GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Joyce Korpi
Sundara Nphc
401 Lincoln
Marquette, MI 49855

December 2, 2024

RE: License #: AL520007247
Investigation #: 2025A0873001
Sundara West Nphc

Dear Ms. Korpi:

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 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 (616) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor - 350 Ottawa, N. W.
Grand Rapids, MI 49503
(906) 250-9318

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

I. IDENTIFYING INFORMATION

License #:	AL520007247
Investigation #:	2025A0873001
Complaint Receipt Date:	10/07/2024
Investigation Initiation Date:	10/07/2024
Report Due Date:	12/06/2024
Licensee Name:	Sundara Nphc
Licensee Address:	401 Lincoln Marquette, MI 49855
Licensee Telephone #:	(906) 228-7053
Administrator:	Joyce Korpi
Licensee Designee:	Joyce Korpi
Name of Facility:	Sundara West Nphc
Facility Address:	401 Lincoln Avenue Marquette, MI 49855-3928
Facility Telephone #:	(906) 228-0848
Original Issuance Date:	02/05/1979
License Status:	REGULAR
Effective Date:	01/07/2024
Expiration Date:	01/06/2026
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents are abused and neglected by staff	No
Medication errors have sent several residents to the hospital.	No
Additional Findings	Yes

III. METHODOLOGY

10/07/2024	Special Investigation Intake 2025A0873001
10/07/2024	Special Investigation Initiated - Telephone Call to CMH ORR
10/08/2024	Inspection Completed On-site
10/09/2024	Contact - Face to Face Interview with Ms. Korpi
11/04/2024	APS Referral
11/25/2024	Inspection Completed On-site
11/25/2024	Contact - Face to Face Interview with Ms. Korpi
11/25/2024	Contact - Telephone call made Interview with Guardian A
11/25/2024	Contact - Telephone call made Interview with Ms. Lancour
11/25/2024	Contact - Telephone call made Interview with Guardian B
11/25/2024	Exit Conference With Ms. Korpi
11/27/2024	Contact - Telephone call made Interview with ORR
11/27/2024	Contact - Telephone call made

	Interview with Chris Stanley, business manager Sundara
11/27/2024	Contact - Telephone call made Interview with Resident C
11/27/2024	Contact - Telephone call made Interview with Mark Fuller, caseworker for Resident D
11/27/2024	Contact - Telephone call made Interview with Emily Richards, case worker for Resident A and E
11/27/2024	Contact - Document Received Received ORR report on med errors
12/02/2024	Inspection Completed-BCAL Sub. Compliance
12/02/2024	Exit Conference With Ms. Korpi

ALLEGATION:

Residents are abused and neglected by staff.

INVESTIGATION:

On 10/7/24, I received a complaint alleging staff are abusing and neglecting Resident A and Resident B.

On 10/8/24, I interviewed licensee designee Joyce Korpi at the facility about the allegation. Resident A became more behavioral than usual several months ago. He was taken to the emergency room and diagnosed with a urinary tract infection. The physician also recommended an MRI to determine if the recent change in behaviors may have another cause. Sundara had been in contact with Resident A's guardian and Pathways community mental health (CMH) caseworker about this. Resident B had issues with incontinence and staff changed her sheets and showered her as soon as possible when she became soiled. CMH was aware of the condition and Resident B was medicated for it.

On 11/25/24, I interviewed Guardian A about the allegation over the telephone. She had not seen any evidence that Resident A was abused. She was aware that Resident A was diagnosed with a urinary tract infection and that Resident A's doctor planned to test him for dementia. Resident A was back to acting like himself since his medication had been adjusted. Resident A enjoyed living at Sundara and

whenever Guardian A visited with him for a time off the property, he was always eager to go back home.

On 11/25/24, I interviewed Guardian B over the telephone. She cannot imagine staff have not changed Resident B after she soiled herself. Resident B expressed no anxiety or fear about living at facility. When Guardian B visited the facility, it was always spotless, odorless, and all residents were clean.

On 11/25/24, I interviewed staff member Laura Lancour over the telephone. Resident B is always cleaned after having soiled herself. Her bed sheets were always changed as needed. Resident B is not neglected. Ms. Lancour, nor any other staff, abused residents. Resident A had been acting irregularly, said inappropriate things and lashed out at staff lately but these behaviors had subsided since a change in medications.

On 11/27/24, I interviewed CMH caseworker Emily Richards over the telephone about the allegations. Resident A was not abused or neglected by staff at the facility. He had demonstrated changes in behavior over the last several months, but after his medications were adjusted he was back to acting like himself. Resident A is scheduled to have an MRI performed to determine if there was fluid build up in his brain. Resident A's physician is also concerned Resident A showed early signs of dementia.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	After interviewing staff at the facility, as well as guardians and CMH caseworkers for several residents, I can find no evidence that staff abused or neglected residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medication errors have sent several residents to the hospital.

INVESTIGATION:

On 10/7/24, I received a complaint alleging there were medication errors at the facility.

On 10/8/24, I interviewed Ms. Korpi at the facility. If there were medication errors these were always noted and reported as required. I was given a tour of the medication room and determined the medications were properly locked and being recorded during administration as required. The complainant alleged the controlled medications were not doubled-locked. I determined this to be accurate, however, there was not a licensing rule requiring medications be doubled-locked.

On 11/24/24, I interviewed the complainant over the telephone to ask for names of specific residents that were sent to the hospital for medication errors. I was told that Residents C, D, and E were all sent to the hospital due to medication errors.

On 11/27/24, I interviewed the facility's business manager Chris Stanley over the telephone. When medication errors occurred, everyone mandated to be notified is notified. Neither Residents C, D, nor E had ever been to the hospital for a medication error.

On 11/27/24, I interviewed Resident C over the telephone. He was never sent to the hospital for a medication error.

On 11/27/24, I interviewed Resident D's CMH caseworker Mark Fuller over the telephone. He was not aware of any medication errors nor medication-related hospitalizations for Resident D.

On 11/27/24, I interviewed Resident A and Resident E's CMH caseworker Ms. Richards over the telephone. She was not aware of any medication errors that resulted in hospitalizations for any residents at the facility.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	After inspecting the medication room, interviewing facility staff, residents, and residents' CMH caseworkers, I could find no evidence of ongoing medication errors or hospitalizations resulting from medication errors.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 11/27/24, I interviewed CMH officer of recipient rights Casey Olson about allegations of medication errors leading to hospitalizations. She was not aware of any. However, CMH recently completed an investigation into a medication error that resulted in the facility having to file a plan of correction with CMH. Ms. Olson provided a copy of the investigation.

On 11/27/24, I interviewed the facility's business manager Mr. Stanley about the findings of the report. Because of several issues the facility had with the pharmacy that previously supplied medications to the facility's residents, it was decided the facility would begin utilizing the services of a different pharmacy. During this transition, the new pharmacy noted that Resident C was receiving half the dose of a particular medication as was prescribed by his physician. For several months Resident C had received the incorrect dose of medication. Staff did not notice the discrepancy between Resident C's doctor's order and what the pharmacy supplied and was only made aware of this when the new pharmacy reported their finding to CMH.

On 11/27/24, I interviewed Resident C over the telephone. During those months Resident C noticed he had trouble sleeping and life was "pretty rough" around that time. He was grateful his medications were sorted out and he is sleeping better again.

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: **(f) Contact the appropriate health care professional if a medication error occurs**
ANALYSIS:	Staff at the facility failed to notice the discrepancy between the medication the pharmacy was supplying for Resident C and what Resident C was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/2/24, I informed licensee designee Ms. Korpi of the findings of this report. She thanked me.

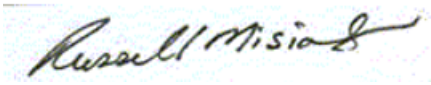
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of this license.

12/2/24

Garrett Peters Date
Licensing Consultant

Approved By:



12/3/24

Russell B. Misiak Date
Area Manager