GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 3, 2025

Carolyn Bruning
Northeast Michigan CMH Authority
400 Johnson Street
Alpena, MI 49707

RE: License #: AS600377762
Investigation #: 2025A0360039
Thunder Bay Home

Dear Ms. Bruning:

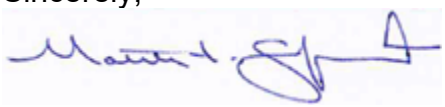
Attached is the Special Investigation Report for the above-referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit #13
Grand Rapids, MI 49503
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS600377762
Investigation #:	2025A0360039
Complaint Receipt Date:	08/06/2025
Investigation Initiation Date:	08/07/2025
Report Due Date:	10/05/2025
Licensee Name:	Northeast Michigan CMH Authority
LicenseeAddress:	400 Johnson Street Alpena, MI 49707
Licensee Telephone #:	(989) 358-7603
Administrator:	Nicole Kaiser
Licensee Designee:	Carolyn Bruning
Name of Facility:	Thunder Bay Home
Facility Address:	15080 Fairway Court Hillman, MI 49746
Facility Telephone #:	(989) 742-3281
Original Issuance Date:	11/16/2015
License **Status:**	REGULAR
Effective Date:	05/16/2024
Expiration Date:	05/15/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was administered the wrong medication.	Yes

III. METHODOLOGY

08/06/2025	Special Investigation Intake 2025A0360039
08/07/2025	APS Referral online
08/07/2025	Special Investigation Initiated - Letter APS
08/12/2025	Inspection Completed On-site DCSM Valerie Cordes, Resident A
08/12/2025	Contact - Telephone call made Home supervisor Saydee Cline
08/12/2025	Contact - Document Received Administrator Nicole Kaiser
08/12/2025	Contact - Document Received Elizabeth Kowalski NEMCMH ORR
10/1/2025	Contact – Telephone call made Home supervisor Saydee Cline, DCSM Angela Standon, DSCM Jessica Breezee, DCSM Lisa Patterson
10/3/2025	Exit Conference With Nicole Kaiser

ALLEGATION:

Resident A was administered the wrong medication.

INVESTIGATION:

On 8/12/25, I conducted an unannounced onsite inspection at the home. The direct care staff member (DCSM) Valerie Cordes stated she was aware of a medication administration issue regarding Resident A but did not know any details. Ms. Cordes stated Resident A was sitting in the living room napping. I observed Resident A in the living room. Resident A is non-verbal and unable to be interviewed. Ms. Cordes referred me to her supervisor who was not at the home for further information.

On 8/12/25, I received a phone call from the home supervisor Saydee Cline. Ms. Cline stated that Resident A was hospitalized as a precaution after an error medication on 8/1/25. Ms. Cline stated that Resident A returned to the facility later that evening.

On 8/12/25, I contacted the administrator Nicole Kaiser and recipient rights officer Elizabeth Kowalski by email. Ms. Kowalski sent me the incident report regarding the medication error on 8/1/25. Ms. Kaiser sent me Resident A's medication administration record for August 2025, resident care agreement, and written assessment plan. The incident report documented that on 8/1/25 DCSM Angela Standon administered another resident's medication to Resident A. It documented that DCSM Lisa Patterson noticed that Resident A was not waking up and contacted 911. The written assessment plan noted that Resident A requires medication administration by staff.

On 10/1/25, I contacted the home manager Saydee Cline by telephone. Ms. Cline stated that Resident A received Resident B's evening medication instead of her own on 8/1/25. She stated the medications included Clozaril, Benztropine, Vitamin D, Haloperidol, Gas-ban, and Colace.

On 10/1/25, I contacted DCSM Angela Standen by telephone. Ms. Standen stated that on 8/1/25 she administered Resident A, another residents' evening medications. She stated the other residents' name began with the same letter and had been in a hurry. Ms. Standen stated that the facility has now implemented a new system to ensure that the medications are not mixed up. I then contacted DCSM Jessica Breezee by telephone. Ms. Breezee stated she was supposed to be the medication checker and was in a hurry and did not complete the check prior to administration. She stated she noticed that after the medications administration Resident A had fallen asleep in the living room and when she went to get her into her bedroom, she could not wake her up. Ms. Breezee stated that she contacted the on-call nurse who suggested that they contact the hospital who stated to contact 911 and have Resident A evaluated after discovering the medication error. Ms. Breezee stated Resident A was taken to the hospital by emergency medical services and was discharged back to the home just after midnight. Ms. Breezee stated that she went to the hospital and picked Resident A up and brought her back to the home. I then contacted DCSM Lisa Patterson by telephone. Ms. Patterson stated that she came into work at about 8 p.m. on 8/1/25 to relieve Ms. Standen. She stated shortly after

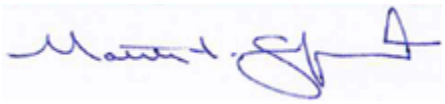
reporting to work is when they discovered the medication error and contacted 911 for Resident A.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Interviews with Ms. Cordes, Ms. Cline, Ms. Breezee, Ms. Standon, and documentation received from Ms. Kaiser and Ms. Kowalski revealed that Resident A was administered the wrong medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/3/25 I conducted an exit conference with administrator Nicole Kaiser. Ms. Kaiser stated she would submit a corrective action plan for approval.

IV. RECOMMENDATION

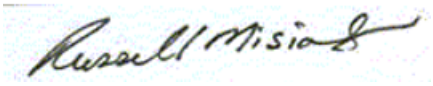
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



10/3/25

Matthew Soderquist Date
Licensing Consultant

Approved By:



10/3/25

Russell B. Misiak Date
Area Manager