GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 10, 2023

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

RE: License #: AL830300832
Investigation #: 2023A0230006
Pleasant Lake Lodge South

Dear Ms. 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL830300832
Investigation #:	2023A0230006
Complaint Receipt Date:	11/16/2022
Investigation Initiation Date:	11/16/2022
Report Due Date:	01/15/2023
Licensee Name:	Pleasant Lake Lodge, Inc.
Licensee Address:	2085 S. 33 1/2 Mile Rd., Cadillac, MI 49601
Licensee Telephone #:	(231) 920-9993
Administrator:	Kristi Fleischfresser
Licensee Designee:	Kristi Fleischfresser
Name of Facility:	Pleasant Lake Lodge South
Facility Address:	2085 S 33 1/2 Mile Road, Cadillac, MI 49601
Facility Telephone #:	(231) 775-5847
Original Issuance Date:	11/06/2009
License Status:	REGULAR
Effective Date:	05/25/2022
Expiration Date:	05/24/2024
Capacity:	20
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not give Resident A her insulin as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/16/2022	Special Investigation Intake 2023A0230006
11/16/2022	Special Investigation Initiated - On Site Interview with Licensee Designee Kristi Fleischfresser
12/13/2022	Contact - Telephone call made Noah Knauf -EMT
12/15/2022	David Turner -Medical Examiner's office
12/19/2022	Contact - Document Received Received Medical Examiner's investigative report
01/03/2023	Contact - Telephone call made With Licensee Kristi Fleischfresser
01/03/2023	Contact - Telephone call made Bruce Messer to Kristi Fleischfresser
01/03/2023	Contact - Telephone call made Bruce Messer to Kevin Dickinson LTC
01/05/2023	Contact - Telephone call made Bruce Messer to Valerie Glendering
01/05/2023	Contact - Telephone call made Bruce Messer to Staff member Amber Harris
01/05/2023	Contact - Telephone call made Bruce Messer to Staff Member Christopher Larive
01/05/2023	Contact - Telephone call made Bruce Messer to staff member Angela Adams
01/05/2023	Contact - Telephone call made Bruce Messer to Kristi Fleischfresser

01/06/2023	Contact - Telephone call received Medical Examiner's Office David Turner
01/06/2023	Contact - Telephone call made Bruce Messer to Staff member Valerie Glendering
01/06/2023	Contact - Telephone call made Bruce Messer to staff member Christopher Larive
01/06/2023	Contact - Telephone call made Bruce Messer to staff member Angela Adams
01/10/2023	Exit Conference With Licensee Designee Kristi Flieschfresser

ALLEGATION: The facility did not give Resident A her insulin as prescribed.

INVESTIGATION: On 11/16/2022, I conducted an unannounced on-site investigation at the facility. I interviewed Licensee Designee Kristi Fleischfresser and reviewed Resident A's records. Ms. Fleischfresser stated that Resident A had been admitted to the facility on 11/1/2022 and passed away unexpectedly on 11/05/2022.

A review of Resident A's records revealed her diagnoses to be adrenal cortical hypofunction, coronary artery disease in native artery, carotid stenosis, degenerative disc disease, lumbar depressive disorder, diabetes, diarrhea, heartburn, history of neoplasm of pituitary gland, history of ovarian cyst, hyperlipidemia, hypertension, hypopituitarism, hypothyroidism, intractable lower back pain, lumbar stenosis, obesity, peripheral artery disease, right lower quadrant abdominal pain, sacroiliitis, stage three chronic kidney disease, supraventricular tachycardia, tension headaches, chronic pulmonary obstructive disorder, humorous fracture, acute kidney injury, syncope, and wound of left ankle.

Ms. Flieschfresser stated Resident A was admitted to Pleasant Lake Lodge the day she was discharged from Munson Medical Center Hospital on 11/01/2022. Additionally, she stated Resident A had been ill with some nausea and vomiting on 11/3/2022 and 11/04/2022. Ms. Fleischfresser stated a stomach virus had been active in the facility at that time with several residents having short lived stomach issues. Ms. Fleischfresser reported that Resident A had been given all her prescribed medications while at the facility except for her sliding scale insulin. Ms. Fleischfresser stated she attempted to have this prescription filled but was unsuccessful. She explained she spoke with discharge staff at the hospital and asked them to send all prescription orders to LTC pharmacy which is the pharmacy used by the facility. When Resident A arrived at the facility all prescriptions had been filled by the hospital pharmacy except for the sliding scale insulin Aspart. She stated Resident A arrived with a paper prescription for the Aspart insulin. On 11/01/2022

Ms. Fleischfresser emailed a copy to the LTC pharmacy. On 11/02/2022 Ms. Flieschfresser contacted LTC to find out where the sliding scale insulin was. She stated the pharmacy told her they needed to verify the prescription through Munson which they would do that day.

On 12/15/2022, I spoke with Noah Knauf who responded as the emergency medical technician to the 911 call regarding Resident A's death on the morning of 11/05/2022. Mr. Knauf stated after he arrived at the facility and observed Resident A was deceased, he contacted the medical examiner. He stated there were no indicators of foul play therefore the police were not contacted. The medical examiner listed cause of death as "natural from diabetic ketoacidosis".

On 12/15/2022, I spoke with David Turner from the medical examiner's office. He confirmed that Resident A had died of a natural cause of diabetic ketoacidosis.

On 12/19/2022, I received and reviewed the medical examiner's report for the death of Resident A. The report concluded that the cause of death was natural due to diabetic ketoacidosis/complication from diabetes. It was noted that the investigator reviewed Resident A's bedside glucometer which showed that nearly every reading since her admission showed levels to read "high".

On 01/03/2023, I received and reviewed medication logs for Resident A. Her medications were listed as atorvastatin calcium, bupropion, famotidine, fluconazole, fludrocortisone acetate, gabapentin, Lantus sololstar, levothyroxine, norvasc, vitamin d, oxycodone. All medications were documented as being given with staff initials.

On 01/05/2023, AFC Licensing Consultant Bruce A. Messer conducted a telephone interview with Licensee Designee Kristi Fleischfresser. Ms. Fleischfresser stated that on November 1, 2022, the day Resident A was admitted to the facility, she spoke with "Kate" from Munson Memorial Hospital care management team and instructed her to send all Resident A's prescription orders to LTC Pharmacy, the pharmacy that the facility uses for their residents. Ms. Fleischfresser noted that upon Resident A's arrival to the facility on November 1, 2022, her prescriptions had all been filled by the MMCH pharmacy, except for the "sliding scale insulin Aspart". She noted that Resident A arrived via medical transportation. Ms. Fleischfresser noted that she was provided with a "paper" prescription for the Aspart insulin, and she sent that prescription, via an email, to LTC Pharmacy that same day, November 1, 2022. Ms. Fleischfresser stated she made a telephone call to LTC Pharmacy on November 2, 2022, to follow-up on the Aspart prescription, "to see when they were shipping it" and was informed by LTC that they could not fill the prescription via an email from her and needed to verify with MMCH, which Ms. Fleischfresser stated they were going to do that same day.

On January 3, 2023, Mr. Messer conducted a telephone interview with Kevin Dickinson, Pharmacy Operations Manager for LTC Pharmacy. Mr. Dickinson stated that LTC "did not dispense any medications to Resident A." He noted that the

emailed paper prescription, which was dated October 18, 2022, was sent to LTC by Ms. Fleischfresser on November 2, 2023, at 12:33 p.m. Mr. Dickinson noted that LTC called MMCH to verify the order that same day at 2:08 p.m. He explained that LTC cannot fill emailed prescriptions from the AFC home and must verify with the prescribing physician before they can fill the order. Mr. Dickinson noted that MMH "did not call back." He further noted that LTC Pharmacy tech Mellissa Garlich spoke with Ms. Fleischfresser to ask if the Aspart insulin prescription had been filled locally and was told "it had not." Mr. Dickinson stated that Ms. Fleischfresser called on November 5, 2022, to inform them that Resident A had died and asked why the Aspart prescription had not been filled. He noted that was the last communication between Ms. Fleischfresser and LTC concerning Resident A's medications.

On January 5, 2023 and again on January 6, 2023, Mr. Messer conducted telephone interviews with staff member Valarie Glendering. Ms. Glendering stated she worked at the facility the day Resident A moved in, November 1, 2022. She noted that she "does not recall giving (Resident A) any insulin." Ms. Glendering noted that, "it was so long ago I may not remember." She stated that, "if it was in the medication log (MAR), it would have flagged me, and I would have given it." Ms. Glendering stated, "I do remember we did not have the sliding scale insulin (Aspart) and it was an issue of not having the correct insulin when she moved in." She stated that Resident A took her own blood sugar readings with a machine she had attached to her skin. Ms. Glendering stated Resident A would take the reading and tell her what the reading was. She stated that on the day Resident A moved in, November 1, 2022, the reading "seemed high" so she went to home manager Amber Harris who instructed her to give Resident A "water." Ms. Glendering stated the only days she worked with Resident A was the day she moved in and on the day, she was sick, vomiting.

On January 5, 2023, Mr. Messer conducted a telephone with staff member Amber Harris. Ms. Harris noted that she never worked "the floor" when Resident A was residing in the facility. She noted that she does remember that they did not have the sliding scale insulin (Aspart) but they did have the Lantus insulin. Ms. Harris stated she could not confirm if staff gave Resident A any of either the Lantus or Aspart insulin during her brief stay at the facility. She did state she was aware that Resident A had a blood sugar testing machine, but could not say if staff took any readings, as she did not work the floor during that time frame.

On January 5, 2023, and again on January 6, 2023, Mr. Messer conducted telephone interviews with staff member Christopher Larive. Mr. Larive stated that he did not dispense any insulin to Resident A during her stay at the facility. He noted that he "didn't even know she was diabetic." Mr. Larive stated he does not remember seeing any insulin for Resident A being stored at the facility. Mr. Messer informed Mr. Larive that Resident A's medication log, which was provided to him by Licensee Designee Fleischfresser, had his initials indicating that he had dispensed Resident A with Lantus insulin on two occasions. Mr. Larive responded by stating, "I don't know why my initials would be on it, I didn't give her any insulin." Mr. Larive

further stated that he never tested Resident A's blood sugar levels and does not know if any staff members tested her. He stated he did not know she had any testing equipment that she used.

On January 5, 2023 and again on January 6, 2023, Mr. Messer conducted telephone interviews with staff member Angela Adams. Ms. Adams stated she only worked with Resident A one day, November 2, 2022. She stated she "does not remember" if she gave Resident A any insulin and noted that "the computer flags us" to give it. Ms. Adams stated does remember that "we did have the Lantus in the refrigerator." Ms. Adams stated she recalls that, "we did not have the sliding scale (Aspart) insulin, but I don't know why we didn't have it." She also stated Resident A, "had a machine" to check her blood sugar levels and would show her the readings. Ms. Harris stated the levels were shown to her a couple of times on the one day she worked with Resident A but stated she does not remember the levels being abnormally high.

On January 5, 2023, and again on January 6, 2023, Mr. Messer conducted telephone interviews with staff member Allyson Scholten. Ms. Scholten stated that she did not give Resident A any insulin. She further stated that, "it was not in the medication log (MAR)" and "we didn't have the insulin to give her or even knew she needed it." Ms. Scholten stated that she did not take any blood sugar readings for Resident A and noted that "no one took them" and that "we didn't know she had the monitor machine until after she had died." Ms. Scholten stated that she observed in the computerized MAR that Ms. Fleischfresser had edited the MAR on November 7, 2022, and added the Lantus insulin into the computer.

On January 5, 2023, Mr. Messer conducted a follow-up telephone interview with Ms. Fleischfresser. She stated that she does not know why the staff are saying that they did not give Resident A the Lantus insulin nor does she know why they would say they did not enter their initials onto the MAR, as is shown in the MAR documents she provided to Mr. Messer. Ms. Fleischfresser stated she entered all Resident A's medications onto the MAR on November 1, 2022, including the Lantus. She denied editing the MAR or falsifying the MAR records. Ms. Fleischfresser reiterated that Resident A arrived on November 1, 2022, with all her pills and the Lantus, just not the Aspart insulin. She stated the Lantus was stored in a locked box in the refrigerator located in the facility kitchen.

On 01/06/2023, I spoke with David Turner from the medical examiner's office to review the death report for Resident A. The cause was listed as diabetic acidosis. He stated the examiner who conducted the investigation noted the glucometer by Resident A's bedside stand read as "HIGH" throughout her stay at the facility. Mr. Turner explained that anything over the number 500 would read as "HIGH". Additionally, he stated the symptoms of nausea and vomiting are signs of diabetic ketoacidosis. He stated staff at the facility reported that Resident A had experienced these symptoms prior to her death.

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: **(a) Medications.**
ANALYSIS:	Licensee Designee Kristi Fleischfresser did not obtain the sliding scale insulin, Aspart, which was prescribed for Resident A. Two staff members stated they did not recall administering any Lantis insulin to Resident A while she was at the facility. Two staff members stated they were unaware of Resident A's diagnoses of diabetes and did not administer any insulin at all.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Hospital discharge instructions from Munson Hospital provided to the facility upon Resident A's admission instructs the licensee to monitor Resident A's blood sugar levels and dispense Aspart insulin in accordance with written instruction. Staff member Ms. Glendering stated Resident A would take her own reading and tell her what the readings were. Ms. Glendering stated that on 11/01/2022 Resident A took her own reading and "it seemed high". Ms. Glendering stated she provided Resident A with water as the facility did not have the Aspart.

Staff member Christopher Larive stated he never tested Resident A's blood sugar. Mr. Larive did not know Resident A had any testing equipment and did not know she was diabetic.

Staff member Amber Adams stated Resident A had a machine to check her sugar levels and showed her the level "a couple of times". Ms. Adams stated she does not remember the levels being abnormally high.

Staff Member Allyson Scholten stated she did not take any blood sugar readings for Resident A. Ms. Scholten stated she was unaware that Resident A had a glucometer.

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: **(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:	Two staff members stated they did not monitor Resident A's blood sugar. The facility did not provide for the health care needs of Resident A by failing to monitor her blood sugar levels in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Ms. Flieschfresser along with staff members stated they did not have the sliding scale insulin Aspart available for Resident A. Ms. Glendering stated on 11/01/2022 Resident A took her own blood sugar and "it seemed high". Ms. Glendering gave Resident A water as the Aspart insulin was not available.

Ms. Fleischfresser and other staff members stated Resident A had been having nausea and vomiting on 11/03/2022 mad 11/04/2022. The facility did not contact Resident A's physician or obtain the Aspart insulin during Resident A's stay at the facility.

APPLICABLE RULE	
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:	Resident A was identified as a diabetic and her blood sugar readings were showing "high". Resident A demonstrated a decline in health. The licensee failed to obtain needed care for Resident A her health continued to decline.

CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

Resident A was prescribed Asapart insulin to be administered on a sliding scale based on her blood glucose levels. Two staff members stated they were unaware Resident A was diabetic and that her blood glucose levels needed to be monitored. They noted they did not monitor Resident A's blood sugar levels. Ms. Flieschfresser and all facility staff state that the prescribed Aspart insulin was not available for Resident A.

Ms. Glendering stated that on one occasion Resident A's blood sugar readings seemed high and she gave Resident A water as the Aspart insulin was not available at the facility.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Appropriate amounts of "sliding scale" Aspart insulin was not provided to Resident A in accordance with the written instructions provided to the facility by Resident A's physicians at Munson Hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/10/2023, I conducted an exit conference with Licensee Designee, Kristi Flieschfresser. I reviewed the findings of the investigation. I informed her that I would be recommending that the license be modified to a six-month provisional license status. Ms. Flieschfresser stated she understood the findings of the investigation and would be submitting a correction action plan.

IV. RECOMMENDATION

I recommend contingent upon the submission of an acceptable corrective action plan, that the license be modified to provisional status for the above-cited quality of care violations.

01/10/2023

Rhondа Richards — Date
Licensing Consultant

Approved By:

01/10/2023

Jerry Hendrick — Date
Area Manager