GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 28, 2022

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

RE: License #: AL250376703
Investigation #: 2022A0580028
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.
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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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250376703
Investigation #:	2022A0580028
Complaint Receipt Date:	03/11/2022
Investigation Initiation Date:	03/17/2022
Report Due Date:	05/10/2022
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 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 AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Relative Guardian A did not receive a 30-day discharge notice.	No
Staff refused to help Resident A to the bathroom.	No
Resident A was not allowed to speak with the nurse from PACE.	Yes
The facility has cashed Resident A's check for the month of March although she is not being allowed to return.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/11/2022	Special Investigation Intake 2022A0580028
03/11/2022	APS Referral This referral was denied by APS for investigation.
03/17/2022	Special Investigation Initiated - Telephone A call was made to the licensee, Mr. Michael Maurice.
03/17/2022	Contact - Telephone call made A call was made to the complainant.
03/23/2022	Inspection Completed On-site An onsite inspection was conducted at Sugarbush Manor. Contact made with the manager, Ms. Jasmine McPherson.
03/23/2022	Contact - Telephone call made A call was made to the licensee. A voice mail was left requesting a return call.
03/30/2022	Contact - Telephone call received A call was received from Mr. Maurice.
03/30/2022	Contact - Document sent An email to was to Mr. Maurice requesting documents.
04/01/2022	Contact - Telephone call made A call was made to direct staff, Ms. Tracie Monge.
04/01/2022	Contact - Telephone call made A call was made to direct staff, Ms. Ashley Caldwell.
04/08/2022	Contact - Document Received

	A copy of documents requested were received.
04/13/2022	Contact - Telephone call made A call was made to Ms. Amber Sinclair of PACE Program in Genesee County.
04/19/2022	Contact - Telephone call made A call was made to Relative A, assigned guardian for Resident A.
04/25/2022	Contact - Telephone call made A call was made to Ms. Karen Hill, On Call RN at PACE of Genesee County.
04/25/2022	Contact - Telephone call made A call was made to Resident A.
04/26/2022	Contact - Document Received A copy of the incident report requested was received.
04/28/2022	Contact - Telephone call made A call was made to Relative Guardian A, assigned guardian for Resident A.
04/28/2022	Exit Conference An exit conference was held with the licensee.

ALLEGATION:

Relative Guardian A did not receive a 30-day discharge notice.

INVESTIGATION:

On 03/11/2022, I received a complaint via BCAL Online complaints. This complaint was denied by APS for investigation.

On 03/17/2022, I placed a call to the licensee, Mr. Michael Maurice. A voice mail message was left requesting a return call.

On 03/17/2022, I placed a call to the complainant. She indicated that she has no firsthand knowledge regarding the allegations. The referral was made based on information provided by Resident A and her guardian.

On 03/23/2022, I conducted an onsite inspection at Sugarbush Manor. Contact was made with the manager, Ms. Jasmine McPherson. She indicated that she assumed the position on 03/16/2022 and is unaware of the events surrounding the allegations.

On 03/23/2022, I made a call to Mr. Michael Maurice, licensee. There was no answer. A voice mail message was left requesting a return call.

On 03/30/2022, I spoke with Mr. Michael Maurice. Mr. Maurice denied that a copy of the 30-day notice was not provided to Relative Guardian A. He indicated that that Relative Guardian A has always difficult to reach, does not respond to phone calls. He has primarily communicated with the guardian through the PACE case manager, Ms. Amber Sinclair. He shared that a copy of the 30-day notice was mailed to Relative Guardian A, the PACE Program case manager and a copy was given to Resident A on 01/10/2022.

On 03/30/2022, I sent an email to Mr. Maurice requesting a copy of the incident report dated on or about 3/09/22, regarding Resident A's fall, the names and numbers of employees working that evening of the Resident's fall, a copy of Resident A's AFC Care Agreement, AFC Assessment Plan, her Resident Funds II sheet for monthly payment, her 30-day discharge notice and a copy of the AFC's discharge policy.

On 04/08/2022, a copy of the 30-day discharge written for Resident A was received, via email from the licensee. The notice is addressed to Relative Guardian A as a letter, with the Discharge of Resident A as the subject matter. The notice is type signed and dated 01/10/2022, from the licensee. The notice indicates that the facility is giving a 30-day decision to discharge Resident A's due to the home being unable to provide the level of care she requires.

On 04/13/2022, I spoke with Ms. Amber Sinclair of PACE Program in Genesee County. She indicated that she did not receive an official 30-day notice. She did acknowledge receiving an email with a letter dated 1/10/2022 from the licensee indicating that Resident A is being given a 30-day discharge from the facility. Ms. Sinclair indicated that she had been actively assisting Relative Guardian A in obtaining a new placement for Resident A prior to her being taken to the hospital.

On 04/19/2022, I spoke with Relative Guardian A, assigned guardian for Resident A. He indicated that he recalls receiving a call from the licensee, Mr. Michael Maurice sometime in January in which the licensee appeared agitated and rudely stated to him that "I'm tired of dealing with your mom. She has to go. Consider it 30 days." Relative A maintained that he never received anything in writing from the licensee. Relative A indicated that he had been actively looking at new AFCs for Resident A to be replaced.

On 04/25/2022, I spoke with Resident A. She indicated that when she fell at the facility and had to go to the hospital on 03/09/2022, the licensee, Mr. Michael Maurice, sent a note with her to the hospital indicating that she is not able to return to the home.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	It was alleged that Relative Guardian A did not receive a 30-day discharge notice. Licensee, Mr. Michael Maurice, stated that a copy of the 30-day notice was mailed to Relative Guardian A, the PACE Program case manager and a copy was given to Resident A on 01/10/2022. A copy of the 30-day discharge written for Resident A received was addressed to Relative Guardian A as a letter, with the Discharge of Resident A as the subject matter. The notice is type signed and dated 01/10/2022, from the licensee. The notice indicates that the facility is giving a 30-day decision to discharge Resident A's due to the home being unable to provide the level of care she requires. Ms. Amber Sinclair of PACE Program in Genesee County. acknowledge receiving an email with a letter dated 1/10/2022 from the licensee indicating that Resident A is being given a 30-day discharge from the facility. Relative Guardian A, assigned guardian for Resident A, recalls receiving a call from the licensee, Mr. Michael Maurice sometime in January in which the licensee appeared agitated and rudely stated to him that "I'm tired of dealing with your mom. She has to go. Consider it 30 days". Relative Guardian A maintains that he never received anything in writing from the licensee. Relative A indicated that he had been actively looking at new AFCs for Resident A to be replaced.

	Both the guardian and the case manager were aware that a 30-day notice had been issued. Based on the information gathered in the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

. Staff refused to help Resident A to the bathroom.

INVESTIGATION:

On 03/30/2022, I spoke with Mr. Michael Maurice, licensee. He denied the allegations. He reports that Resident A does not require assistance to use the bathroom. While on the floor after her reported fall, Resident A refused to allow anyone to touch her, or any assistance offered to help her off the floor, until the EMS arrived.

On 04/01/2022, I spoke with direct staff, Ms. Ashley Caldwell. Ms. Caldwell indicated that Resident A does not require assistance when toileting and takes herself to the bathroom. She indicated that Resident A did not fall as alleged. She stated that Resident A was walking with her walker alongside another resident when she all of a sudden laid herself on the floor and began screaming for help over and over. She indicated that when staff tried to assist her off the floor, she cursed all the staff out and refused to allow anyone to assist her. She then asked for her cell phone and called 911.

On 04/01/2022, I spoke with direct staff, Ms. Tracie Monge. Ms. Monge indicated that Resident A does not require assistance to use the bathroom. She indicated that Resident A did not fall, she laid herself on the floor. Staff tried to assist Resident A off the floor, however, she cursed everyone out and refused any help.

On 04/08/2022, I received a copy of the AFC Assessment Plan for Resident A. For toileting it indicates that Resident A requires reminding to use the bathroom. A walker and a shower chair are listed as her assistive devices.

On 04/25/2022, I spoke with Resident A. Resident A indicated that she typically uses her walker to get around, however, on 03/08/2022, PACE Program provided her with a wheelchair. On 03/09/2022 she was in her wheelchair and requested that staff, Ms. Tracie Monge wheel her to the restroom. Ms. Monge told her no because she is able to walk. While transferring herself from her wheelchair to her walker, she fell on the floor. Resident A indicated that she requested Mr. Maurice leave her on the floor and let the EMS do their job.

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:	It was alleged that staff refused to help Resident A to the bathroom. Mr. Michael Maurice denied the allegations. He reports that Resident A does not require assistance to use the bathroom. While on the floor after her reported fall, Resident A refused to allow anyone to touch her, or any assistance offered to help her off the floor, until the EMS arrived. Direct staff, Ms. Ashley Caldwell. Ms. Caldwell indicated that Resident A does not require assistance when toileting and takes herself to the bathroom. Direct staff, Ms. Tracie Monge, indicated that Resident A does not require assistance to use the bathroom. Resident A did not fall, she laid herself on the floor. Staff tried to assist Resident A off the floor, however, she cursed everyone out and refused any help. The AFC Assessment Plan for Resident A indicates that Resident A requires reminding to use the bathroom. Resident A indicated that she requested that staff, Ms. Tracie Monge wheel her to the restroom. Ms. Monge told her no because she is able to walk. While transferring herself from her wheelchair to her walker, she fell on the floor. Resident A indicated that she requested Mr. Maurice leave her on the floor and let the EMS do their job. Resident A's plan does not indicate that she requires assistance with toileting. Based on the information gathered in the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not allowed to speak with the nurse from PACE.

INVESTIGATION:

On 03/30/2022, I spoke with Mr. Michael Maurice, licensee. He indicated that Resident A was not allowed to speak with the nurse due to heading to the hospital. He adds that Resident A has her own cell phone.

On 04/13/2022, I spoke with Ms. Ms. Amber Sinclair of PACE Program in Genesee County. She shared that on call nurse, Ms. Karen Hill reported that on the night of Resident A's fall, licensee, Mr. Maurice would not allow her to speak with her to assess her pain or calm her down.

On 04/19/2022, Relative Guardian A shared that he was informed by the nurse at PACE that Mr. Maurice denied her a phone call with Resident A.

On 04/25/2022, I spoke with Ms. Karen Hill, RN at Pace. Ms. Hill verified that she was the on-call nurse working the evening of 03/09/2022 when she received a call from the licensee indicating that Resident A had fallen, she's not hurt, she's refusing to get up, and she's acting irrational. Mr. Maurice then indicated that Resident A is being sent to the hospital and will not be able to return to the facility. Ms. Hill indicate that due to her longstanding relationship with Resident A, she thought she may be able to speak with her and calm her down. Ms. Hill indicated that Mr. Maurice flatly denied Resident A the call by stating, "No, the EMS is already here", and abruptly hung up the phone. Ms. Hill indicated that she later found out that the EMS did not arrive until at least another 30-45 minutes.

On 04/26/2022, I received a copy of the incident report dated 03/09/2022. The report indicates that caregivers found Resident A on the floor near the front of the building. Resident indicated she tripped and fell. Caregivers tried to assist and check resident, but she refused. Owner tried to assist Resident A. Resident refused care, assistance, and would not allow owner to check for injuries. Resident began yelling and demanding she be taken to the hospital because she was in pain. Owner contacted 911 to have resident taken to the hospital. As a corrective measure the resident was discharged. Resident's POA had been given a 30-day notice, 60 days prior. A letter explaining that Resident A cannot return was sent with Resident A to the hospital.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or

	the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.**
ANALYSIS:	It was alleged that Resident A was not allowed to speak with the nurse from PACE. Mr. Michael Maurice, licensee, indicated that Resident A was not allowed to speak with the nurse due to heading to the hospital. He adds that Resident A has her own cell phone. Ms. Ms. Amber Sinclair, Case Manager at PACE Program in Genesee County, shared that on call nurse, Ms. Karen Hill reported that on the night of Resident A's fall, licensee, Mr. Maurice would not allow her to speak with her to assess her pain or calm her down. Relative Guardian A shared that he was informed by the nurse at PACE that Mr. Maurice denied her a phone call with Resident A. Ms. Karen Hill, RN at Pace, indicated that on the evening of 03/09/2022, she requested to speak with Resident A to assist with calming her down. Licensee, Mr. Maurice flatly denied Resident A the call by stating, "No, the EMS is already here", and abruptly hung up the phone. Resident A was not allowed to speak with Nurse, Ms. Karen Hill of PACE. Based on the information gathered in the course of this investigation, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility has cashed Resident A's check for the month of March although she is not being allowed to return.

INVESTIGATION:

On 03/30/2022, I spoke with Mr. Michael Maurice, licensee. Mr. Maurice indicated that Resident A pays part of the monthly rent while PACE Program pays the remaining amount. The check for the month of March has been received, however, it has not been cashed.

On 04/08/2022, I received a copy of the AFC Care Agreement for Resident A., the Resident Funds II sheet for Resident A in addition to a copy Sugarbush Manor's Refund Policy. Also attached is a copy of the uncashed cashier's check for Resident A's March 2022 rent payment.

The AFC Care Agreement indicates that Resident A pays $3600 a month. Resident A is a participant in the Genesee Count PACE Program. Resident A is responsible for the payment amount of $934.50 a month. The remaining total is paid by the PACE Program. The Resident Funds II sheet indicates that the licensee received payments of $934.50 once a month from Relative Guardian A.

The refund agreement indicates that Sugarbush Living will disperse appropriate funds within 5 days of discharge from the residence to the designated funding source. Prorated rent will only be refunded before the 15th of the month only if the resident is given an emergency discharge due to incompatibility, failure to fit in with the existing residents, severe behavior towards others, self-inflicted injuries, or damage or destruction of property. Emergency discharges will be prorated taking total rent and dividing it by the number of days left in the month to calculate the amount.

On 04/19/2022, I spoke with Relative Guardian A. He indicated that he has not received any refund from the licensee for the month of March. Resident A was sent to the hospital on 03/09/2022 and not allowed to return. Relative Guardian A was able to stop the payment for the 2nd half of March.

On 04/28/2022, I spoke with Relative Guardian A. He confirmed that the funds have not been returned to his bank account.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(14) A licensee shall have a written refund agreement with the resident or his or her designated representative. The agreement shall state under what conditions a refund of the unused portion of the monthly charge that is paid to the home shall be returned to the resident or his or her designated representative. The refund agreement shall provide for, at a minimum, refunds under any of the following conditions:

	(a) When an emergency discharge from the home occurs as described in R400.15302. **(b) When a resident has been determined to be at risk pursuant to the provisions of sections 11 and 11a to 11f of Act No. 280 of the Public Acts of 1939, as amended, being {{400.11 and 400.11a to 400.11f of the Michigan Compiled Laws.** **(c) When a resident has been determined to be at risk due to substantial noncompliance with these licensing rules which results in the department taking action to issue a provisional license or to revoke or summarily suspend, or refuse to renew, a license and the resident relocates. The amount of the monthly charge that is returned to the resident shall be based upon the written refund agreement and shall be prorated based on the number of days that the resident lived in the home during that month.**
ANALYSIS:	It was alleged that the facility has cashed Resident A's check for the month of March although she is not being allowed to return. Licensee, Mr. Maurice indicated that the check for the month of March has been received, however, it has not been cashed. On 04/08/2022, I received an emailed copy of the uncashed cashier's check for Resident A's March 2022 rent payment in the amount of 934.50, dated 03/04/2022. The Resident Funds II sheet indicates Resident A is responsible for monthly payments of $934.50. Relative Guardian A indicated that he has not received any refund from the licensee for the month of March. Resident A was sent to the hospital on 03/09/2022 and not allowed to return. Although the licensee has not cashed the check for month of March as alleged, the funds have not been returned to Resident A's account. Based on the information gathered in the course of this investigation, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/23/2022, I conducted an onsite inspection at Sugarbush Manor. Contact was made with the manager, Ms. Jasmine McPherson. Upon requesting documents from the Resident A's file, she indicated that the licensee had just left the facility and had taken the file with him.

On 04/28/2022, I conducted an exit conference with Mr. Michael Maurice. Mr. Maurice was informed of the violations found. A corrective action plan is due within 15 days.

APPLICABLE RULE	
R 400.15316	**Resident records.**
	(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.
ANALYSIS:	At the 03/23/2022 onsite inspection, Resident A's file was not on file at the home. Resident A was discharged on 03/09/2022. Due to the Resident A's file being unavailable at the home, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

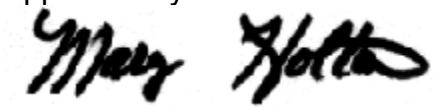
IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

April 28, 2022

Sabrina McGowan — Date
Licensing Consultant

Approved By:



April 28, 2022

Mary E Holton — Date
Area Manager