GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 25, 2023

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

RE: License #: AL250376703
Investigation #: 2023A0872035
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 (517) 643-7960.

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 #:	AL250376703
Investigation #:	2023A0872035
Complaint Receipt Date:	04/06/2023
Investigation Initiation Date:	04/10/2023
Report Due Date:	06/05/2023
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:	04/19/2022
Expiration Date:	04/18/2024
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 03/08/23, staff did not assist Resident A for hours. Staff is putting Resident A's phone on airplane mode so she cannot make or receive calls. Her room is dirty with rodents and trash that has been in the trashcan for 3 weeks. Staff is not changing her, she has bruises on her arms, staff is not answering her call button for hours, some staff are violent with her, she has bed sores.	No
Additional Findings	Yes

III. METHODOLOGY

04/06/2023	Special Investigation Intake 2023A0872035
04/10/2023	Special Investigation Initiated - Letter
04/10/2023	APS Referral I made an APS complaint via email
04/14/2023	Inspection Completed On-site Unannounced
04/14/2023	Contact - Document Sent I emailed the licensee designee, Michael Maurice, requesting information about this complaint
04/14/2023	Contact - Document Received I received AFC documentation from Mr. Maurice
04/18/2023	Contact - Document Received I received AFC documentation from Mr. Maurice
05/15/2023	Contact - Document Received I exchanged emails with APS Worker, Anessa Staple
05/16/2023	Contact - Telephone call made I interviewed Mid-Michigan Director of Nursing, Caryn Knappen
05/16/2023	Exit Conference I conducted an exit conference with the licensee designee, Michael Maurice

05/16/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 03/08/23, staff did not assist Resident A for hours. Staff is putting Resident A's phone on airplane mode so she cannot make or receive calls. Her room is dirty with rodents and trash that has been in the trashcan for 3 weeks. Staff is not changing her, she has bruises on her arms, staff is not answering her call button for hours, some staff are violent with her, she has bed sores.

INVESTIGATION: On 04/13/23, I received an email and an Incident/Accident Report (IR) from the licensee designee, Michael Maurice regarding Resident A. According to the email, Resident A has lived at Sugarbush Manor for approximately three months, and she receives hospice services. Mr. Maurice said that since being admitted, Resident A has experienced "multiple incidents of erratic and delusional behaviors including her calling 911 multiple times from her cell phone stating that she had not been fed, changed, or properly cared for." Mr. Maurice said that he is working with staff and Resident A's hospice team to try and remedy any issues.

According to the IR dated 04/01/23 at 5:30pm, "Resident called out for help, when staff walked in [she] had dialed 911 on her phone and was talking to the operator. She requested an ambulance because of her diarrhea." Staff contacted the home manager and Resident A's hospice team. Resident A was transported to the hospital and was released later that evening with a prescription for an antibiotic for a possible UTI (Urinary Tract Infection).

Later, on 04/13/23, I conducted an unannounced onsite inspection of Sugarbush Manor. I interviewed Resident A, conducted a visual inspection of her room and bathroom, and interviewed the licensee designee, Michael Maurice.

Resident A was in her room, in bed, watching television when I met with her. Resident A appeared to be clean and was wearing clean clothing. I did not detect a malodorous odor. I reviewed the allegations with her, and she said that she has lived at this facility for approximately two years. I asked her about staff, and she said, "Some staff are better than others but they're all okay." I asked her if any of the staff have ever physically harmed her in any way and she said no. I asked her if she currently has any bruises on her arms or elsewhere on her body and she said no. She showed me her arms and I did not see any evidence of bruises. I asked her if she has any sores on her bottom or anywhere else on her body and she said no.

Resident A told me that she uses a wheelchair for mobility, but she cannot transfer from her bed to her wheelchair by herself. She said that she is basically bedbound, and she receives care from Sugarbush Manor staff and hospice staff. Resident A told me that hospice gives her a bed bath twice a week and sometimes Sugarbush Manor staff gives her a bed bath as well.

I asked Resident A if she ever has trouble reaching staff and she said yes. She showed me her call button which is attached to her bed and is easily within her reach. She told me that whenever she needs something, she presses her call button and if staff does not respond, she will yell out “Help me!” until someone comes. Resident A said, “Sometimes they don’t come at all” when she presses her call button. She stated that she wears briefs, and she has sat in a soiled brief “For a whole day. From morning until night because no one will help me.” Resident A told me that she “poops” her pants and has had to lay in her soiled brief “all day” because staff will not help her. I asked her if she ever had any bed sores from being in a soiled brief and she said no.

I asked Resident A if she ever saw rodents or insects in her room. She told me that she has seen mice in her room “not that often” and could not recall the last time. She said that she has never seen insects.

I asked Resident A if she uses a cell phone, and she said yes but she does not know how to use it. She showed me her cell phone and was able to turn it on but did not seem to know how to navigate it. I asked her if staff ever touches her cell phone or takes her cell phone, and she said no. She asked me to look at her cell phone and tell her the names of the people she has saved. I looked at her cell phone and read her the names and phone numbers in her saved contacts. I also noted that her cell phone was on airplane mode. I asked her if she knew why her phone was on airplane mode and she said no. I again asked her if staff touches her cell phone or if one of the staff put her phone on airplane mode and she again said that staff does not touch her cell phone. I took her phone off airplane mode and attempted to show her the difference, but she did not seem to understand. She took the cell phone from me and began pushing some buttons and then she handed it back to me. Somehow, she put it back on airplane mode and when I pointed it out to her, she said she does not know how she did it. I asked her if family and friends can reach her any other way and she said they can call the facility and staff will bring her a phone to talk on but said that she does not like to do it that way.

I visually inspected her bedroom and bathroom and found both areas to be clean, with no evidence of a malodorous odor. I saw her trashcan which was not overflowing, and I did not see any evidence of rodents or insects.

Mr. Maurice said that Resident A was admitted to Sugarbush Manor on 02/06/23. He said that she has terminal cancer and has hospice services. According to Mr. Maurice, on 02/08/23, Resident A called 911 and told the operator that she had not been changed for 12 hours. He said that because of that, the facility has her on a brief-change schedule which he agreed to send me. He said that staff checks on Resident A several times throughout the day and night but at least every two hours. He denied that Resident A is ever left in a soiled brief for any length of time.

Mr. Maurice denied that staff has ever physically harmed Resident A and said that she has never reported any abuse to him. He said that Resident A was having some problematic behaviors for a while, and she was calling 911 often.

Mr. Maurice told me that to his knowledge, Resident A has never had any unexplained bruises on her arms or anywhere else on her body. He said that recently, he observed staff changing her brief and she did have a small healing wound on her coccyx, but it did not require medical attention and her hospice nurse was aware of it. Mr. Maurice stated that the facility does have a script for a Hoyer lift, but Resident A says it is too painful to use so she typically chooses to stay in bed rather than use the Hoyer lift to transfer to her wheelchair. According to Mr. Maurice, Resident A's room is cleaned regularly, and her trash can is never overflowing. He denied having rodents or insects in the facility.

On 04/18/23, I received AFC paperwork related to Resident A. According to her Health Care Appraisal dated 03/16/23, she is diagnosed with hypertension, uterine cancer with mets, history of pulmonary embolism, history of deep vein thrombosis, anxiety, malaise, cardiomegaly, osteoarthritis, hepatomegaly, and obesity. RN Alexandria Huntley noted that Resident A was "clean and well kept" and she suffers from confusion and hallucinations. She is bedbound and requires a wheelchair for mobility.

According to Resident A's Assessment Plan dated 02/06/23, she requires staff assistance with toileting, bathing, grooming, dressing, and personal hygiene. She uses a wheelchair and Hoyer lift for mobility, but she is unable to bear weight.

Resident A receives services through Mid-Michigan Hospice. I reviewed a hospice progress note dated 04/03/23 completed by Alexandria Huntley, RN. According to this document, "[Resident A] bed bound; unsafe to attempt any transfer."

I reviewed two IRs dated 02/20/23 regarding Resident A. According to the first IR, when staff entered Resident A's room, they noticed that she had a lot of vaginal bleeding. Staff called 911 and Resident A was transported to the hospital. The corrective measures taken were, Resident A was taken off the medication, Elquis. According to the second IR, "[Resident A] returned home [from hospital] with bruising on her arms. Manager asked EMS and said bruising was caused by the IV."

I reviewed staff progress notes from 03/05/23 through 04/18/23. During each shift, staff documented if there were any issues related to Resident A. Sometimes, staff noted being called to Resident A's room multiple times throughout the shift. On 03/11/23 during second shift, staff noted that Resident A was given a bed bath and staff noted that she had an open wound on her buttock. Staff cleaned and administered a topical cream to the area.

According to the staff progress note from 03/08/23, during third shift, Resident A's bed linen was changed. Staff noted "went in room total of 6 times still complaints and screaming the entire shift. Threats to call the police and that nobody has changed her all night."

I reviewed Resident A's behavior log from 03/21/23 through 04/17/23. I noted that Resident A often had aggressive behaviors which included screaming, yelling, and threatening staff. Most of these behaviors took place during sleeping hours.

I reviewed Resident A's brief check/change tracker and noted that staff documented checking and changing Resident A's brief multiple times a day.

On 05/16/23, I interviewed Mid-Michigan Home Health & Hospice Director of Nursing, Caryn Knappen. RN Knappen confirmed that Resident A has been a patient of her agency for several months. She said that a nurse and social worker attend to Resident A at least two times per week. RN Knappen said that Resident A has a history of calling 911 and she is often confused. On one occasion, she met with Resident A while she was eating lunch which was spaghetti. Shortly after eating, Resident A told her that the facility only serves her hot dogs. On another occasion, Resident A told her that staff had not been in to change her brief "all day." RN Knappen said that she examined Resident A's brief change schedule and noted that staff had last been in to change her brief 30 minutes ago. When she brought this information to Resident A's attention, Resident A said, "Oh, I must have forgot."

RN Knappen said that she and her team do not have any concerns about the care or treatment that Resident A receives from Sugarbush Manor staff. She said that Sugarbush Manor staff is attentive to Resident A's needs, and they provide good care to her. She said that she and her team have not seen any evidence of abuse and/or neglect.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
ANALYSIS:	**(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.**
	Resident A said that staff does not touch her phone and they do not stop her from making telephone calls. She said that she has seen mice in her room" not that often." Resident A told me that staff has not physically abused her and she does not have any marks, bruises, or injuries. Resident A stated that oftentimes, staff does not respond when she uses her call button, so she has to yell "Help me!" until someone comes. On 04/13/23, I conducted a visual inspection of Resident A's room and bathroom. Resident A, as well as her room and bathroom, appeared to be clean, with no evidence of a malodorous odor. Resident A did not have any marks, bruises, or bed sores at the time of my inspection.

ANALYSIS:	The licensee designee, Michael Maurice said that staff attends to Resident A's needs, staff does not put her cell phone on airplane mode, her room is kept clean, staff does not physically abuse or mistreat her, the facility does not have rodents or insects, and Resident A does not have any unexplained marks or bruises. I examined numerous documents related to Resident A's care. Based on the documentation I reviewed, I determined that staff attends to Resident A's needs including checking on her often and changing her brief. RN Knappen said that she and her team do not have any concerns about the care or treatment that Resident A receives from Sugarbush Manor staff. She said that Sugarbush Manor staff is attentive to Resident A's needs, and they provide good care to her. She said that she and her team have not seen any evidence of abuse and/or neglect. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/18/23, I reviewed two Incident/Accident Reports (IR) regarding Resident A. According to the IR dated 02/20/23, Resident A was sent to the hospital due to vaginal bleeding. According to the IR dated 04/01/23, Resident A called 911 and was sent to the hospital due to diarrhea. I did not receive copies of these IRs until 04/18/23.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1)(b) Any accident or illness that requires hospitalization.

ANALYSIS:	On 04/18/23, I reviewed two Incident/Accident Reports (IR) regarding Resident A. According to the IR dated 02/20/23, Resident A was sent to the hospital due to vaginal bleeding. According to the IR dated 04/01/23, Resident A called 911 and was sent to the hospital due to diarrhea. I did not receive copies of these IRs until 04/18/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/16/23, I conducted an exit conference with the licensee designee, Michael Maurice. I discussed the findings of my investigation and explained which rule violation I am substantiating. I asked Mr. Maurice to complete and submit a corrective action plan upon the receipt of my investigation report.

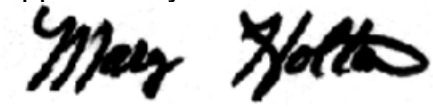
IV. RECOMMENDATION

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

May 23, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 23, 2023

Mary E. Holton Area Manager	Date