GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 18, 2021

Michael Maurice
Sugarbush Living, Inc.
15125 Northline Rd.
Southgate, MI 48195

RE: License #:	AL250376703
Investigation #:	2022A0872001
	Sugarbush Manor

Dear Mr. Maurice:

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 (906) 226-4171.

Sincerely,

Susan Hutchinson

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250376703
Investigation #:	2022A0872001
Complaint Receipt Date:	10/05/2021
Investigation Initiation Date:	10/05/2021
Report Due Date:	12/04/2021
Licensee Name:	Sugarbush Living, Inc.
Licensee Address:	15125 Northline Rd. Southgate, MI 48195
Licensee Telephone #:	(810) 496-0002
Administrator:	Michael Maurice
Licensee Designee:	Michael Maurice
Name of Facility:	Sugarbush Manor
Facility Address:	Suite A G-3237 Beecher Rd Flint, MI 48532
Facility Telephone #:	(810) 496-0002
Original Issuance Date:	10/19/2015
License Status:	REGULAR
Effective Date:	04/19/2020
Expiration Date:	04/18/2022
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is a double amputee and wheelchair bound but has eloped from the facility on at least two occasions. Resident A sits in a soiled brief with no other clothes on while in common areas of the facility.	Yes
Staff are not monitoring Resident A's blood sugar appropriately.	No
Additional Findings	Yes

III. METHODOLOGY

10/05/2021	Special Investigation Intake 2022A0872001
10/05/2021	Special Investigation Initiated - Letter Additional information received from Resident A's social worker
10/06/2021	APS Referral I made an APS referral via email
10/13/2021	Inspection Completed On-site Unannounced
10/20/2021	Contact - Document Sent I emailed the licensee designee, Michael Maurice, requesting information about this complaint
10/26/2021	Contact - Document Received AFC documentation received from Mr. Maurice
11/16/2021	Contact – Telephone call made I interviewed Relative A1
11/16/2021	Exit Conference I conducted an exit conference with the licensee designee, Michael Maurice, via telephone

ALLEGATION: Resident A is a double amputee and wheelchair bound but has eloped from the facility on at least two occasions. Resident A sits in a soiled brief with no other clothes on while in common areas of the facility.

INVESTIGATION: On 10/13/21, I conducted an unannounced onsite inspection of Sugarbush Manor Adult Foster Care facility. I interviewed Resident A and the home manager, Danielle Brown. I also observed four residents in the common area of the facility. All four residents were interacting with each other and appeared clean and dressed appropriately. I did not detect a foul odor in the facility.

Resident A was lying in bed, taking a nap but he did wake up and allow me to interview him. He said that he has lived at this facility for approximately two years. He said that he wears briefs full time and said that staff changes his brief "whenever it's needed" but said that he can change his own briefs as well. He said that he gets dressed if he's going out in the common area of the facility. He said that staff does "alright" taking care of him and he has no complaints. I asked him how often he bathes and/or showers and he said, "whenever it's needed." Resident A had a blanket covering his lower body but the shirt he had on appeared clean as well as his face and hands. I did not detect any foul odors in his room and his room appeared cluttered but clean.

I asked Resident A if he is allowed community access and he said that he is not allowed to leave the facility unattended. He said that he has "left out the front door" without telling staff even though he knows he is not supposed to. He said that when he leaves, he leaves in his wheelchair, and he wheels himself down the street. He estimates that he has left the facility "about 20 times" and on one occasion, he made it almost to Ballenger Highway before staff found him and brought him back. According to www.Mapquest.com, Ballenger Highway is approximately ½ mile from Sugarbush Manor.

On 10/13/21, staff Danielle Brown said that she has been the home manager of this facility for approximately five months and has worked at this facility for a year. She said that she is very familiar with Resident A and said that she and other staff take good care of him. Ms. Brown said that Resident A has been at this facility for approximately four years and his family has very limited involvement with him. She said that Resident A does not have many visitors.

According to Ms. Brown, Resident A does wear a brief full time and he is a double amputee. She said that he has come out of his room "a handful of times" with only a brief on, but it has never been soiled. She said that Resident A can transfer from his wheelchair to his bed and/or chair on his own and can change his own brief. Ms. Brown denied that staff has ever left Resident A in a soiled brief and denied that Resident A has ever been in the common area of the facility in a soiled brief. Ms. Brown said that on one occasion, she found Resident A in his bathroom with a feces-soiled brief. He was attempting to clean himself up and had feces "all over the place." Ms. Brown said that she immediately cleaned Resident A and his bathroom.

Ms. Brown told me that Resident A is an elopement risk although he is wheelchair bound. On one occasion, Ms. Brown was showering another resident and she heard the front doorbell. She looked in the corridor but did not see anything. When she was finished showering the resident, she went outside to smoke a cigarette and found Resident A on the ground. He had apparently left the facility and fell out of his wheelchair.

Ms. Brown said that staff knows that whenever Resident A comes out of his room fully dressed, he may intend on trying to elope, so staff watches him closely and tries to redirect him. When Resident A goes outside, he must be accompanied by staff, or he will try to elope. Ms. Brown said that the facility has a door alarm which is always enabled but there is no delayed egress.

On 10/27/21, I reviewed AFC paperwork related to Resident A. Resident A was admitted to Sugarbush Manor AFC on 5/08/18. According to his Health Care Appraisal (HCA) dated 5/20/20, he is diagnosed with hypertension, diabetes, mellitus, dementia, vitamin D deficiency, chronic kidney disease stage 3, depression, amputation of lower extremity below knees, glaucoma, and benign prostate hyperplasia. He uses a wheelchair and is on a general diet. Dr. Randolph Schumacher completed the HCA and noted that Resident A was “alert, well hydrated, no distress.”

According to his Assessment Plan dated 5/20/20, he is partially incontinent but can transfer from his wheelchair to the toilet. He requires full assistance with bathing and grooming and partial assistance with personal hygiene. He has a bilateral amputation below the knee. He is not on a special diet.

I reviewed three Incident/Accident Reports (IR) regarding Resident A’s elopements. The first IR is dated 5/31/21 and completed by staff Danielle Brown. According to the report, after attending to another resident, Ms. Brown found that Resident A was not in his room or in the facility. She went outside and found him at the end of the driveway. He had fallen out of his wheelchair. Ms. Brown checked him for injuries and since he was complaining of pain in his hip, he was sent to McLaren Hospital. The corrective measures taken are to consult with hospice about a bed alarm and additional measures that can be taken.

The second IR is dated 6/27/21 and completed by staff Shaquice Grear. According to the report, Ms. Grear was changing another resident and Resident A left the building. He made it all the way to the light. Ms. Grear drove her car to go and get him but had to call an ambulance to have him transported back to the facility. Under corrective measures taken, Ms. Grear wrote, “The only way to correct it is to have less people or take his chair away while dealing with another resident.”

The third IR is dated 8/13/21 and completed by staff Tashina Scales. According to the report, Resident A was outside on the patio sitting in his chair. Ms. Scales went inside to attend to another resident and when she went back outside, she found Resident A on the ground because he had fallen out of his chair. She helped him back in his chair and

Resident A said he was not hurt; he was trying to leave the facility. No corrective measures were noted.

On 11/16/21, I interviewed Relative A1 via telephone. Relative A1 confirmed that Resident A resided at Sugarbush Manor for several years. He said that he recently moved Resident A to another facility. According to Relative A1, he lives out of state and does not see Resident A often. He said that the last time he saw Resident A was approximately three months ago. Resident A said that he has never seen Resident A in a soiled brief and Resident A has always been dressed when he visits with him. However, he said that when he was last at Sugarbush Manor, the facility had a foul odor and Resident A's bathroom was excessively dirty.

Relative A1 said that on approximately three separate occasions, staff has called to tell him that Resident A eloped from the facility. Relative A1 said that he found this concerning since Resident A is a double amputee and is wheelchair bound. Relative A1 told me that he and other family have since moved Resident A to a more secure facility.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS	On 10/13/21, I interviewed Resident A who I found to be clean and dressed appropriately. He said that he is not left in a soiled brief and said that he does not sit in the common area in just a brief. Resident A's room was cluttered but there was no foul odor, and I did not detect a foul odor in the facility. Staff Danielle Brown denied that Resident A is left in a soiled brief and denied that he sits in the common area in just a brief. Relative A1 said that when he has seen Resident A, he has never been in a soiled brief and has always been fully dressed. However, when he was at the facility approximately three months ago, there was a foul odor in the facility and Resident A's bathroom was excessively dirty. According to Resident A, he has eloped from the facility "about 20 times."
	I reviewed three Incident/Accident Reports regarding Resident A eloping from the facility.

	Staff Danielle Brown, the licensee designee Michael Maurice, and Relative A1 said that Resident A has eloped from the facility on three occasions. I conclude that although Resident A is an elopement risk, he was still able to elope from Sugarbush Manor on at least three occasions which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff are not monitoring Resident A's blood sugar appropriately.

INVESTIGATION: During my interview with Resident A on 10/13/21, he said that he is diabetic, and staff monitors his diet, his insulin, and his blood sugar levels.

During my interview with staff Danielle Brown on 10/13/21, she stated that Resident A is on hospice. She confirmed that Resident A is diabetic, and his doctors have not been able to get it under control. According to doctor's orders, staff are required to check Resident A's blood sugar four times per day. His blood sugar fluctuates significantly, and staff is trained on what to do when his numbers are off. Ms. Brown said that staff closely follows doctor's orders, and they ensure that Resident A's dietary needs are met. She told me that Resident A has a new hospice nurse who will not give the facility a prn insulin to pass. Because of this, staff has a difficult time keeping Resident A's glucose levels stable.

According to Resident A's Assessment Plan and Health Care Appraisal, he is not on a special diet.

I reviewed Resident A's blood sugar and insulin log from 8/31/21 through 10/19/21. I noted that staff checks Resident A's blood sugar at least four times a day and administers treatment as necessary. I did not see any discrepancies in the blood sugar/insulin log. Resident A's Health Care Appraisal states that Resident A is on a general diet. When I exchanged emails with the licensee designee, Michael Maurice on 10/26/21, he stated that Resident A has never been on a specialized diet.

During my interview with Relative A1 on 11/16/21, he said that he knows that staff is supposed to check Resident A's insulin levels on a regular basis, and he does not know if Sugarbush staff did that. I told him that according to Resident A's AFC paperwork, he is not on a special or restrictive diet and Relative A1 said that he was not aware of that. He said that he thought Resident A was supposed to have a diabetic diet. Relative A1 said that he does not have any evidence that staff was not treating his diabetes like they were supposed to.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A, staff Danielle Brown, and licensee designee Michael Maurice confirmed that Resident A is a diabetic but said that staff monitors his blood sugar and administers treatment appropriately. Resident A's Health Care Appraisal and Assessment Plan state that Resident A is on a general diet. I examined Resident A's blood sugar/insulin logs from 8/31/21 through 10/19/21 and did not see any discrepancies. I observed staff documentation that Resident A's blood sugar is checked at least four times per day and treatment is administered appropriately. Relative A1 said that he does not know if staff monitors Resident A's blood sugar appropriately but does not have evidence showing that they do not. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my investigation, I reviewed Resident A's Assessment Plan and Health Care Appraisal which were dated 5/20/20. I exchanged emails with the licensee designee, Michael Maurice who stated that the facility does not have an updated Assessment Plan or Health Care Appraisal.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before

	the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	As of 10/27/21, Resident A's Health Care Appraisal was last completed on 5/20/20. Mr. Maurice confirmed that it had not been updated since that time which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	As of 10/27/21, Resident A's Assessment Plan was last completed on 5/20/20. Mr. Maurice confirmed that it had not been updated since that time which is a direct violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/16/21, I conducted an exit conference with the licensee designee, Michael Maurice, via telephone. I discussed the findings of my investigation and explained which rule violations I am substantiating. Mr. Maurice agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

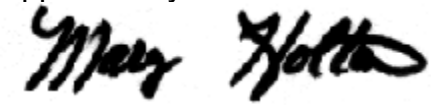
IV. RECOMMENDATION

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

November 16, 2021

Susan Hutchinson Licensing Consultant	Date

Approved By:



November 18, 2021

Mary E Holton Area Manager	Date