GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 29, 2026

Donna Bacigalupo
Pineview Cottage
3498 Harbor-Petoskey Rd
Harbor Springs, MI 49740

RE: License #: AH240389978
Investigation #: 2026A1010047
Pineview Cottage

Dear Licensee:

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 authorized representative 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 (877) 458-2757.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH240389978
Investigation #:	2026A1010047
Complaint Receipt Date:	05/08/2026
Investigation Initiation Date:	05/11/2026
Report Due Date:	07/07/2026
Licensee Name:	Pineview Cottage, LLC
Licensee Address:	8121 Broken Ridge East Harbor Springs, MI 49740
Licensee Telephone #:	(810) 516-8928
Administrator:	Lady Fletcher
Authorized Representative:	Donna Bacigalupo
Name of Facility:	Pineview Cottage
Facility Address:	3498 Harbor-Petoskey Rd Harbor Springs, MI 49740
Facility Telephone #:	(231) 412-6069
Original Issuance Date:	08/03/2018
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	40
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 04/30/2026, Staff Person 1 (SP1) kicked Resident A in her back resulting in pain and redness.	No
Additional Finding	Yes

III. METHODOLOGY

05/08/2026	Special Investigation Intake 2026A1010047
05/11/2026	Special Investigation Initiated - Letter Emailed assigned Emmet Co. APS worker, Nicole Lull
05/18/2026	Contact - Document Received Email received from Ms. Lull
05/19/2026	Inspection Completed On-site
05/19/2026	Contact - Document Received Received resident service plan, staff training documents, resident progress notes, and facility 24-hour report document
06/18/2026	Contact – Telephone call made Message left for SP1, telephone call back was requested
06/29/2026	Exit Conference

ALLEGATION:

On 04/30/2026, Staff Person 1 (SP1) kicked Resident A in her back resulting in pain and redness.

INVESTIGATION:

On 05/08/2026, the Bureau received the complaint from Adult Protective Services (APS). The complaint read, “Within the last year, [SP1] pulled [Resident A] by the arm resulting in arm pain as [Resident A] wasn’t moving fast enough for [SP1]. [Resident A] utilized a walker at the time. On April 30, 2026, [SP1] kicked [Resident A] in the back resulting in pain and redness in front of [SP2].”

On 05/11/2026, I email assigned Emmet County APS worker Nicole Lull. Ms. Lull reported she interviewed Resident A at the facility and will likely be substantiating her APS case.

On 05/18/2026, I received an email from Ms. Lull. The email contained the Emmet County Sheriff Department's report regarding the incident. The *DISPOSITION* section of the police report read, "No signs or evidence of physical abuse."

On 05/19/2026, I interviewed the administrator at the facility. The administrator explained that Resident A has a history of "dropping her weight" when staff are assisting her during transfers. The administrator stated this occurred while SP2 was transferring Resident A to the toilet on 04/23/2026. The administrator said SP1 "radioed" SP2 and requested her assistance to transfer Resident A. The administrator reported that when SP1 arrived, Resident A continued to "drop her weight." The administrator said that rather than letting Resident A fall to the floor, SP1 used her knee to "prop" Resident A up so she would not fall. The administrator reported SP1 did not intentionally kick Resident A in the back.

The administrator said Resident A has a history of being non-complaint with staff during the provision of her care. The administrator explained this includes Resident A intentionally "dropping her weight" during transfers and being verbally aggressive towards staff during the provision of her care. The administrator explained Resident A recently changed to requiring the assistance of two staff persons to transfer with a hoyer lift. The administrator said Resident A is now toileted with a commode that is placed near her recliner chair and her bed when she is laying down. The administrator stated one staff person can assist Resident A onto the nearby commode.

The administrator reported SP1 has not received any formal or verbal reprimands regarding her work performance. The administrator said there have been no other residents who have made complaints regarding SP1 being physically or verbally aggressive towards them. The administrator stated this allegation is out of character for SP1. The administrator reported SP1 received resident rights training upon hire at the facility.

The administrator explained staff are not comfortable providing care to Resident A one on one because Resident A made several false allegations against staff in the past. The administrator stated staff always make sure two staff persons are present during the provision of Resident A's care.

The administrator provided me with a copy of SP1's *Elder Abuse and Neglect* training document for my review that included a test. The document read SP1 completed this training on 03/17/2024. The administrator provided me with a copy of SP1's written statement regarding the incident. The statement read, "On April 23, [SP2] and I were in [Resident A's room] [SP2] asked for my help to stand her up off the tolit [sic] she refused to stand I came in to help I put my left knee to help her

stand to not have her not fall [sic]. Due to the fact she was sliding deforming [sic] unable to stand, yes she did have shoes on both of her feet." The statement was signed by SP1 and SP2.

The administrator provided me with a copy of Resident A's staff *Progress Notes* for my review. Notes dated 04/12/2026, 04/21/2026, and 04/28/2026 read Resident A "dropped her weight" and refused to stand for staff. Notes dated 04/21/2026, 04/27/2026, 05/09/2026, and 05/10/2026 read Resident A refused to care when staff attempted to assist her. Notes dated 04/26/2026 and 04/27/2026 read Resident A exhibited verbal aggression towards staff during the provision of her care.

On 05/19/2026, I interviewed SP3 at the facility. SP3's statements were consistent with the administrator. SP3 reported Resident A is "rude and belittles" staff during the provision of her care. SP3 stated she is not comfortable assisting Resident A alone in her room; therefore, she ensures there is always another staff person present when she is in Resident A's room. SP3 said this is true for all staff who enter Resident A's room. SP3 denied observing SP1, or any other staff persons, become physically or verbally aggressive towards Resident A.

On 05/19/2026, I interviewed Resident A at the facility. Resident A reported when she was "holding the bars" in her bathroom near the toilet, SP1 was present and was assisting her with putting a new brief on. Resident A said she asked SP1 to "push her forward," and she suddenly felt SP1 "kick" her in her back to keep her from falling. Resident A said her back felt sore after the incident. Resident A reported a different staff person did assess her back after the incident. Resident A stated that after she reported this incident, SP1 no longer enters her room to assist her with her activities of daily living (ADLs).

On 05/19/2026, I was unable to interview SP1 and SP2 because they work second shift and were not present in the facility.

On 06/18/2026, I left a voicemail for SP1. I requested a telephone call back. As of 06/22/2026, I have not received a telephone call back from SP1.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical**

	care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	The interviews with the administrator, along with review of SP1's written statement that she and SP2 signed revealed SP1 used her knee to prevent Resident A from falling onto the floor while she was being toileted. There is insufficient evidence to suggest SP1 intentionally caused harm or attempted to "kick" Resident A when she kept her from falling.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 05/19/2026, the administrator provided me with a copy of Resident A's service plan for my review. The *PERSONALITY TRAITS* section of the plan read, "Introvert, Friendly, Happy-cheerful, Considerate, Can be critical of others." The *TRANSFER/MOBILITY/STABILITY/AMBULATION* section of the plan read, "Independent with walker- can only walk very short distances, Potential for falls – assist, High fall risk, Wheelchair for long distances." The *ADAPTIVE DEVICES* section of the plan read, "Walker, Wheelchair, Gailt Belt when getting out of bed, Wheelchair, Chair alarm, Pendant on at all times, O2 as needed." The *BEHAVIOR* section of the plan read, "No behaviors at this time." The *TOILETING* section of the plan read, "Can be incontinent of bowel and bladder. Needs incontinence care products, one person assist with toileting."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	Review of Resident A's service plan revealed it was not updated to reflect her current care needs. Resident A now requires the use of a hoyer lift with the assistance of two staff persons to transfer. Resident A also requires the assistance of one staff person to transfer onto her commode that is placed near her recliner chair or her bed when she is in it. Resident A also has a history of being non-compliant during the provision of her care. These needs were not documented in Resident A's service plan, therefore the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility's authorized representative on 06/29/2026.

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

06/22/2026

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Lauren Wohlfert Date
Licensing Staff

Approved By:

06/29/2026

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section