

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

November 17, 2022

Tristan Schramke The Lighthouse, Inc. PO Box 289 Caro, MI 48723

RE: License #:	AM790405945
Investigation #:	2023A0871002
-	Jamie's House

Dear Mr. Schramke:

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 (517) 643-7960.

Sincerely,

Kathrys Habe

Kathryn A. Huber, Licensing Consultant Bureau of Community and Health Systems 411 Genesee P.O. Box 5070 Saginaw, MI 48605 (989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM700405045
License #:	AM790405945
Investigation #	2023A0871002
Investigation #:	2023A0671002
Complaint Passint Data	10/11/2022
Complaint Receipt Date:	10/11/2022
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Investigation Initiation Date:	10/14/2022
Deve evit Dure Deter	40/40/0000
Report Due Date:	12/10/2022
Licensee Name:	The Lighthouse, Inc.
Licensee Address:	1655 East Caro Road
	Caro, MI 48723
	
Licensee Telephone #:	(989) 673-2500
Administrator:	Tristan Schramke
Licensee Designee:	Tristan Schramke
Name of Facility:	Jamie's House
Facility Address:	1771 Luder Rd
_	Caro, MI 48723
Facility Telephone #:	(989) 673-2500
Original Issuance Date:	12/07/2021
License Status:	REGULAR
Effective Date:	06/07/2022
Expiration Date:	06/06/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED
riogiani iype.	DEVELOPMENTALLY DISABLED
	MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED ALZHEIMERS AGED
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II. ALLEGATION(S)

	Violation Established?
Resident A tested positive for THC. It is alleged that a staff member provided Resident A with the drug.	Yes

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A0871002
10/11/2022	APS Referral From Adult Protective Service Worker Tyler Erla
10/14/2022	Special Investigation Initiated - Telephone Telephone contact with Licensee Tristan Schramke
10/18/2022	Inspection Completed On-site Interviewed Licensee Tristan Schramke, Home Manager Christopher Lowrey, Observed Resident A
11/17/2022	Contact - Telephone call made Telephone call to Guardian A1
11/17/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A tested positive for THC. It is alleged that a staff member provided Resident A with the drug.

INVESTIGATION:

On September 16, 2022, I received an *AFC Licensing Division – Incident/Accident Report* that was written, signed, and dated by Licensee Tristan Schramke on 09/16/2022. What happened indicates "On 09-11-22 [Resident A] (resident) was acting lethargic, and not his normal self. Staff administered a drug test, that was sent to the lab for confirmation. On 9-16-22 we received results indicating [Resident

A] tested positive for THC." Action taken by staff indicates "Notified guardian Licensing, and Recipient Rights. The staff (Tyler Withers) working with him on 9-11-22 was also tested and refused to submit a sample and was terminated." Corrective measures indicate "[Resident A] will be closely monitored and tested frequently in the future to ensure that this is not happening."

On October 18, 2022, I conducted an onsite investigation and interviewed Licensee Tristan Schramke. Licensee Schramke indicated that staff noticed that Resident A was "lethargic and noticed unusual behavior." Licensee Schramke stated Staff Tyler Withers was 1:1 with Resident A on 09/11/2022 and he was offered a drug test but refused. Mr. Withers' employment was terminated as it is The Lighthouse police you must submit to a drug test when requested.

I also interviewed Home Manager Christopher Lowrey. Manager Lower indicated that Mr. Withers was assigned to Resident A on Friday and Saturday, September 9thaand 10th. Manager Lowrey indicated when a drug test was requested from Mr. Withers, he told him that he would fail. Manager Lowrey indicated Resident A is does not have a prescription for THC.

On October 18, 2022, I observed Resident A in the facility. He is nonverbal and unable to be interviewed. Resident A is very busy and does not sit still for a long period of time and walks quickly.

Licensee Schramke provided me the staff log which contained the behaviors of Resident A. On 09/09/2022, Staff Hillary Gasta worked second shift and wrote "[Resident A] seemed tired all shift." Staff Lena Shepherd worked 09/10/2022 first shift and reported "@7a staff change [Resident A] was asleep. He got up at 9a and completed shower, treatments, and MR. Ate breakfast then completed oral care. Went on country drive 11a-1p, at lunch on drive. After returned relaxed and played with toys, then listened to music until staff change at 3p." On 09/10/2022 Staff Tyler Withers worked second shift and he indicated "at 6p while sitting in the living room, [Resident A] voided himself and removed his pants. [Resident A] refused to wear pants until the ones he wanted came out of the dryer at 6:30 p. No further issues."

Staff Ashleigh Heron worked first shift on 09/11/2022 and wrote "[Resident A] had an okay shift. When eating breakfast this morning, staff noticed that [Resident A] was continuously drooling while eating. He was then fine until 12:15pm and he was sitting in his bed and voided in his clothing and on his bed. Staff prompted, he got up and helped get his bed cleaned up and changed. He then went to the table to wait for lunch, and he began making gaging noises and almost made his self puke while at the table. Staff prompted him and was able to redirect him out of the area to see if that would help and once in his room he sat on the floor and voided in his pants. He then took them off and voided on his floor and then took his shorts and cleaned up the mess with it. Staff prompted and he was making his whining noises and started to go to the garage where his dresser was. Staff then let him pick out something else, and he went to the bathroom to get changed. But once in the

bathroom he refused to put the shorts on and then laid on the bathroom floor and was doing his whining noises. He continued to do this until 1:15 pm and then he complied and had no other issues the rest of the shift."

On 09/11/2022, Staff Chelsea Stevens worked second shift and her notes indicated "[Resident A] was wet at shift change after he finished his snack. He then was cleaned up and picked out some new clothes to wear. He then relaxed in his bed with a movie until dinner time. After dinner he completed oral care and relaxed in his bed some more. His [Guardian A1] came to visit and she brought him a pop, staff asked her what kind of pop she brought him. She said Coke zero. Staff would pour some in a cup and hand it to [Resident A] to drink. He would drink it and hand it back to staff. Staff continued to do this until all the pop was gone. He then laid back into his bed with his [Guardian A1] and watched some more of his movie. [Resident A] then got up and went to the table to get a drink. Staff gave him a drink and he would go back to his room and then would walk back to the kitchen. Staff reminded him that he just had a drink and redirected him to the bathroom. While sitting on the toilet staff and [Guardian A1] noticed that [Resident A] was shaking. She asked him if he was cold. He looked at [Guardian A1] and attempted to stand up. Staff prompted him to go the bathroom, and then he could go cuddle up to his blankets. He voided, and then continued to obsess over drinks. He would walk into the kitchen and attempted to open the fridge. Staff would prompt him to have a seat at the table and staff would get him a drink. [Resident A] complied and had a drink. [Resident A] also had a pickle and then went back to his room. He laid in bed with [Guardian A1] and then wet himself. He then got into the shower. He then sat down on the ground an began to drink water out of the shower head. He would play with the water and then continued to drink it. He was in the shower for about 10 minutes. He then dried off and got dressed. [Resident A] laid in bed and [Guardian A1] left. He then continued to lay in bed until falling asleep for the night."

Guardian A1 noticed that Resident A was not acting his usual self. She noticed that Resident A could hardly keep his eyes open and only wanted to stay in his bed.

Licensee Schramke provided me a copy of a note written by Staff Tyler Withers and it indicates "At no point have I provided anything to anyone, or any resident," It was signed and dated by Tyler Withers on 09/13/2022.

On October 16, 2022, Adult Protective Service Worker Tyler Erla provided me information that indicated "Attempts to contact the alleged perpetrator were unsuccessful therefore an interview could not be completed. Law enforcement closed their investigation on the basis that they could not identify a perpetrator. There is evidence to support neglect of [Resident A] by Tyler Withers who was the 1:1 worker. There may not be evidence that support Tyler providing THC to [Resident A], however if he was the 1:1 worker with [Resident A], he should have been able to prevent [Resident A] from ingesting THC."

On November 17, 2022, I telephoned Guardian A1. Guardian A1 stated she has no other concerns other than the incident when Resident A ingested THC. Guardian A 1 reported they now have a plan to get him tested regularly. Guardian A 1 said she is not sure staff gave it to him or if he stole it "because he likes to steal things."

On October 18, 2022, I conducted a face-to-face exit conference with Licensee designee, Tristan Schramke. I advised him that this is a rule violation as Resident A was not prescribed THC.

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:	It is unknown who had the THC in the facility or who gave it to Resident A. Resident A is not prescribed THC and he had THC in his system. I confirm violation of this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care medium group home remain unchanged (capacity 1-12).

Kathrys Habe

11/17/2022

Kathryn A. Huber Licensing Consultant

Date

Approved By:

Mary E. Holton Area Manager

<u>11/17/2022</u> Date