GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2024

Kristi Fleischfresser
Pleasant Lake Lodge, Inc.
2085 S. 33 1/2 Mile Rd.
Cadillac, MI 49601

RE: License #: AL830309090
Investigation #: 2024A0870028
Pleasant Lake Lodge North

Dear Kristi Fleischfresser:

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 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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**
**BUREAU OF COMMUNITY AND HEALTH SYSTEMS**
**SPECIAL INVESTIGATION REPORT**

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL830309090 |
| | |
| **Investigation #:** | 2024A0870028 |
| | |
| **Complaint Receipt Date:** | 05/28/2024 |
| | |
| **Investigation Initiation Date:** | 05/28/2024 |
| | |
| **Report Due Date:** | 07/27/2024 |
| | |
| **Licensee Name:** | Pleasant Lake Lodge, Inc. |
| | |
| **Licensee Address:** | 2085 S. 33 1/2 Mile Rd.<br>Cadillac, MI 49601 |
| | |
| **Licensee Telephone #:** | (231) 920-9993 |
| | |
| **Administrator:** | Kristi Fleischfresser |
| | |
| **Licensee Designee:** | Kristi Fleischfresser |
| | |
| **Name of Facility:** | Pleasant Lake Lodge North |
| | |
| **Facility Address:** | 2035 S. 33 1/2 Mile Road<br>Cadillac, MI 49601 |
| | |
| **Facility Telephone #:** | (231) 775-7366 |
| | |
| **Original Issuance Date:** | 06/30/2011 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 12/31/2023 |
| | |
| **Expiration Date:** | 12/30/2025 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff did not provide Resident A with her insulin per her physician's order. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 05/28/2024 | Special Investigation Intake<br>2024A0870028 |
| 05/28/2024 | APS Referral<br>This referral came from Michigan Department of Health and Human Services, Wexford County, Adult Protective Services worker Glenda Brintnell. |
| 05/28/2024 | Special Investigation Initiated - On Site<br>Interviews conducted with Licensee Designee Kristi Fleischfresser and facility staff. |
| 06/13/2024 | Contact – Telephone call made.<br>Completed with Licensee Designee Kristi Fleischfresser. |
| 06/13/2024 | Inspection Completed-BCAL Sub. Compliance |
| 06/13/2024 | Exit Conference<br>Completed with Licensee Designee Kristi Fleischfresser. |

**ALLEGATION: Staff did not provide Resident A with her insulin per her physician's order.**

**INVESTIGATION:** On May 28, 2024, I spoke with Michigan Department of Health and Human Services, Wexford County, Adult Protective Services (APS) worker Glenda Brintnell. Ms. Brintnell informed me that she had opened an APS investigation into this allegation. We reviewed her efforts to that point.

On May 28, 2024, I conducted an unannounced on-site special investigation at the Pleasant Lake Lodge AFC home. I met with Licensee Designee Kristi Fleischfresser and informed her of the above stated allegation. She acknowledged that Resident A had run out of one of her prescription insulin medications, noting the medication is Trulicity. She stated this injection medication is given to Resident A once per week. Ms. Fleischfresser stated that the pharmacy used for this medication "automatically" sends new medication "pens" to the AFC home on a

revolving basis, meaning that a new supply of insulin is delivered to the AFC home prior to when the previous supply would be used up.

Ms. Fleischfresser provided Resident A's Medication Administration Record for my review. I noted that Resident A was last provided with the prescription medication Trulicity on April 11, 2024. The MAR notes this medication is to be injected once weekly. The MAR further shows that Resident A was not provided with another Trulicity injection until May 16, 2024, meaning that Resident A missed her Trulicity injection on April 18, 2024, April 25, 2024, May 2, 2024, and May 9, 2024.

Ms. Fleischfresser stated that she has no record of any facility staff contacting Resident A's physician to inform them that Resident A was not receiving her prescribed medication Trulicity during this time. Ms. Fleischfresser further noted that Resident A's physician was refusing to see her due to an outstanding bill balance. She noted Resident A was hospitalized on May 19, 2024.

On May 28, 2024, I conducted an in-person interview with staff member Nicole Tucker. Ms. Tucker stated she is in charge of resident medication coordination, which includes contacting the pharmacy, doctors, and ensuring the AFC has the appropriate medications for the residents of the facility. She stated she contacted Resident A's pharmacy on April 26, 2024, and questioned them as to why they were not delivering Resident A's Trulicity, noting that she had depleted her supply and was not receiving the medication. Ms. Tucker stated the pharmacy told her they were waiting for Resident A's insurance for approval of payment. I asked Ms. Tucker if she was aware that Resident A was out of Trulicity after she received her April 11, 2024, injection. Ms. Tucker acknowledged she was aware of this. I asked her if she had contacted the pharmacy regarding the fact that Resident A had run out of Trulicity prior to Resident A's scheduled injection of April 18, 2024. She stated she did not contact the pharmacy between the time that Resident A ran out of Trulicity on April 11, 2024, and when she called them on April 26, 2024.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15310** | **Resident health care.** |
| | **(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:**<br>**(a) Medications.** |
| **ANALYSIS:** | Resident A's Medication Administration Records shows that Resident A was not provided with her Trulicity medications on April 18, 2024, April 25, 2024, May 2, 2024, and May 9, 2024. |

| | |
|---|---|
| | The licensee failed to follow the instructions of Resident A's physician regarding providing Resident A with her Trulicity insulin medication. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:**<br>**(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.** |
| **ANALYSIS:** | Ms. Fleischfresser stated that no one from the facility contacted Resident A physician to inform them that Resident A had run out of and was not being provided with her Trulicity insulin medication as of April 18, 2024, until Resident A was hospitalized on May 19, 2024.<br><br>Ms. Tucker stated that she, or the facility staff, did not contact Resident A's pharmacy to inform them that Resident A had run out of, and was not being provided with, her Trulicity insulin medication as of April 18, 2024, until April 26, 2024.<br><br>The licensee failed to contact Resident A's health care provider to inform that Resident A was not being provided with her prescribed Trulicity insulin medication. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On June 13, 2024, I conducted an exit conference with Licensee Designee Kristi Fleischfresser. I explained my findings as noted above. Ms. Fleischfresser stated she understood. She noted that Resident A's medications, including her insulin, have been reviewed since my May 28, 2024, on-site and that Resident A is receiving all of her medications as ordered. Ms. Fleischfresser stated she would complete a written corrective action plan which addresses the cited findings and has already implemented some of the suggestions we discussed on May 28, 2024. She had no further information to provide, or questions to ask, concerning this special investigation.

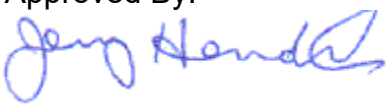
## IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

June 14, 2024

Bruce A. Messer — Date
Licensing Consultant

Approved By:



June 17, 2024

Jerry Hendrick — Date
Area Manager