GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 23, 2024

Mark Wilson
Traverse Neuro Rehabilitation, LLC
654 Hastings St.
Traverse City, MI 49686

RE: License #: AS280401994
Investigation #: 2025A0009007
Traverse Neuro Rehabilitation

Dear Mr. Wilson:

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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame 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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS280401994
Investigation #:	2025A0009007
Complaint Receipt Date:	12/03/2024
Investigation Initiation Date:	12/04/2024
Report Due Date:	01/02/2025
Licensee Name:	Traverse Neuro Rehabilitation, LLC
Licensee Address:	654 Hastings St. Traverse City, MI 49686
Licensee Telephone #:	(231) 252-2485
Administrator:	Mark Wilson
Licensee Designee:	Mark Wilson
Name of Facility:	Traverse Neuro Rehabilitation
Facility Address:	654 Hastings St. Traverse City, MI 49686
Facility Telephone #:	(231) 252-2485
Original Issuance Date:	02/05/2020
License Status:	REGULAR
Effective Date:	08/05/2024
Expiration Date:	08/04/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff intentionally gave Resident A another resident's anti-anxiety medication.	Yes

III. METHODOLOGY

12/03/2024	Special Investigation Intake 2025A0009007
12/04/2024	Special Investigation Initiated – Telephone call made to Complainant
12/06/2024	Inspection Completed On-site Interview with Resident A and operations coordinator Tonya Woodworth
12/16/2024	Contact – Telephone call received by licensee designee Mark Wilson
12/09/2024	Contact - Telephone call made to direct care worker Clarissa Young
12/09/2024	Contact - Telephone call made to medication supervisor Gail Macomber
12/10/2024	Contact - Telephone call received from medication supervisor Gail Macomber and licensee designee Mark Wilson
12/11/2024	APS Referral
12/12/2024	Contact – Telephone call received from adult protective services worker Daryl Stallworth
12/20/2024	Contact – Telephone call made to home manager Janne Clifton
12/23/2024	Exit conference with licensee designee Mark Wilson

ALLEGATION: S**taff intentionally gave Resident A another resident's anti-anxiety medication.**

INVESTIGATION: I spoke with the complainant by telephone on December 4, 2024. They said they had been told by Resident A that she had intentionally been given another resident's anti-anxiety medication.

I conducted an unannounced site visit at the Traverse Neuro Rehabilitation adult foster care home on December 6, 2024 and spoke with Resident A at that time. I asked her about the report of her getting another resident's medication. She said it happened on Thanksgiving Day (November 28) of this year. Resident A said that she was feeling anxious because another resident's mother was visiting who she does not get along with. She spoke with staff Janne Clifton about it. Ms. Clifton told her that she would give her something for her anxiety and that if it worked, she might be able to get it prescribed to her. She said that Ms. Clifton had a second staff person, Clarissa Young, give her the pill. Resident A said that she knew that it was not one of her regularly prescribed medications. It was a small round, pale yellow pill. She said that after she took it, she felt tired and went to sleep.

Resident A went on to say that the owner, Mark Wilson, found out about it and asked her and Ms. Young about it. He showed them a pill that was located in a medication packet and asked them if that was the pill that Resident A had been given. Both of them said yes. It was the small round, pale yellow pill. It was in a packet so she knew it was another resident's prescribed medication. Resident A said that Ms. Clifton is now saying that she gave her a Sudafed PM. Resident A said that she does not think those are yellow. I asked her if she has Sudafed on her medication list. She said no, she used to take Sudafed in the past when she was sick but hasn't recently. She said that her doctor has told her that if she is ever sick she should be brought in and they will give her whatever medication she needs.

I then spoke with operations coordinator Tonya Woodworth. She said that she wasn't involved with the issue of Resident A getting an over-the-counter medication or another resident's prescribed medication, whichever had happened. She said that the owner, Mark Wilson, has conducted his own internal investigation into the matter. She said that he would know more about the matter and called him at that time. Mr. Wilson said that this issue had been brought to his attention and he had done his own investigation. He said that Ms. Clifton had said that she had given Resident A a generic Sudafed. She said that it was the last one in the package and that she had thrown away the package. Mr. Wilson said that he had searched the garbage but did not find any empty packaging for Sudafed. I asked if Sudafed was yellow. He said that they did find some generic Sudafed pills that were yellow. Ms. Woodworth also showed this to me on her laptop computer. I observed that out of many different options, there was one or two generic Sudafed pills that were yellow, although they were oval. Mr. Wilson said that he was not able to determine whether Resident A was given an over-the-counter medication or another resident's prescribed medication. I told him that either way it was a violation of licensing rules since Sudafed is not on Resident A's medication list. He said that he understood that and has given Ms. Clifton a "written warning". Mr. Wilson told Ms. Woodworth to provide me with that document. I told him that it seemed more likely that Resident A

had been given Resident B's prescription medication rather than a Sudafed. Mr. Wilson said that he did not agree with that assessment and that it could be either one or the other. He said that he wanted me to document that this information was coming from a disgruntled employee whom he had recently given a pay cut and whom he was requiring do additional training. He felt that the disgruntled employee might be trying to make Ms. Clifton look bad for his own purposes. I told him that I would like to count Resident B's Olanzapine medication with Ms. Woodwoltrth while I was there. He agreed to that.

I reviewed the "written warning" given to staff Janne Clifton on December 2, 2024. It read, "*On Thanksgiving, Janne gave (Resident A) a Sudafed for anxiety. There was no PRN order for this medication. It was alleged by (Resident A) and Clarissa that the medication could have been a prescribed medication for another client*." The document went on to read that Ms. Clifton adamantly denied giving Resident A another resident's prescribed medication and that she had given her a "Sudafed PM". It further read, "*I then met with Clarissa privately, she did say it could have been a Sudafed PM. Conclusion: I did meet again with Janne and explained to her you never give any medication (prescribed or over-the-counter medication). Janne did agree with this mistake and understood this written warning*."

Ms. Woodworth and I then checked the medication cart. She retrieved Resident B's Olanzapine and her medication administration record (MAR). Ms. Woodworth wanted me to know that she does not handle the supervision of the medications and that the person who handles that might be a better person to approach about this. We counted that there were 26 Olanzapine pills prescribed to Resident B in the medication cart. 30 pills were filled on October 18, 2024. The MAR indicated that 4 pills had been administered to Resident B in October after the 18th of that month. Three had been administered in November and none in December. The information that we did not have and that Ms. Woodworth did not know how to find was how many Olanzapine pills had still been present on October 18, 2024, when 30 pills had come into the home.

I requested and Ms. Woodworth provided me with the Daily Activities Log for November 28, 2024, regarding Resident A.

I spoke with direct care worker Clarissa Young by telephone on December 9, 2024. She confirmed that she had worked on Thanksgiving with direct care worker Janne Clifton. I asked her about the pill issue regarding Resident A. Ms. Young said that Resident A kept telling them that she was really anxious. Ms. Clifton then gave Resident A a medication for the anxiety. Ms. Clifton handed her a cup with the pill in it and told her to give it to Resident A. She said that Resident A asked her what it was and she told her that she didn't know that she should talk to Ms. Clifton about it. I asked Ms. Young why Ms. Clifton had given it to her to give to Resident A. She replied that she didn't know. Ms. Clifton was writing something in the medication book at the time. She said it was a little, round yellow pill that she told her to give to Resident A. She wasn't sure what it was. She said that Mr. Wilson later showed her

Resident B's Olanzapine as well as some pictures of different generic brands of Sudafed. Both her and Resident B said that they thought it was Resident B's Olanzapine. Ms. Clifton said that it was Sudafed PM, though. She said that they do have Sudafed on-hand but she thought it was for the staff. I asked her if they ever give over-the-counter medication to residents. She said only if it is on their medication list. She said they sometimes give them Tylenol or Ibuprofen if it is on their list. I asked Ms. Young what she thought of Ms. Clifton's report that Resident A had been given Sudafed. She replied, "It doesn't make sense. Why would you give someone Sudafed for anxiety?"

I read the Daily Activities Log as penned by Ms. Clifton to direct care worker Clarissa Young. The log stated that Resident A had asked staff if she could have something for anxiety. The log read that she was told she did not have anything prescribed for anxiety. The log read that Resident A asked for another resident's anxiety medication. The log further read that Resident A "insisted" on having another resident's medication. Ms. Clifton logged that Resident A was told that she could not have another resident's medication but could have a "cold med PM" to calm her. I asked Ms. Young what she thought about what was written in the log. Ms. Young replied that she did not agree with how the log read. She said that Resident A never tried to get anyone to give her another resident's medication. Resident A did want medication for anxiety, but never asked to be given another resident's medication. In fact, when Ms. Young handed her the little round yellow pill, Resident A was worried that it was another resident's medication and said so. Ms. Young denied that she told Resident A that she had to take the pill but she did take it.

I spoke with the medication supervisor Gail Macomber by telephone on December 9, 2024. I asked her what she knew about the recent medication issue regarding Resident A. Ms. Macomber replied that she knew, "They gave her a wrong med but that is all I know." She said that she would do an official count of the medication as soon as she was able to get to the facility and would let me know what she found.

I received a telephone call from Gail Macomber on December 10, 2024. She was speaking to me by speaker with Mr. Wilson present. She stated that she had spoken with Resident A and the caregiver involved. She said that after doing a count of Resident B's medication, she had found that one of her Olanzapine 5 mg pills is missing. She said that she was sure of this fact. Ms. Macomber explained that they receive Resident B's Olanzapine in roles of 30. Three doses of the medication had been administered to Resident B since they received the 30 doses. There were only 26 pills present, there should be 27. Ms. Macomber stated that it was her assessment that Resident B's Olanzapine is what was given to Resident A on November 28, 2024. She said that she showed both Resident A and direct care worker Clarissa Young the Olanzapine 5 mg and they had both identified that as the pill that was given.

I spoke with home manager Janne Clifton by telephone on December 20, 2024. I asked her about the events of November 28, 2024, regarding Resident A being

given something for anxiety. She said that Resident A was anxious because of another resident's family member visiting. Ms. Clifton said that Resident A asked her for another resident's medication. She told her no. Ms. Clifton said that she told Resident A that the only thing she could give her was one of her own cold medications. I asked Ms. Clifton about this given that it was my understanding that Resident A did not have any cold medications on her approved medication list from her primary physician. She said that Resident A had bought it herself and they kept it locked up for her. I asked her why she would give Resident A a cold medication for anxiety. Ms. Clifton replied that it is what Resident A takes at night to "de-escalate". It helps her to relax and fall asleep. She said that it is Sudafed PM and that it is a little, white pill. I told her that the packaging for this reported Sudafed PM was not found in the medication cart or the garbage. Ms. Clifton replied, "It should have been there." She said that there was "very little of each left" but said it was not expired. Ms. Clifton said she did not know what happened at the facility after that day because she was off work for the following two days. Ms. Clifton denied that she gave Resident A an Olanzapine and said that this had been reported because of a disgruntled employee who doesn't like her. I asked her about the medication supervisor, Ms. Macomber, reporting that one of Resident B's Olanzapine pills was missing. Ms. Clifton said that when myself and Ms. Woodworth counted them, they were all there. I told her that was not true, that we did not have all the information needed to assess whether they were all there or not. Ms. Clifton said that Ms. Macomber is rarely around the facility. I stated that Ms. Macomber is the medication supervisor and it is her job to know if any medication is missing.

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:	On November 28, 2024, Resident A requested a medication to help her with anxiety. She was given a small, pale yellow pill which she did not recognize. This matches the description of another resident's prescribed Olanzapine. The staff person who gave her the medication insisted it was a Sudafed PM. Sudafed PM is not on Resident A's medication list from her physician. Resident A denied that she has taken Sudafed recently. Both Resident A and the other staff person on duty stated that what Resident A had been given looked like the Olanzapine that is prescribed to Resident B. The medication supervisor counted Resident B's medication and found that Resident B was missing one Olanzapine 5 mg pill.

	It was confirmed through this investigation that the licensee did not take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Mark Wilson by telephone on December 23, 2024. I told him of the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

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

12/23/2024

Adam Robarge Date
Licensing Consultant

Approved By:

12/23/2024

Jerry Hendrick Date
Area Manager