GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 22, 2022

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

RE: License #:	AS250306415
Investigation #:	2022A0872026
	Sugarbush 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 #:	AS250306415
Investigation #:	2022A0872026
Complaint Receipt Date:	03/17/2022
Investigation Initiation Date:	03/17/2022
Report Due Date:	05/16/2022
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 House
Facility Address:	5631 Sugarbush Lane Flint, MI 48532
Facility Telephone #:	(810) 496-0002
Original Issuance Date:	02/08/2010
License Status:	REGULAR
Effective Date:	08/14/2020
Expiration Date:	08/13/2022
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 3/16/22, Resident A ingested a cleaning chemical while at this AFC. He was transported to Hurley hospital for treatment. He has early onset dementia.	Yes

III. METHODOLOGY

03/17/2022	Special Investigation Intake 2022A0872026
03/17/2022	APS Referral I made an APS complaint via email
03/17/2022	Special Investigation Initiated - Letter I made an APS complaint
03/30/2022	Inspection Completed On-site Unannounced
03/30/2022	Contact - Document Sent I exchanged emails with the licensee designee, Michael Maurice
04/22/2022	Contact - Telephone call made I interviewed former staff Dellisha Box
04/22/2022	Contact - Telephone call made I interviewed Relative A1
04/22/2022	Exit Conference I conducted an exit conference with the licensee designee, Michael Maurice, via email
04/22/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 3/16/22, Resident A ingested a cleaning chemical while at this AFC. He was transported to Hurley hospital for treatment. He has early onset dementia.

INVESTIGATION: I reviewed an Incident/Accident report (IR) dated 3/16/22 completed by staff Jaroi Coleman regarding Resident A. According to the IR, Resident A has early onset dementia. “(He) was able to get ahold of a bottle of disinfectant cleaner, opened

bottle and drank from it. Resident had never displayed behavior like this before. Staff immediately took bottle away and called 911. Resident is on hospice, Heartland Promedica, nurse was notified. Resident's wife was contacted. EMS arrived and took resident to Hurley Hospital. Resident was admitted following vomiting. Caregiver notified management of the situation." The corrective measures taken were, "POA informed that memory care needed. Resident had increased exit seeking behaviors, aggression, and needs care/oversite greater than we can provide. Had spoken to family and agency previous to this event and had been making plans to discharge. Staff training on chemical storage to take place ASAP."

On 3/30/22, I conducted an unannounced onsite inspection of Sugarbush House Adult Foster Care facility and I interviewed staff Jaroi Coleman. Mr. Coleman confirmed that on 3/16/22, Resident A was able to gain access to a bottle of disinfectant cleaner and he drank some of it. According to Mr. Coleman, he arrived for work that morning at approximately 7:00am at which time he relieved 3rd shift staff, Dellisha Box. Mr. Coleman said that he began preparing breakfast. Resident A was already awake, so Mr. Brown gave him some apple juice which he began drinking while sitting down in the living room. After a few minutes, Resident A began wandering around the kitchen which he is prone to do because he becomes "antsy." Mr. Coleman said that out of the corner of his eye, he saw Resident A tipping a large bottle down after apparently taking a drink. Mr. Brown said he was approximately three feet away from Resident A and quickly realized it was a disinfectant cleaner, so he immediately took it away from Resident A and called 911. Mr. Coleman was transferred to poison control, and he followed their instructions until EMS arrived and transported Resident A to the hospital.

According to Mr. Coleman, all cleaning supplies and poisons/caustics are kept locked in the cabinet under the kitchen sink which he showed me. Mr. Coleman said that he did not place the disinfectant cleaner on the counter, and he did not see it on the counter when he started his shift, or he would have moved it. Mr. Coleman told me that Resident A does not typically display this type of behavior but his dementia was becoming more increased so his wife decided that once he was released from the hospital, he would go to a memory care facility rather than returning to Sugarbush House. Mr. Coleman said nothing like this has happened while he has been employee of Sugarbush House. I was unable to interview Resident A because he is no longer a resident of this facility.

On 3/30/22, I exchanged emails with the licensee designee, Michael Maurice. He provided me with contact information for Relative A1 and agreed to send me other documentation related to this complaint.

On 4/22/22, I interviewed former staff Dellisha Box, via telephone. According to Ms. Box, she worked 3rd shift on 3/15/22. She said that she left the morning of 3/16/22 without incident. Ms. Box said that she later found out that Resident A ingested a cleaning chemical that was left on the counter. According to Ms. Box, she did not leave the disinfectant on the counter and said that it was there when she came in for her shift. Ms. Box told me that she was never told that cleaning supplies are supposed to be

locked up and said that cleaning supplies were often left out in the open. Ms. Box said that she only worked at Sugarbush House for 3 weeks before quitting for another job.

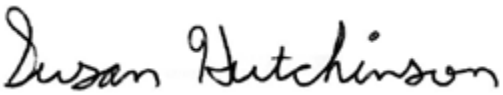
On 4/22/22, I interviewed Relative A1 via telephone. Relative A1 said that Resident A was admitted to Sugarbush House AFC in January 2022. Prior to that, he was at Sugarbush House for respite care in December 2021. Relative A1 said that Resident A was diagnosed with Alzheimer's approximately 10 years ago. She cared for him at her home until December 2021 when his condition began to deteriorate. Relative A1 said that in early January 2022, both she and Resident A contracted Covid-19. After their recovery, Resident A's condition seemed to rapidly deteriorate. Relative A1 told me that on 3/16/22, she was contacted and told that Resident A had ingested a cleaning chemical. She transported Resident A to McLaren Hospital where he was treated and released. After his release, he was in the car with her, and he began vomiting. She ended up taking him to Hurley Medical Center where he was again treated. He had a scope procedure which showed that he had redness but not blistering or holes in his stomach or esophagus. When he was released from Hurley Medical Center, she placed him at a memory care facility which she felt would be better able to meet his needs.

On 4/22/22, I conducted an exit conference with the licensee designee, Michael Maurice, via email. I told Mr. Maurice which rule violation I am substantiating and he agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	On 3/16/22, Resident A ingested some disinfectant cleaner which was sitting on the kitchen counter within reach of the residents. Resident A was taken to Hurley Medical Center and upon his release, he was admitted to a memory care facility. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

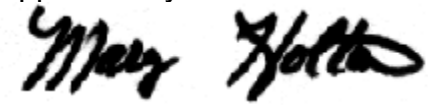
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



April 22, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



April 22, 2022

Mary E Holton Area Manager	Date