GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 13, 2024

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

RE: License #:	AL250376703
Investigation #:	2024A0872054
	Sugarbush Manor

Dear Michael 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
THIS COMPLAINT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL250376703
Investigation #:	2024A0872054
Complaint Receipt Date:	08/06/2024
Investigation Initiation Date:	08/07/2024
Report Due Date:	10/05/2024
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:	04/19/2024
Expiration Date:	04/18/2026
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED

	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Vickie Whittaker slapped Resident A in the face.	No
Additional Findings	Yes

III. METHODOLOGY

08/06/2024	Special Investigation Intake 2024A0872054
08/06/2024	APS Referral This complaint was referred by APS. The worker is Brandi Morris
08/07/2024	Special Investigation Initiated - On Site Unannounced
08/09/2024	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
08/21/2024	Contact - Document Received I received AFC documentation related to this complaint
08/27/2024	Contact - Face to Face I interviewed Resident A at his new AFC home
09/11/2024	Exit Conference I conducted an exit conference with the licensee designee, Michael Maurice
09/11/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Staff Vickie Whittaker slapped Resident A in the face.

INVESTIGATION: On 08/07/24, I conducted an unannounced onsite inspection of Sugarbush Manor Adult Foster Care facility. I interviewed the home manager (HM), Vickie Whittaker and the licensee designee (LD), Michael Maurice. Resident A is no longer a resident of this facility as Relative A1 moved him to another facility on 08/02/24. While at the facility, I observed several residents who were all clean, dressed appropriately, and were being supervised by staff.

I reviewed the allegations with HM Whittaker, and she denied them. HM Whittaker said that Resident A is diagnosed with alcohol induced dementia and he had a stroke in the past. HM Whittaker said that his condition has been worsening. According to HM Whittaker, Resident A has become increasingly argumentative, he has been cussing at staff, refusing showers, and following staff around complaining about different things. He has also been accusing HM Whittaker of "picking on him." Resident A's confusion has also been increasing. After staff gives him his inhaler, he will tell people that they did not give it to him because he forgets.

According to HM Whittaker, Resident A keeps losing his hearing aids and/or will forget they are in his ear. On one occasion, Resident A told HM Whittaker that he could not find his hearing aids. HM Whittaker looked for them in his room and in her office where he charges his hearing aids, and she could not find them. Eventually, Resident A realized they were in his ears. HM Whittaker said that she called him silly and "wiped my hand down the front of his face." HM Whittaker said that Resident A became agitated and told her not to touch him. Later, he told other staff and Relative A1 that she had hit him. HM Whittaker said that Resident A has used the words, "smoosh, slap, and hit" when describing the incident. HM Whittaker told me that she did not slap or hit Resident A and said that she never treated him poorly.

LD Maurice confirmed that he received a complaint that HM Whittaker had slapped Resident A. LD Maurice said that he conducted an internal investigation and did not find any evidence of abuse. LD Maurice told me that when he spoke to Resident A about the incident, Resident A told him that he lost his hearing aids and when he found them in his ear, HM Whittaker "smooshed" his face. LD Maurice said that Resident A used the terms, "smoosh, slap, and hit" when describing the incident to others. LD Maurice told me that Resident A did not have any marks, bruises, or injuries from the incident and he does not believe that HM Whittaker physically abused Resident A.

According to LD Maurice, Resident A has resided at this facility for several years with no problems. His dementia has been getting worse as well as his behaviors and mood. LD Maurice said that after HM Whittaker began working at this facility, it was apparent that Resident A did not like her. LD Maurice explained that HM Whittaker is very energetic, loud, and physically demonstrative.

On 08/21/24, I reviewed AFC paperwork related to this complaint. Resident A was admitted to Sugarbush Manor on 01/18/20 and was discharged on 08/02/24. According to Resident A's health care appraisal, he is chronically ill, has lower extremity weakness and he is "susceptible to dementia." According to his Assessment Plan, he uses a walker for mobility, and he has extreme hearing loss.

I reviewed staff progress notes regarding Resident A's behaviors. Staff noted that Resident A would complain of not receiving breakfast even though he had eaten breakfast earlier in the morning. Resident A would follow staff around cussing at them. I reviewed an Incident/Accident Report (IR) dated 07/26/24. According to that IR, staff asked Resident A if he was going to shower and he refused, saying that he doesn't

have to do “shit” that the owner or staff asks him to do. The corrective measures taken by staff were, “Reported to manager, walked away from him.”

On 08/23/24, I interviewed Relative A1 via telephone. Relative A1 said that she sees Resident A on an almost daily basis. Relative A1 confirmed that Resident A resided at Sugarbush Manor for several years and he received good care. Relative A1 said that when HM Whittaker began working at the facility, Resident A disliked her. Relative A1 confirmed that Resident A’s dementia has worsened, and Resident A has become more argumentative, and Resident A’s behaviors have become more problematic. Relative A1 said that Resident A often complained about HM Whittaker and told Relative A1 that she “picked on” him. Relative A1 told me that when she learned that Resident A accused HM Whittaker of slapping him, she asked him about it. Relative A1 said that Resident A told her that everyone was looking for his hearing aids because he could not find them. Resident A told her that they eventually found his hearing aids in his ear. Resident A told her that HM Whittaker “mooshed” him in the face. Resident A told another relative that HM Whittaker hit Resident A in the face. Relative A1 told me that she does not believe that HM Whittaker hit Resident A or deliberately harmed Resident A in any way. Relative A1 said that because of Resident A’s increasingly problematic behaviors and his increasing dementia symptoms, Relative A1 removed him from Sugarbush Manor AFC and placed him at the Landings of Genesee Valley AFC.

On 08/27/24, I conducted an unannounced face-to-face interview with Resident A at the Landings of Genesee Valley AFC. Resident A was in his bedroom watching television. I reviewed the allegations with Resident A. Resident A told me that on one occasion, he could not find his hearing aids, so everyone was looking for them. Resident A said that when he realized they were in his ear, he told HM Whittaker. I asked Resident A what HM Whittaker did when she told him and he said, “She slapped me upside the head.” Resident A then said that HM Whittaker said, “Oh (Resident A)!” and touched him on the face. I asked him if HM Whittaker was angry when this incident occurred, and Resident A said no. I asked Resident A if HM Whittaker was smiling or joking around, and Resident A said probably. I asked Resident A to show me what happened, and Resident A reached both his hands up near the front of my face and wiped them down, saying “Oh [Resident A]!” Resident A said that he was surprised when this incident occurred and he thought, “Oh shit, what are you doing?” Resident A told me that HM Whittaker did not hurt him, and he said, “It was more of a surprise than a slap.”

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes

	a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	HM Whittaker said that she called Resident A "silly", and she wiped her hands down the front of Resident A's face when Resident A found his lost hearing aids in his ear. HM Whittaker said that she did not hit, or slap Resident A and she did not harm Resident A in any way. HM Whittaker and LD Maurice said that Resident A used the terms, "smoosh, slap, and hit" when describing the incident. LD Maurice said that Resident A told her that HM Whittaker "smooshed" his face. Relative A1 said that Resident A told her that HM Whittaker "mooshed" him in the face and told another relative that she slapped him. Relative A1 said that she does not believe that HM Whittaker hit Resident A or harmed him in any way. Initially, Resident A told me that HM Whittaker, "slapped me upside the head." Resident A then told me that when Resident A found his missing hearing aids in his ear, HM Whittaker said, "Oh [Resident A]!" and she touched Resident A on the face. Finally, Resident A told me that HM Whittaker did not hurt him and said, "It was more of a surprise than a slap." I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During the course of my investigation, I reviewed Resident A's Health Care Appraisal dated 04/06/23. On 09/11/24, LD Maurice stated he did not have an updated appraisal for Resident A.

On 09/11/24, I conducted an exit conference with the licensee designee, Michael Maurice. I discussed the results of my investigation and explained which rule violations I am substantiating. LD Maurice agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

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:	During the course of my investigation, I reviewed Resident A's Health Care Appraisal dated 04/06/23. On 09/12/24, LD Maurice stated he did not have an updated appraisal for Resident A. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During the course of my investigation, I reviewed Resident A's Assessment Plan dated 03/15/23. On 09/11/24 LD Maurice stated he did not have an updated assessment for Resident A.

On 09/11/24, I conducted an exit conference with the licensee designee, Michael Maurice. I discussed the results of my investigation and explained which rule violations I am substantiating. LD Maurice agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

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:	During the course of my investigation, I reviewed Resident A's Assessment Plan dated 03/15/23. On 09/12/24, LD Maurice stated he did not have an updated assessment for Resident A. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Susan Hutchinson September 13, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary E. Holton September 13, 2024

Mary E. Holton Date
Area Manager