GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 3, 2022

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

RE: License #: AL250376703
Investigation #: 2022A0580032
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.

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) 284-9700.

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

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|---|---|
| **License #:** | AL250376703 |
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| **Investigation #:** | 2022A0580032 |
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| **Complaint Receipt Date:** | 04/08/2022 |
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| **Investigation Initiation Date:** | 04/13/2022 |
| | |
| **Report Due Date:** | 06/07/2022 |
| | |
| **Licensee Name:** | Sugarbush Living, Inc. |
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| **Licensee Address:** | 15125 Northline Rd.<br>Southgate, MI 48195 |
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| **Licensee Telephone #:** | (810) 496-0002 |
| | |
| **Administrator:** | Michael Maurice |
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| **Licensee Designee:** | Michael Maurice |
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| **Name of Facility:** | Sugarbush Manor |
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| **Facility Address:** | Suite A<br>G-3237 Beecher Rd<br>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 |
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| **Capacity:** | 16 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>ALZHEIMERS |

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| | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
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| On 4/7/22 Resident A had not been eating or drinking and did not want to get out of bed. Resident A was found deceased during staff rounds on 4/8/22. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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| 04/08/2022 | Special Investigation Intake<br>2022A0580032 |
| 04/13/2022 | Special Investigation Initiated - Telephone<br>A call was made to the Valley Area Agency on Aging assigned case manager for Resident A, Ms. Heather Roca. |
| 04/26/2022 | Contact - Telephone call made<br>A call was made to Mr. Maurice, Licensee. |
| 05/04/2022 | Contact - Document Received<br>Documents requested were received from the licensee via email. |
| 05/11/2022 | Contact - Telephone call made<br>A call was made to Guardian A. |
| 05/11/2022 | Inspection Completed On-site<br>An onsite inspection was conducted at Sugarbush Manor. Contact made with the licensee. |
| 05/11/2022 | Contact - Face to Face<br>An interview was conducted with Resident B, spouse of deceased Resident A. |
| 05/11/2022 | Contact - Telephone call made<br>A call was made to staff, Ms. Tanisha Breedlove. |
| 06/02/2022 | Contact - Telephone call made<br>A call was made to Guardian A. |

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| 06/02/2022 | Exit Conference<br>An exit conference was held with the licensee, Mr. Michael Maurice. |

**ALLEGATION:**

On 4/7/22 Resident A had not been eating or drinking and did not want to get out of bed. Resident A was found deceased during staff rounds on 4/8/22.

**INVESTIGATION:**

On 04/13/2022, I received a complaint via BCAL Online Complaints.

On 04/13/2022, I spoke with Ms. Heather Roca, Case Manager, Valley Area Agency on Aging. She indicated that there was concern that Resident A passed away so suddenly and wondered if anything different should have been done.

On 04/26/2022, I spoke with the licensee designee, Mr. Michael Maurice. He indicated that Resident A came to the facility with no appetite. Upon addressing her continued unwillingness to eat or drink to the guardian, the guardian would instruct the facility to push her to eat. Resident A's family used an outside physician, who only came to visit her once while at the facility. Mr. Maurice indicated that he and his staff suggested hospice care to the family, however, they denied the service. Documents were requested.

On 05/04/2022, I received a copy of Resident A's AFC Assessment Plan, Health Care Appraisal, weight record, and incident report, via email, from the licensee, Mr. Michael Maurice.

The AFC Assessment Plan indicates that Resident A requires assistance with eating and staff will provide needed assistance at mealtimes. The most recent Health Care Appraisal, completed by the physician on 02/28/2022, indicates that Resident A's food should consist of a regular diet with regular texture. At the time of the appraisal, Resident A's weight was recorded at 96.6 lb. Resident A began residing at Sugarbush Manor on 03/01/2022. Her weight record indicates that on 03/01/2022, Resident A entered the facility weighing 96lbs. Resident A passed away on 04/08/2022. No April 2022 weight was recorded. The incident report dated 04/08/2022 at 6:40am, indicates that the caregiver went to wake and change Resident A and found her non-responsive. The time was noted at 6:30am. Prior to passing, Resident had been refusing care and meals. Management had discussions with POA and family about care options. Hospice was recommended. POA and family refused. The caregiver contacted management

and 911. EMS assessed resident and contacted coroner. POA was contacted. Resident A's body was released to the funeral home.

On 05/11/2022, I spoke with Guardian A. She indicated that Resident A was getting thin and had lost weight prior to being placed at Sugarbush Manor. She shared that while in home care, Resident A would have periods when she would did not want to get out of bed or eat, which landed her in the hospital. Resident A resided at Regency Nursing Home for about 6 weeks. They got her to eating again and she returned back home. Resident A would eat at times at times she will not. Resident A often required coaxing to get her to eat. Guardian A indicated that she declined hospice care for Resident A. She indicated that Resident A's death was imminent.

Guardian A indicated confirmed that she wanted both residents to keep their same health care providers they had prior to entering the facility therefore she made all medical and dental appointments for Resident A.

Resident A and her spouse, Resident B were both placed in the facility on 03/01/2022. She visits at least 4-5 times a week due to its proximity to her home. She shared that Resident B likes the facility and continues to reside at Sugarbush Manor.

On 05/11/2022, I conducted an onsite inspection. Contact was made with Resident B, spouse of Resident A. Resident B indicated that he likes living in the home. He shared that his wife, Resident A had recently passed away. He adds that she had Dementia and stopped eating. He shared that he had heard that happens when someone has Dementia. Resident B added that Resident A would get out of bed every now and then. He indicated that he gets enough food to eat.

On 05/11/2022, I spoke with direct staff, Ms. Tanisha Breedlove. She shared that she was working third shift on the day that Resident A passed away. She recalled that she had made her rounds, doing bed checks on the residents between 2:am-3:30am and Resident A was fine, sleeping peacefully. When she had gone back around to check the residents, she noticed Resident A was crooked in her bed. Ms. Breedlove indicated that because Resident A and Resident B shared a room, she began changing Resident B first, while indicating to Resident A that she would assist her in changing her and straightening up in the bed once she was finished. Resident A did not respond. When she went to the bed to move her, she was cold to the touch and was not breathing. The owner, 911 and the guardian were all notified. The time was noted at 6:30am.

On 06/02/2022, I conducted a follow-up call to Guardian A regarding the cause of death listed for Resident A on her death certificate. A voice mail message was left requesting a return call.

| APPLICABLE RULE | |
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| **R 400.15310** | **Resident health care.** |
| | **(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.** |
| **ANALYSIS:** | It was alleged that Resident A had not been eating or drinking and did not want to get out of bed. Resident A was found deceased during staff rounds on 4/8/22.<br><br>Licensee designee, Mr. Michael Maurice indicated that Resident A came to the facility with no appetite. The guardian would instruct the facility to push her to eat when addressing her continued unwillingness to eat or drink to the guardian. Resident A's guardian used an outside physician. Resident A's guardian declined hospice care.<br><br>The AFC Assessment Plan indicates that Resident A requires assistance with eating and staff will provide needed assistance at mealtimes.<br><br>The Health Care Appraisal, completed by the physician on 02/28/2022, indicates that Resident A's food should consist of a regular diet with regular texture. At the time of the appraisal, Resident A's weight was recorded at 96.6 lb. Resident A entered the facility weighing 96lbs. Resident A passed away on 04/08/2022. An incident report was completed and reviewed.<br><br>Guardian A indicated that Resident A was getting thin and had lost weight prior to being placed at Sugarbush Manor. She shared that while in home care, Resident A would have periods when she would did not want to get out of bed or eat, which landed her in the hospital. Resident A often required coaxing to get her to eat. Guardian A indicated that she declined hospice care for Resident A. She indicated that Resident A's death was imminent.<br><br>Resident B indicated that he likes living in the home. He shared that his wife, Resident A had recently passed away. He adds that she had Dementia and stopped eating. He indicated that he gets enough food to eat. |

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| | Direct staff, Ms. Tanisha Breedlove, recalled that she had made her rounds, doing bed checks on the residents between 2:am-3:30am and Resident A was fine, sleeping peacefully. When she had gone back around to check the residents, she noticed Resident A was crooked in her bed. When she went to the bed to move her, she was cold to the touch and was not breathing. The owner, 911 and the guardian were all notified.<br><br>Based on the information found in the course of this investigation, there is insufficient evidence to support the rule violation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 06/02/2022, I conducted an exit conference with the licensee designee, Mr. Michael Maurice adds that Resident A's lack of eating was an issue from the onset of her placement. He recalled that she would eat bird-like bites or portions. Related to her care, Resident A would often refuse to get out of bed, requiring constant encouraging to get up. This was also an issue from the onset of the placement which was discussed with the guardian as well as the Valley Area on Aging case manager. When asked what medical care was sought for Resident A, Mr. Maurice indicated that due to the resident having an outside physician, he was unable to have direct contact with Resident A's assigned physician. I then informed Mr. Maurice that regardless of the Resident has an outside physician, the licensee is responsible to know what the physician finds and recommends for each appointment. Due to the lack of contact with the physician, a violation of licensing rule R400.15301(11). A corrective action plan is due within 15 days.

| **APPLICABLE RULE** | |
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| **R 400.15301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician instructions; health care appraisal.** |
| | **(11) A licensee shall contact a resident's physician for instructions as to the care of the resident if the resident requires the care of a physician while living in the home. A licensee shall record, in the resident's record, any instructions for the care of the resident** |
| **ANALYSIS:** | Licensee designee, Mr. Maurice, indicated that Resident A's lack of eating and refusing care began occurring from the onset of her placement in March 2022. |

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| | Licensee designee, Mr. Maurice, indicated that due to the resident having an outside physician, he was unable to have direct contact with Resident A's assigned physician.<br><br>Based on the information gathered in the course of the investigation indicating that licensee did not maintain contact with the outside physician, there is sufficient evidence to support the rule violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

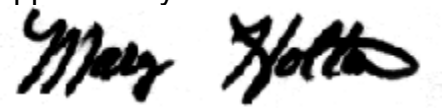
## IV. RECOMMENDATION

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

June 2, 2022

Sabrina McGowan — Date
Licensing Consultant

Approved By:



June 3, 2022

Mary E Holton — Date
Area Manager