealed Resident A refused a shower on 05/11, 05/18, and 05/21. The documentation revealed the shower on 05/26 was documented as completed at 0412am.

I reviewed Resident A's service plan. The service plan read,

*"Staff will empty trash each shift and PRN. I need one person to assist me with showering. I require assistance with showers/bathing. I need some assistance to change incontinence product. I require assistance to and from bathroom of 1. I can ambulate short distances (150 feet) with FWW and limit assist of 1 staff. Staff will encourage me to wheel myself to meals in my wheelchair. Staff to assist if I can't make it the whole way. Staff to encourage me to walk to dine to all meals- 1 assist 4ww outside of her room."*

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

<b>ANALYSIS:</b>	<p>Interviews conducted revealed Resident A has a history of yelling at care staff, refusing care, and requesting more assistance than she requires; only uses the wheelchair; can take herself to the bathroom; has a history of purposefully being incontinent; is a PACE program participant; wears a CGM. In addition, Resident A is to receive a shower on Sunday and Wednesdays after 7:30am.</p> <p>Review of shower documentation revealed Resident A was not offered a shower on Wednesday 05/14/2025, which is her scheduled shower day. Also, it was documented that Resident A received a shower on Monday 05/26/2025 at 0412 which is not consistent with her shower schedule, nor the requested timeframe as set by Resident A.</p> <p>Review of Resident A's service plan revealed statements that Resident A ambulates with a 4ww walker and requires assistance to use the bathroom. There was no information on the behaviors of Resident A, the importance of encouraging independence, information at involvement in the PACE program, and the use of the CGM.</p> <p>Due to inconsistent shower documentation and lack of detailed information in the service plan, the facility is non-compliant with this licensing rule.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **ALLEGATION:**

**Resident A's room has not been cleaned.**

#### **INVESTIGATION:**

The complainant alleged Resident A's room has not been cleaned.

The administrator reported Resident A's room is to be tidied up daily and a deep clean every week. The administrator reported Resident A does not refuse this service.

SP2 reported Resident A does allow for her room to be cleaned and prefers it to be cleaned.

I viewed Resident A's room at the facility. The room was neat and tidy as evidenced by the bed was made, the trash was taken out, and the bathroom was cleaned.

<b>APPLICABLE RULE</b>	
<b>R 325.1979</b>	<b>General maintenance and storage.</b>
	<b>(1) The building, equipment, and furniture shall be kept clean and in good repair.</b>
<b>ANALYSIS:</b>	Interviews conducted and observations made revealed lack of evidence to support this allegation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED.</b>

#### **IV. RECOMMENDATION**

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



06/11/2025

\_\_\_\_\_  
Kimberly Horst  
Licensing Staff

\_\_\_\_\_  
Date

Approved By:



06/30/2025

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

\_\_\_\_\_  
Date