STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING
ORLENE HAWKS
DIRECTOR

December 9, 2021

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

RE: License #:	AS250338095
Investigation #:	2022A0872006
	Sugarbush Living-Beecher Circle House

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, 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 #:	AS250338095
Investigation #:	2022A0872006
Complaint Receipt Date:	11/03/2021
Investigation Initiation Date:	11/03/2021
Report Due Date:	01/02/2022
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 Living-Beecher Circle House
Facility Address:	4226 Beecher Rd Flint, MI 48532
Facility Telephone #:	(810) 496-0002
Original Issuance Date:	02/22/2013
License Status:	1ST PROVISIONAL
Effective Date:	08/13/2021
Expiration Date:	02/12/2022
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 10/29/21, Resident A fell down the basement stairs. He sustained a brain bleed and hematoma. Concern that he was not being supervised. He has dementia and is legally blind.	Yes

III. METHODOLOGY

11/03/2021	Special Investigation Intake 2022A0872006
11/03/2021	APS Referral This complaint was referred by APS but was denied
11/03/2021	Special Investigation Initiated - Letter I emailed the licensee requesting information about this complaint
11/04/2021	Contact - Document Received I received AFC documentation from Mr. Maurice about Resident A
11/10/2021	Inspection Completed On-site Unannounced
11/30/2021	Inspection Completed On-site
12/09/2021	Contact - Telephone call made I interviewed Guardian A1
12/09/2021	Contact - Telephone call made I interviewed staff Takiesha Smith
12/09/2021	Exit Conference I conducted an exit conference with the licensee designee, Michael Maurice, via telephone
12/09/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 10/29/21, Resident A fell down the basement stairs. He sustained a brain bleed and hematoma. Concern that he was not being supervised. He has dementia and is legally blind.

INVESTIGATION: On 11/04/21, I received AFC paperwork related to Resident A from the licensee designee, Michael Maurice. I reviewed an Incident/Accident Report dated 10/29/21 regarding Resident A. According to the report, “While caregivers were attending to other residents in the home, (Resident A) opened the door to the basement and fell down the stairs. Staff found a skin tear on Resident A’s arm, and he was bleeding from his head. Resident A was able to stand and walk back up the stairs. Staff contacted 911 and Resident A was transported to the hospital. The corrective measures taken are, “Lock will be placed on the interior door of the home leading to the basement keeping residents from accidentally opening door and going downstairs.”

Resident A was admitted to this facility on 10/21/21. According to his Health Care Appraisal dated 10/15/21, he is diagnosed with hypertension, dementia, impaired vision, atrial fibrillation, and elevated lipids. The doctor also noted that Resident A has dementia and psychotic agitation at times. According to his Assessment Plan dated 10/07/21, due to his impaired vision, “staff will assist and guide and make sure path is clear.” Resident A is ambulatory and does not use any assistive devices.

On 11/10/21, I conducted an unannounced inspection of Sugarbush Living-Beecher Circle House Adult Foster Care facility. I interviewed staff Andrea Cain and conducted a visual inspection of parts of the facility.

Ms. Cain said that she has worked for Sugarbush Living for approximately three years. She said that Resident A moved into Sugarbush Living-Beecher Circle House in October 2021. She believes that he was at a different AFC facility prior to being admitted to Sugarbush Living. According to Ms. Cain, Resident A is blind, and he has dementia. He is often confused and hard to redirect. He does not use a wheelchair, walker, or cane. He maneuvers around the facility with his hands out, feeling his way as he goes because although legally blind, he can still see some things.

According to Ms. Cain, on 10/30/21, she left work at approximately 7:00pm. Staff Tanisha Breedlove came on shift at 7:00pm along with another staff, Takeisha Smith, who was in training. Ms. Cain said that according to Ms. Breedlove, she was tending to another resident when she heard a loud noise. Ms. Breedlove discovered that Resident A had opened the fire door leading to the basement and had fallen down the stairs. According to Ms. Cain, Ms. Breedlove called 911 and Resident A was taken to the hospital. He will not be returning to the facility.

I examined the door leading to the basement. The door is a fire door and has an automatic self-closing device. There is not a lock on the door. Ms. Cain said that there have never been any incidents of any of the residents attempting to open the door prior to the incident involving Resident A. She said that Mr. Maurice has ordered a lock for the basement door to prevent any incidents like this from happening again.

On 11/30/21, I conducted another onsite inspection of Sugarbush Living-Beecher Circle House. The licensee designee, Michael Maurice showed me the basement door which now has a combination lock on it. Mr. Maurice confirmed that Resident A did not return to the facility once he was released from the hospital.

On 12/09/21, I interviewed Guardian A1 via telephone. Guardian A1 confirmed that Resident A was a resident of Sugarbush living-Beecher Circle House for eight days. She said that while a resident of that facility, he often wandered around, opening doors, and entering other residents' bedroom doors. On 10/27/21, Guardian A1 picked Resident A up for an appointment and saw a white substance on his shirt. She asked staff what it was, and staff explained that Resident A had gotten into some putty in the garage. She asked staff to make sure the garage door remains locked to prevent this from happening again.

According to Guardian A1, Resident A fell down the basement stairs on 10/29/21. She said that she was told that staff were attending to other residents when Resident A fell. Guardian A1 said that Resident A sustained a sub-arachnoid bleed, three broken ribs, a gash over his eye, and numerous bruises from this incident. She said that he remained in the hospital for one week and when he was released, she admitted him to a more secure memory care facility. Guardian A1 said that she noticed the basement door at this facility and assumed it had a lock on it. She said that if she knew the basement door was unlocked, she would have asked that a lock be put on it.

On 12/09/21, I interviewed staff Takeisha Smith via telephone. Ms. Smith confirmed that she and Tanisha Breedlove were working on 10/29/21 when Resident A fell. Ms. Smith said that she was in a resident's room, changing him and she heard a loud "boom." She went to investigate and when she could not find Resident A in his room, she opened the basement door and saw him laying at the bottom of the steps. She immediately went to assist him and called out to her co-worker to help her. Resident A was sent to the hospital, and he did not return to Sugarbush Living-Beecher Circle House.

Ms. Smith confirmed that Resident A wandered around the facility, opening doors. She said that he used to stay up all night, roaming around the house. He would open other resident bedroom doors and scare them. Ms. Smith said that she never saw Resident A open any of the egress doors and never saw him open the basement door, but she and other staff were aware that they needed to watch him closely due to him roaming the facility and opening doors.

On 12/09/21, I conducted an exit conference with the licensee designee, Michael Maurice via telephone. I discussed the results of my investigation and explained which rule violation I am substantiating. Mr. Maurice agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14303	**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 10/29/21, Resident A fell down the basement stairs and sustained multiple injuries. According to his Health Care Appraisal, he is diagnosed with hypertension, dementia, and impaired vision. According to Guardian A1 and staff Andrea Cain and Takeisha Smith, Resident A was known to roam around the facility and open doors. Guardian A1 said that on one occasion, Resident A got into some putty in the garage and she asked staff to put a lock on that door. Guardian A1 and staff said that staff was aware that Resident A had a tendency to roam, and open doors and they were instructed to keep a close eye on him for his safety. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Susan Hutchinson

December 9, 2021

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton

December 9, 2021

Mary E Holton Area Manager	Date