GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2026

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

RE: License #: AH240389978
Investigation #: 2026A1041009
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.
- 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. 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) 335-5985.

Sincerely,

Tammie Daniels

Tammie Daniels, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH240389978
Investigation #:	2026A1041009
Complaint Receipt Date:	05/29/2026
Investigation Initiation Date:	06/01/2026
Report Due Date:	07/28/2026
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility does not have adequate staffing.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/29/2026	Special Investigation Intake 2026A1041009
06/01/2026	Special Investigation Initiated - Telephone Call to Complainant
06/09/2026	Contact - Face to Face Onsite Investigation
06/10/2026	Contact - Document Received Requested Documentation Received from Employee 1
06/16/2026	Contact - Telephone call made Microsoft Teams Meeting with Authorized Representative; Administrator; LTC State Licensing Manager; and Surveyor
06/22/2026	Contact - Document Received Partial Requested Documentation Received
06/30/2026	Contact- Telephone call made Microsoft Teams Meeting with Authorized Representative; Administrator; LTC State Licensing Manager; and Surveyor
07/28/2026	Exit Conference

ALLEGATION:

The facility does not have adequate staffing.

INVESTIGATION:

On 05/29/2026, the department received the allegations through the online complaint system.

On 06/01/2026, I interviewed the complainant by phone. The complainant alleged that on 05/28/2026 through 05/31/2026, the facility did not have enough staff to provide appropriate care to their residents.

On 06/09/2026, I interviewed the Authorized Representative (AR), Donna Bacigalupo, and the Administrator, Lady Fletcher, at the facility. The AR reported that multiple staff members had recently suddenly quit. The AR reported that there is a current staffing issue but that the facility was working to address it by contracting with local staffing agencies, placing ads for vacancies, interviewing applicants, and working with facility leadership partners to establish short-term positions for staff from other facilities to assist until permanent hires are made. The Administrator reported there were currently 31 residents in total, including 18 residents in their secured memory care unit and 13 in their general assisted living unit. The Administrator reported that the facility operated three shifts: first shift from 7:00 AM to 3:00 PM, second shift from 3:00 PM to 11:00 PM, and third shift from 11:00 PM to 7:00 AM. The Administrator reported that expected staffing levels were three caregivers and one medication technician on first and second shifts, and two caregivers and one medication technician on third shift. The Administrator reported that recently the facility has only been able to have one caregiver and one medication technician on third shift due to the staffing shortage.

On 06/09/2026, I interviewed Employee 1 at the facility. Employee 1 reported that multiple staff had recently quit abruptly, leaving the facility with limited staffing. Employee 1 reported that the facility has been using staff from housekeeping and the front office to assist with caregiving duties since they have been short staffed. Employee 1 reported that only two caregivers were working *“today”* and neither of them were able to pass medications. Employee 1 reported that at least four residents required the assistance of two caregivers for transfers. Employee 1 reported that the Administrator does work as a caregiver to help but does not pass medications.

On 06/09/2026, I interviewed Employees 2 and 3 at the facility. Employees 2 and 3 reported statements consistent with those provided by Employee 1.

The Administrator reported that although she was trained as a caregiver and assists with caregiving tasks, she is not yet trained as a medication technician. The Administrator acknowledged that the facility was utilizing the housekeeper and the front office staff members according to their training to assist with care of residents when staffing was short. The Administrator reported that the facility had not previously gone without a medication technician and that the first shift medication technician “*called in and quit at 6:30 in the morning*.” The Administrator reported that the third shift medication technician stayed over to pass today’s morning

medications and did not leave the facility until 8:45 AM. The Administrator reported that she had reached out to other medication technicians and Employee 4 would be coming in to pass afternoon medications.

On 06/09/2026, I reviewed the service plans for Residents A and B. The following information was revealed:

- Resident A needed assistance from two caregivers for transfers with the Hoyer lift.
- Resident B needed assistance from two caregivers for transfers with the Hoyer lift.

On 06/10/2026, I reviewed the facility's staffing assignment sheets between the dates of 05/25/2026 and 06/09/2026. The following was revealed:

- On 05/28/2026, 05/29/2026, 05/30/2026, and 06/01/2026 through 06/07/2026, there were three staff members on first shift.
- On 05/26/2026, 05/27/2026, 05/29/2026, and 06/07/2026, there were three staff members on second shift.
- On 06/09/2026, there was no medication technician in the facility on first shift between 9:00 AM and 12:00 PM, and on second shift between 3:00 PM and 7:00 PM.
- On every day that was reviewed, there were only two staff members who worked on third shift each night, including one medication technician.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Interviews with staff and review of staffing documentation revealed insufficient staffing as evidenced by hours during at least two days when the facility was without a medication technician, and the use of housekeeping and front office staff to support care staff. At least two residents whose service plans were reviewed require two caregivers for assistance, yet at times only two caregivers are assigned across the two units, leaving one unit without needed support during those periods.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/09/2026, I reviewed the Medication Administration Records (MARs) for Residents A and B between the dates of 5/01/2026 through 05/31/2026. The following information was revealed:

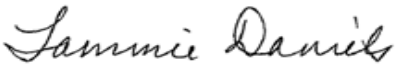
- There were no staff initials indicating that Resident A received three out of four medications scheduled for 7:00 PM on 05/29/2026, including Desvenlafaxine ER for depression, Senna for constipation, and Quetiapine (an antipsychotic). There were no notes explaining why they were not administered.

- There were no staff initials indicating that Resident B received a 6:00 PM dose of Hydrocodone for pain on 05/28/2026. Additionally, there were no staff initials on 05/29/2026 for medications due at various times throughout the day including Doxepin for depression, Gabapentin (an antiseizure medication), and Senna for constipation. There were no notes explaining why they were not administered.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	Review of the MARs for Residents A and B revealed multiple instances of undocumented medication administrations, therefore, the facility is not compliant with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



06/30/2026

Tammie Daniels Date
Licensing Staff

Approved By:

07/28/2026

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