GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 30, 2025

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

RE: License #:	AL250376703
Investigation #:	2025A0872028
	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.

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.

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) 643-4960.

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 #:	2025A0872028
Complaint Receipt Date:	03/11/2025
Investigation Initiation Date:	03/12/2025
Report Due Date:	05/10/2025
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 ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 03/06/25, Resident A fell from her bed resulting in brain bleeding, multiple skull fractures, and a broken pelvis. Concern that Resident A's full bed rails were not in position at the time of Resident A's fall. Resident A has had several falls while residing at this facility.	No
Additional Findings	Yes

III. METHODOLOGY

03/11/2025	Special Investigation Intake 2025A0872028
03/12/2025	Special Investigation Initiated - Letter
03/13/2025	Inspection Completed On-site Unannounced
04/11/2025	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
04/15/2025	Contact - Document Received AFC documentation received
04/18/2025	Contact - Telephone call made I interviewed Relative A2
04/18/2025	Contact - Telephone call made I left a message for Resident A's All American Hospice Nurse
04/18/2025	Contact - Telephone call made I interviewed hospice nursing supervisor, Allie Huntley
04/18/2025	Contact - Telephone call made I interviewed staff Victoria Prewitt
04/18/2025	Contact - Document Received I received documentation from the licensee designee
04/28/2025	Contact - Document Received I received the medical records for Resident A

04/28/2025	Inspection Completed-BCAL Sub. Compliance
04/30/2025	Exit Conference – I conducted an exit conference with the licensee designee, Michael Maurice

ALLEGATION: On 03/06/2025, Resident A fell from her bed resulting in brain bleeding, multiple skull fractures, and a broken pelvis. Concern that Resident A's full bed rails were not in position at the time of her fall. Resident A has had several falls while residing at this facility.

INVESTIGATION: On 03/13/2025, I conducted an unannounced onsite inspection of Sugarbush Manor Adult Foster Care facility. I interviewed home manager (HM), Kendralia Sweeney and home manager (HM) Dasia Marks via telephone. HM Marks confirmed that Resident A resided at Sugarbush Manor AFC for several years. On 03/16/2025 at 1:45am, staff Victoria Prewitt contacted HM Marks to report that Resident A had climbed over her bed rails and had fallen out of bed. Staff Prewitt reported to HM Marks that apparently, Resident A was trying to go to the bathroom. Staff Prewitt told HM Marks that Resident A had hit her head, and she was bleeding. HM Marks advised Staff Prewitt to contact hospice and an ambulance. Resident A was transported to the hospital and died later that morning. HM Marks confirmed that according to Staff Prewitt, Resident A had four bedrails on her bed that were in position at the time of her fall. HM Marks told me that Resident A's hospice team ordered full bedrails for Resident A's safety. HM Marks told me that Resident A did not have a history of trying to climb over her bedrails. HM Marks also confirmed that Resident A had hospice services at the time of her death.

On 03/16/2025, I received an email from Relative A1. According to Relative A1, Resident A resided at one of the Sugarbush Living facilities since 2021. She has a history of falls and fractures of her hip. However, once Resident A was prescribed a hospital bed, her falls stopped, and she has not had a fall since 2021. In February 2024, Sugarbush staff and BCBS recommended hospice services as an additional level of care. Hospital bed rails were recommended and installed at that time.

According to Relative A1, on 03/06/2025, Relative A2 received a call from hospice and Sugarbush Manor staff stating that Resident A had fallen out of bed. An ambulance was called, and Resident A was transported to Henry Ford Genesys Hospital. Resident A was examined at the hospital, and she received a CT scan and x-rays which showed she had a brain bleed, skull fractures, and a fractured pelvis. Her condition deteriorated quickly, and she died on 03/06/25 at 7:08am. According to Relative A1, Resident A had been doing well but she was diagnosed with high blood pressure, arthritis, early onset dementia, depression, blood clotting because of a Factor V mutation and diabetes.

On 04/15/2025, I reviewed the death certificate for Resident A. According to this document, Resident A died at Henry Ford Genesys Hospital on 03/06/2025 at the age of 81-years. Resident A's manner of death is listed as "accident", and the immediate

cause of death is listed as “multiple injuries.” Other significant conditions at the time of her death are listed as “hypertensive and atherosclerotic cardiovascular disease, and anticoagulation therapy.” An autopsy was not performed.

On 04/18/2025, I reviewed AFC documentation related to this complaint. Resident A was admitted to Sugarbush Manor on 03/01/2021. According to her Health Care Appraisal, dated 02/20/2024 completed by Claire McDowell, Family Nurse Practitioner (FNP) she is diagnosed with hypertension, diabetes mellitus type II, protein resistance, and chronic kidney disease. FNP McDowell noted that Resident A is hard of hearing, she uses a wheelchair for mobility, and she requires assistance with activities of daily living. FNP McDowell ordered a home health care consult. According to Resident A’s Assessment Plan dated 02/20/2024, she requires staff assistance with toileting, bathing, grooming, dressing, personal hygiene, mobility and transfers. Her assistive devices listed are a wheelchair, hospital bed, and shower chair. I reviewed Resident A’s assistive device prescription list dated 02/23/2024 signed by Alexandria Huntley, RN. Resident A was prescribed a shower chair, wheelchair, hospital bed, and bedrails. Resident A was able to transfer to and from her wheelchair independently. However, due to increased weakness, staff encouraged her to ask for help when transferring.

I reviewed an Incident/Accident Report (IR) dated 03/06/2025 at 1:40am completed by staff Victoria Prewitt. According to this document, “Caregiver heard a loud noise and checked on the resident. Resident had gone over her full bed rails and was on the floor. Caregiver checked resident, found her bleeding from her nose and mouth.” The action taken by staff was, “Resident was on hospice services, so hospice was immediately contacted and informed of the situation. Hospice suggested laying her on her side. Caregiver contacted (Relative A2) and was instructed to have her taken to a hospital for evaluation. Caregiver called 911 and resident was taken out.”

I reviewed eight other IRs from 2021 regarding Resident A falling out of bed. Only one of the incidents resulted in Resident A being transported to the hospital for examination. According to the other IRs, Resident A did not receive any injuries that warranted medical attention. The last IR was dated 08/28/21 and the corrective measures taken were to get Resident A a new hospital bed with bed rails to hopefully prevent her from falling out of bed. The last IR I reviewed was from 2021. Once Resident A was prescribed a hospital bed, her falls stopped.

On 04/18/2025, I interviewed Relative A2 via telephone. Relative A2 confirmed that Resident A resided at Sugarbush Manor for approximately four years, and she was under hospice care. According to Relative A2, Resident A had a history of falls in 2021 but when she received a new bed, her falls stopped. Relative A2 said that Resident A had a hospital bed with remote and full bed rails on both sides of her bed.

According to Relative A2, on 03/06/2025 at approximately 2am, Sugarbush Manor staff and Resident A’s hospice nurse contacted him to let him know that Resident A had fallen out of bed and sustained multiple injuries. Relative A2 consented to have Resident A transported to the hospital where she was treated by doctors. Relative A2

told me that he spoke to one of the hospital nurses who explained the extensive injuries that Resident A experienced from the fall. Relative A2 said that he and other family members were concerned due to the extent and severity of the injuries. Relative A2 stated that prior to this incident, Resident A was doing very well, and she had not had any falls for several years. Relative A2 said that he questions whether staff had Resident A's bedrails in place at the time of her fall. Relative A2 agreed to send me copies of the hospital records from this incident.

On 04/18/2025, I interviewed All American Hospice nursing supervisor (NS), Allie Huntley. NS Huntley said that Resident A began receiving hospice services from her company on 02/22/24. Resident A had a registered nurse who saw her 2x's per week, a certified nursing assistant who saw her 2x's per week, and a social worker who saw her 1x per month. NS Huntley confirmed that Resident A had a hospital bed with full bedrails that were prescribed by All American Hospice.

According to NS Huntley, on 03/06/2025 Sugarbush Manor staff called the All-American Hospice on-call number to report that Resident A had fallen out of bed. The on-call nurse (RN) at the time was Aarian Childs. NS Huntley said that based on the injuries Sugarbush Manor staff described, RN Childs contacted Relative A2 and requested Resident A be sent to the hospital. Relative A2 agreed so RN Childs met Resident A at the hospital. RN Childs did not go to the facility prior to going to the hospital.

NS Huntley reported that RN Childs called her from the hospital and was very disturbed about the extent of Resident A's injuries. NS Huntley said that RN Childs told her that staff suspected that Resident A may have tried to crawl over her bedrails which resulted in her fall. However, NS Huntley told me that she worked with Resident A on several occasions, and she does not believe that Resident A had the strength to crawl over her bedrails. I asked NS Huntley if any of Resident A's hospice staff reported having concerns about Resident A's care or treatment by Sugarbush Manor staff. NS Huntley told me that according to Resident A's chart, none of her care team had concerns that warranted a complaint to be made to Adult Protective Services or another agency.

On 04/18/2025, I interviewed staff Victoria Prewitt via telephone. Staff Prewitt said that she has worked at Sugarbush Manor for over two years, and she typically works 3rd shift. Staff Prewitt said that she is the only staff on shift when she is working. According to the licensee designee, at the time of this complaint the facility had 10 residents. None of them were 2-person assists.

According to Staff Prewitt, on 03/06/2025, she was walking down the hall from the employee bathroom, and she heard a loud "boom." Since none of the residents had called out, Staff Prewitt began checking on all the residents in the hallway trying to determine what had happened. Staff Prewitt said that Resident A's door was cracked and when she opened it all the way, she found Resident A on the floor between her bathroom and her bed. Staff Prewitt turned the light on and found Resident A lying on her right side, the right side of her face was on the bathroom floor, and she was bleeding. According to Staff Prewitt, Resident A had low carpeting in her room, but her

bathroom floor was vinyl. Staff Prewitt observed the right side of Resident A's face lying on the vinyl floor. Staff Prewitt said that she immediately called hospice on-call and spoke to a nurse. Staff Prewitt stated that she told the nurse that she felt Resident A needed to be sent to the hospital to be evaluated. The hospice nurse told Staff Prewitt to try and get Resident A up and back in bed. Staff Prewitt told me that when she put her hand on Resident A's shoulder, "she screamed in agonizing pain" so Staff Prewitt stopped and told the hospice nurse that she could not get her up.

Staff Prewitt told me that she was waiting for Relative A2 and/or the hospice nurse to give her permission to contact 911 and have Resident A transported to the hospital. Staff Prewitt told me that eventually the hospice nurse and Relative A2 told her to call 911 but in the meantime, Staff Prewitt took it upon herself to call 911. Staff Prewitt said that EMS arrived in approximately 10 minutes and Resident A was transported to the hospital.

Staff Prewitt confirmed that Resident A had a hospital bed with full bed rails on both sides. Staff were told that when Resident A was in bed, her bed was supposed to be in the lowest position and her bedrails were supposed to be up completely. Staff Prewitt said that Resident A liked to watch television while in bed, so staff did raise the head portion of her bed to make it easier for her to see the television. According to Staff Prewitt, when she found Resident A on the floor, Resident A's bed was in the lowest position and both her bedrails were up. Staff Prewitt said that Resident A's wheelchair was on the left side of her bed as was her bathroom. Staff Prewitt reported that it looked like Resident A had bypassed her wheelchair, tried to walk to the bathroom by herself, and that is when she fell.

Staff Prewitt confirmed that Resident A was weak, and she does not believe that Resident A had the strength to try and crawl over her bedrails. Staff Prewitt said that Resident A wore briefs, but she would sometimes ask for staff assistance with toileting and other times would go to the bathroom by herself. Sometimes, Resident A would appear in the hallway, sitting in her wheelchair and when staff checked her room, they found her bedrails up. Staff Prewitt said that she suspects that Resident A may have scooted down to the end of her bed to get out of bed and into her wheelchair. Staff Prewitt told me that she never found Resident A on the floor before and to her knowledge, this is the first time that Resident A fell and received an injury.

On 04/28/2025, I reviewed the medical records from Resident A's hospitalization on 03/06/2025. According to these documents, Resident A was seen for a fall and the initial triage states, "Walking to bathroom and fell, unsure of blood thinners, possibly on floor for 10 min, hematoma noted to R eye, respond to painful touch." Resident A presented to the emergency room with "multiple extensive intracranial hemorrhages, facial fractures, and C-spine fractures." Later documentation stated that Resident A was on Plavix which is a blood thinner. Hospital staff noted that Resident A was found on the ground near the bathroom and staff estimated that she was on the ground for approximately 10 minutes before being found. This was a ground-level fall. Resident A was unable to answer questions or follow commands.

Upon reevaluation, the following was noted: “CT brain reveals significant intracranial hemorrhage including multicompartmental intraparenchymal hemorrhage with multiple skull and facial fractures. CT cervical spine shows fractures of C6 and C3. CTA chest abdomen pelvis shows multiple pelvic fractures with right lower pelvic hematoma with active extravasation as well as number of incidental findings.” Her prognosis was extremely poor, so hospice was consulted, and comfort measures were implemented rather than treatment.

On 04/30/2025, I conducted an exit conference with the licensee designee (LD), Michael Maurice. I discussed the results of my investigation. LD Maurice said that he feels staff acted appropriately when handling Resident A’s care. LD Maurice confirmed that because of Resident A’s falls in 2021, a hospital bed was ordered which seemed to solve the problem. LD Maurice said that he feels that additional corrective measures such as a bed alarm or bed mat were not necessary because Resident A was no longer falling.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
ANALYSIS:	**(1) A licensee, with a resident’s cooperation, shall follow the instructions and recommendations of a resident’s physician or other health care professional with regard to such items as any of the following:** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident’s record.**
ANALYSIS:	On 03/06/2025, Resident A was found on the floor in her bedroom. Resident A was transported to the hospital and diagnosed with brain bleeding, multiple skull fractures, and a broken pelvis. Relative A1 and Relative A2 said that Resident A was on hospice services. Her hospice team ordered full bed rails for Resident A’s hospital bed and the rails were supposed to be up whenever Resident A was in bed. Hospice nursing supervisor, Allie Huntley confirmed that Resident A was on hospice services and her hospice team ordered full bed rails that were supposed to be up whenever Resident A was in bed. I reviewed Resident A’s assistive device prescription list dated 02/23/2024 signed by Alexandria Huntley, RN. Resident A was prescribed a shower chair, wheelchair, hospital bed, and

	bedrails. I reviewed Resident A's Assessment Plan which stated that Resident A uses a shower chair, wheelchair, hospital bed, and shower chair. According to staff Victoria Prewitt, she heard a loud "boom" and found Resident A on the floor of her bedroom laying on her right side, with the right side of her face on the bathroom floor. Staff Prewitt said that Resident A had full bed rails on both sides of her bed which were still in position when Staff Prewitt found her on the floor. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During the course of my investigation, I reviewed Resident A's Health Care Appraisal dated 02/20/24. According to the licensee designee, Michael Maurice, Resident A did not have an updated Health Care Appraisal at the time of Resident A's death. LD Maurice said that Resident A was on hospice services at the time of her death.

On 09/13/2024, I completed a special investigation report #2024A0872054. I determined that one of the residents did not have an updated Health Care Appraisal as required by this rule. The licensee designee completed and submitted a corrective action plan dated 09/19/2024 stating that Health Care Appraisals will be updated annually.

On 04/30/2025, I conducted an exit conference with the licensee designee (LD), 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 02/20/24. According to the licensee designee, Michael Maurice, Resident A did not have an updated Health Care Appraisal at the time of her death. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref: SIR# 20240872054, CAP dated 09/20/2024**

INVESTIGATION: During the course of my investigation, I reviewed Resident A's Assessment Plan dated 02/20/2024. According to the licensee designee, Michael Maurice, Resident A did not have an updated Assessment Plan at the time of her death. LD Maurice said that staff had been attempting to reach Resident A's family to get an updated Assessment Plan.

On 09/13/2024, I completed a special investigation report #2024A0872054. I determined that one of the residents did not have an updated Assessment Plan as required by this rule. The licensee designee completed and submitted a corrective action plan dated 09/19/24 stating that Assessment Plans will be updated annually.

On 04/30/2025, I conducted an exit conference with the licensee designee (LD), Michael Maurice. I discussed the results of my investigation and explained which rule violations I am substantiating. LD Maurice said that he feels staff acted appropriately when handling Resident A's care. He confirmed that because of Resident A's falls in 2021, a hospital bed was ordered which seemed to solve the problem. LD Maurice said that he feels that additional corrective measures such as a bed alarm or bed mat were not necessary because she was no longer falling. 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 02/20/2024. According to the licensee designee, Michael Maurice, Resident A did not have an updated Assessment Plan at the time of her death. LD Maurice said that staff had been attempting to reach Resident A's family to get an updated Assessment Plan. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref: SIR# 20240872054, CAP dated 09/20/2024**

IV. RECOMMENDATION

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

Susan Hutchinson April 30, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton April 30, 2025

Mary E. Holton Area Manager	Date