GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 8, 2024

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

RE: License #: AL830300832
Investigation #: 2024A0870033
Pleasant Lake Lodge South

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 #:	AL830300832
Investigation #:	2024A0870033
Complaint Receipt Date:	07/12/2024
Investigation Initiation Date:	07/17/2024
Report Due Date:	08/11/2024
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:	07/23/2023
Expiration Date:	07/22/2025
Capacity:	20
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The home occasionally has insufficient staff on duty.	Yes
Staff member Nicole Tucker grabbed Resident A by both wrists and told him that she would hit him.	Yes

III. METHODOLOGY

07/12/2024	Special Investigation Intake 2024A0870033
07/17/2024	Special Investigation Initiated - Telephone Case discussion with Wexford County MDHHS APS.
07/18/2024	APS Referral Referral made to the Michigan Department of Health and Human Services, Protective Services, Centralized Intake unit.
07/19/2024	Inspection Completed On-site Interviews with facility staff and Resident A.
07/22/2024	Contact - Telephone call made Interview with Licensee Designee Kristi Fleischfresser.
07/29/2024	Contact - Telephone call made Telephone interview conducted with staff member Nicole Tucker.
08/06/2024	Inspection Completed-BCAL Sub. Compliance
08/08/2024	Exit Conference Completed with Licensee Designee Kristi Fleischfresser.

ALLEGATION: The home occasionally has insufficient staff on duty.

INVESTIGATION: On July 19, 2024, I conducted an unannounced on-site investigation at the Pleasant Lake Lodge – South AFC home. I met with home manger Valerie Glendenning and informed her of the above stated allegations. Ms. Glendenning stated that the facility currently has 19 residents in care. She acknowledged that “at times there is a shift gap.” Ms. Glendenning described what she meant by “shift gap” by informing me that this means that the facility only will have one staff member on duty for “an hour or two” between the morning shift and

when the afternoon shift staff member arrives. She acknowledged that during this timeframe the facility does have 16 or more residents present.

On July 19, 2024, I conducted an interview with staff member Stacey DeBolt. Ms. DeBolt informed me that the home currently has 19 residents in care. She stated that “almost every day, for an hour or two” the facility has only one staff on duty when 16 or more residents are present at the home. Ms. DeBolt further noted that one of the residents requires two staff to assist her with transferring. She noted this resident is 99 years old, uses a wheelchair, does not walk, and is approximately 200 pounds. Ms. DeBolt noted “it takes two staff to toilet her.”

On July 22, 2024, I conducted a telephone interview with Licensee Designee Kristi Fleischfresser. I informed Ms. Fleischfresser of the above stated allegation. Ms. Fleischfresser stated “sometimes there is a gap” noting two or three times per week, between the morning and the afternoon shift, when only one staff member is present in the facility. She noted that she was unsure of the number of residents in the facility during those times but that the home currently has 19 residents in care. Ms. Fleischfresser commented that “it’s a problem with the ability to hire good staff right now.”

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Home manager Valerie Glendenning and staff member Stacey DeBolt both state the facility is staffed with only one direct care staff member for a period in the afternoon, when 16 or more residents are present in the home. Licensee Designee Kristi Fleischfresser states that sometimes, between the morning and afternoon shifts, only one staff member is present in the facility. She noted she was unsure of the number of residents present in the facility during those times but acknowledged the home currently has 19 residents in care. The Licensee is not maintaining an adequate staff-to-resident ratio of no less that one direct care staff per 15 residents during waking hours.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Staff member Nicole Tucker grabbed Resident A by both wrists and told him that she would hit him.

INVESTIGATION: On July 19, 2024, I conducted an in-person interview, at the facility, with home manager Valerie Glendenning. Ms. Glendenning stated that she observed "significant" bruising on both arms of Resident A during her July 5, 2024, shift. She further stated that Resident A did not have these bruises prior to her observations of July 5, 2024. Ms. Glendenning stated staff members Stacey DeBolt and Nicole Tucker had worked on July 4, 2024. She noted that she took photos of Resident A's bruised arms on July 10, 2024, and provided me with copies. I observed in the photographs, bruising in the wrist and lower arms areas, indicative of a grab/hold. It appears that the bruising was less than 10 days old as they all were deep red/purple in color. Ms. Glendenning identified that these photos were of Resident A and were taken by herself on July 10, 2024.

On July 19, 2024, I conducted an in-person interview, at the facility with staff member Stacey DeBolt. Ms. DeBolt stated that she worked the day shift of July 4, 2024, along with staff member Nicole Tucker. She described that on July 4, 2024, at "breakfast time, 8 a.m." staff member Nicole Tucker approached Resident A to get him to come to breakfast. Ms. DeBolt noted that Ms. Tucker startled Resident A and as he stood up, Ms. Tucker grabbed Resident A by both of his wrists, and while holding his wrists, Ms. Tucker said to Resident A, "you hit me, and I'll hit you back." Ms. DeBolt noted that Ms. Tucker and Resident A were both in her direct line of sight and within earshot. She noted that while Ms. Tucker was holding Resident A's wrists, he was "struggling, trying to get Nicole to let go." Ms. DeBolt stated she went over to where Ms. Tucker and Resident A were standing, and Ms. Tucker let go of Resident A's arms and walked into the kitchen area. Ms. DeBolt stated she stayed with Resident A and took him to the table where he ate his breakfast. She noted that she did not look at Resident A's arms at the time and Resident A did not comment that he was injured in any way. Ms. DeBolt stated that she had not observed any bruising on Resident A prior to July 4, 2024, noting she had worked two days prior, July 2, 2024. She noted that no other staff were present the day shift of July 4, 2024.

On July 19, 2024, I attempted to conduct an in-person interview with Resident A at the facility. I was unable to obtain a coherent interview with him due to his significant dementia. I did observe bruises on his arms that were in their final healing stages.

On July 22, 2024, I conducted a telephone interview with Licensee Designee Kristi Fleischfresser. Ms. Fleischfresser noted that Resident A "gets combative at times" and this behavior has increased recently. She noted he has begun to hit, pull hair and scratch the facility staff. Ms. Fleischfresser also noted that Resident A bruises

easily and get skin tears. She stated that she is aware of the recent bruising on Resident A's arms and stated that she did see the photo's taken by Ms. Glendenning. Ms. Fleischfresser noted she was away from the facility/area during that week and did not directly see Resident A's bruising when it was first noted by Ms. Glendenning.

On July 29, 2024, I conducted a telephone interview with staff member Nicole Tucker. Ms. Tucker stated she worked the morning of July 4, 2024, along with staff member Stacey DeBolt. Ms. Tucker stated that Resident A was sitting in his pajamas, at the breakfast table, and as he rose to walk to his chair in the living room, she noticed "he was soaked" (in urine). Ms. Tucker stated she approached Resident A from behind, put her hand on his back, and told him that he was wet, and she would help him change. She noted she startled Resident A and he "didn't want to go." She than stated that Resident A let go of his walker and she grabbed his arm to stabilize him, "so he didn't fall." Ms. Tucker stated that Resident A then took his other arm and began to hit her and pull her hair. She noted that "out of frustration" she told Resident A "if you hit me, I'll hit you." Ms. Tucker acknowledged that "I know it wasn't right" and that she "was upset and frustrated" that Resident A had hit her. She noted that she did not hit Resident A, and only held onto his arms so he would not fall, as Resident A had let go of is walker and was unsteady on his feet. Ms. Tucker stated that Ms. DeBolt came over to where she and Resident A were standing and asked Resident A if he would go with her and get his clothes changed. Ms. Tucker noted Resident A walked with Ms. DeBolt to the bathroom and she continued "about my business."

For reference: R400.15102(1)(p), defines "Physical Restraint" as "the bodily holding of a resident with no more force than is necessary to limit the resident's movement."

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(f) Subject a resident to any of the following:** **(iv) Threats.**
ANALYSIS:	Home Manager Valerie Glendenning states that she observed significant bruising on Resident A's arms on July 5, 2024. She noted she had not observed these bruises prior to that date.

	Staff member Stacey DeBolt states she observed, during her shift of July 4, 2024, staff member Nicole Tucker grab and hold Resident A's wrists while telling him "you hit me, I'll hit you back." She noted that while Ms. Tucker was holding Resident A's wrists, he was "struggling, trying to get Nicole to let go." Staff member Nicole Tucker states she held onto Resident A's arms, to stabilize him so he would not fall. She noted Resident A began to hit her and pull her hair. Ms. Tucker acknowledged that she did tell Resident A, "if you hit me, I'll hit you." She stated that she "was upset and frustrated" that Resident A had hit her and acknowledged that she knows this "wasn't right." Direct care staff member Nicole Tucker did use a form of physical force with Resident A that exceeded the amount of force necessary to limit his movement. The physical force employed by Ms. Tucker caused significant bruising to Resident A's lower arm/wrist area. Ms. Tucker did subject Resident A to threats of physical assault when she told him "if you hit me, I'll hit you."
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 8, 2024, I conducted an exit conference with Licensee Designee Kristi Fleischfresser. I explained my findings as noted above. Ms. Fleischfresser stated she understood the findings, had no additional information to provide, or questions to ask, concerning this special investigation. She stated that she would submit a corrective action plan addressing these cited rule violations.

IV. RECOMMENDATION

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

August 8, 2024

Bruce A. Messer Date
Licensing Consultant

Approved By:

August 8, 2024

Jerry Hendrick Date
Area Manager