GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 28, 2025

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

RE: License #: AM790405945
Investigation #: 2025A0623022
Jamie's House

Dear Tristan 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(517) 648-8877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM790405945
Investigation #:	2025A0623022
Complaint Receipt Date:	02/18/2025
Investigation Initiation Date:	02/20/2025
Report Due Date:	04/19/2025
Licensee Name:	The Lighthouse, Inc.
Licensee Address:	1655 East Caro Road Caro, MI 48723
Licensee Telephone #:	(989) 673-2500
Administrator:	Tristan Schramke
Licensee Designee:	Brant Wilson
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:	06/07/2024
Expiration Date:	06/06/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 2/14/2025, Staff Joshua Durussell used inappropriate physical interventions on Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

02/18/2025	Special Investigation Intake 2025A0623022
02/19/2025	APS Referral I completed an APS referral
02/20/2025	Special Investigation Initiated - Telephone I contacted Lapeer County CMH case manager Christine Robertson
02/25/2025	Inspection Completed On-site Observation and Interviews
02/25/2025	Contact - Document Received I received AFC documents.
02/28/2025	Contact - Telephone call made I contacted APS worker Gerald Edwards.
03/13/2025	Contact - Telephone call made I contacted staff Joshua Durussell
03/13/2025	Contact - Document Received Documentation received from Administrator Tristan Schramke.
03/13/2025	Inspection Completed-BCAL Sub. Compliance
03/18/2025	Contact - Document Received I received a copy of the police report.
03/24/2025	Contact - Telephone call made I contacted Guardian A.
03/24/2025	Contact - Telephone call made I contacted Lapeer County Recipient Rights Officer Lisa Jolly.

03/24/2025	Exit Conference I contacted Administrator Tristan Schramke

ALLEGATION:
On 2/14/2025, Staff Joshua Durussell used inappropriate physical interventions on Resident A.

INVESTIGATION:
On 2/19/2025, I completed an APS (Adult Protective Services) referral. APS was notified of the allegation received in this investigation.

On 2/20/2025, I contacted Lapeer County CMH case manager (CM) Christine Robertson. CM Robertson stated that she has been Resident A's case manager since 2021. CM Robertson stated that Resident A was living with their dad when they were placed at Jamie's House on 7/17/2023. CM Robertson stated that Resident A has learned new skills at the home, and this has been their first incident with staff. CM Robertson stated that Resident A attends school Monday-Friday until 1pm daily. CM Robertson stated that Resident A is Autistic and unable to be interviewed due to their cognitive impairment. CM Robertson stated that Resident A requires 1:1 supervision, except when sleeping.

On 2/25/2025, I conducted an unscheduled onsite inspection of the home. I interviewed Home Manager (HM) Chris Lowery, and attempted to interview Resident A.
HM Chris Lowery stated that he was not working on 2/14/2025 when the incident occurred. HM Lowery stated that he was approached by Staff Hayden Martin on the evening of 2/17/2025. Staff Hayden Martin stated that Staff Joshua Durussell used excessive force on Resident A on 2/14/2025. HM Lowery stated that he had staff write statements that were present on Friday and completed an Incident Report with the information notifying Adult Protective Services. HM Lowery stated that Staff Durussell had been reassigned and then suspended during the investigation. HM Lowery stated that Resident A had a small abrasion at the top of their head which healed.

On 2/25/2025, I observed Resident A walking around the living room area of the home wearing headphones and pacing around the room. I greeted Resident A to attempt an interview, however, they did not respond, and I did not want to agitate, so I discontinued my interaction with them. Resident A appeared clean, neatly groomed, dressed in a black sweatshirt and black sweatpants. I did not observe any visible marks, bruises or abrasions on Resident A.

On 2/25/2025, I received the following documents:

Incident Report on 2/14/2025 physical intervention needed for Resident A.
Adult Behavioral Incident Analysis Report for incident with Resident A on 2/14/2025.

Antecedent Conditions. Resident A was in the shower completing their nightly routine. Resident A was in the shower and was drinking the water coming out of the shower head, staff prompted to finish their shower and get a drink after because they then began to throw up what they drank. Resident A then turned to staff and attempted to hit staff. Other residents were not around due to Resident A being in the shower. No other staff were present until assigned staff called for assistance.
Behavior. Assigned staff went to block Resident A and then Resident A went over and grabbed their shower caddy that had all their personal hygiene items and started to throw that at staff while yelling at staff as well. Assigned staff called for assistance as Resident A grabbed the staff's arm and with the other arm went to hit staff on the head. Another staff member went in to try to redirect and distract Resident A in an attempt to calm them down. Non assigned staff were attempting breathing techniques that Resident A knows. At this time, they appeared to be coming to baseline by responding with breathing inhale and exhale and they were asked if they wanted to go to bed. Resident A responded that they wanted to lay down. Resident A then spit in the other staff's face. Another staff member came in for assistance and Resident A not only went to throw personal hygiene items and then while blocking Resident A kicked staff repeatedly and then threw their headphones at the wall. With no redirection at this time, Resident A became more aggressive and verbal with staff.
Consequences. Staff used the following interventions. De-escalation strategy, blocking, 2-person seated stability hold, 2-person floor drop transition due to dropping weight, 2-person floor seated stability hold, seated to supine transition due to Resident A attempting to bite and get out of holds throwing themselves backwards, supine stability hold with leg wrap.
Resident A's response to intervention. Resident A was yelling at staff stating they loved the staff, that they wanted to lay down and asking for a countdown. Resident A was offered PRN, and they replied yes.
Physical well-being of Resident A. Noted small abrasion in the middle top portion of head. Nursing assessed and said to monitor as long as they are in baseline, no concerns at this time. Resident A received PRN diazepam 5mg total.

I observed the following written statement dated 2/17/2025, by staff Brandon Giddings.

On Friday, February 14th, Resident A was involved in 2 PI's (Physical Interventions). Resident A's staff was prompting him not to drink the water and Resident A had grown verbally agitated. Resident A yelled at this staff and began to throw objects at staff. Staff had called for assistance and when I had gotten down to the bathroom, staff and assisting staff had Resident A pinned against the wall. Staff had asked the med tech to administer his PRN. As med tech was attempting to give Resident A his PRN, Resident A had knocked it out of her hands and attempted to bite said med tech. That's when the PI had started in the bathroom. As the PI was taking place, (Staff) Joshua Durussell had put a washcloth over Resident A's mouth and had turned the water on. Staff and assisting staff had told Josh (Staff Durussell) to stop, but he did not listen. Additional staff had gotten the washcloth away from Resident A's face and

Joshua (Staff Durussell) did not have the right position on Resident A's head and Resident A had thrashed his head forward and then backward on the bathroom floor. Staff had stopped the safety care and supportive guided Resident A to his room. Resident A, still showing agitation had attempted to attack staff once again. Safety care was utilized and in the midst of safety care, (Staff) Joshua Durussell had first shoved a pair of socks down Joseph's throat. Once again, staff had told Josh (Staff Durussell) to get the sock out of Resident A's mouth, but he did not listen. Josh (Staff Durussell) eventually took the sock out of Resident A's mouth and then proceeded to shove a book of Resident A's in his mouth. Once again, assisting staff had told Joshua (Staff Durussell) to take the book out of his mouth but Joshua (Staff Durussell) did not listen. Josh (Staff Durussell) once again eventually took the book out of his mouth, spit in Resident A's mouth and once again staff had told Josh (Staff Durussell) not to do that, but Josh (Staff Durussell) did not seem to care. Safety care was let go of, Resident A received his PRN and then Resident A had gone to sleep.

I observed the following written statement dated 2/17/2025, by staff Hayden Martin.

> While in an intervention with a client (Resident A), (Staff) Josh Durussell grabbed client's (Resident A's) leg while client was standing and took client's (Resident A's) leg and pushed it up to client's (Resident A's) chest and neck. Staff repeatedly asked staff Josh (Staff Durussell) to stop. While in an intervention with client (Resident A) in client's (Resident A's) bedroom Josh (Staff Durussell) was using a book and shoving it to the back of client's (Resident A's) throat making client (Resident A) gag. Staff again asked Josh (Staff Durussell) to stop several times after the 3rd time Josh (Staff Durussell) stopped and client (Resident A) relaxed afterwards.

On 2/28/2025, I contacted APS worker Gerald Edwards. APS Edwards stated that they are substantiating physical abuse.

On 3/13/2025, I contacted staff Joshua Durussell. I identified myself and the reason for my call. Staff Durussell stated that he did work with Resident A on 2/14/2025. Staff Durussell stated that he has not worked with Resident A since that day. Staff Durussell stated that due to being criminally charged he is not going to talk about anything as advised by his lawyer. I thanked staff Durussell and ended the call.

On 3/13/2025, I received the following information from staff Tristan Schramke. Staff Schramke stated that staff Durussell had been employed first, from 10/5/2022-6/6/2024. Two disciplinary actions noted for pushing a co-worker during an argument, sold his urine to a co-worker so the co-worker could pass a drug test. Staff Durussell was terminated from his first employment as a result of falling asleep while assigned to a 1:1 resident. On the 2nd employment from 7/24/2024 to current, Staff Durussell had been on unpaid suspension since 2/18/2025. Staff Durussell's trainings and checks were up to date and behavior management update training was completed on 8/23/2024. Staff Durussell had no disciplinary issues prior to this incident. I observed Staff Durussell suspension letter dated 2/18/2024.

On 3/13/2025, I observed a copy of Resident A's Behavior Program. Resident A is diagnosed with autism spectrum disorder. If Resident A demonstrates the following:

- Verbal aggression: calmly-redirect focus to an alternative activity or area to distract attention, if behavior continues, instruct with alternative use of appropriate words, praise when appropriate behavior/communication is used.
- Physical Aggression: verbally-instruct to stop; redirect; follow protocol for safety.
- Property destruction/disruption: verbally instruct to stop, direct away from the item being targeted provide alternative positive options, praise for return to calm actions.
- Self-injurious behavior: verbally instruct to stop; redirect and monitor for health and safety concerns.
- Refusal/non-compliance: encourage Resident A to participate, provide a choice of tow preferred options, if time allows take a brief break and return with a choice, praise their participation.

On 3/18/2025, I received a copy of the police report. Tuscola County Sheriff's Office case report no. 25000113. I observed the following statement from staff Joshua Durussell taken by Deputy Tiffany Reynolds.

> I (Deputy Tiffany Reynolds) spoke to Joshua Durussell (Staff Durussell) in the interview room at Tuscola County Sheriff's Office. Joshua (Staff Durussell) was read his Miranda Rights and agreed to speak with me. I asked Joshua (Staff Durussell) to tell me what happened during the incident. Joshua (Staff Durussell) was with Hayden (Staff Hayden Martin) and Resident A. Resident A was trying to throw up with the water and got agitated. Resident A grabbed the shower head and tried throwing it. Hayden (Staff Hayden Martin) told him to stop. Resident A threw his shower caddy, which had hygiene products in it, on the ground. Laura (Staff Laura Brigham-Tuttle), Brandon (Staff Brandon Giddings) and Andrew (Staff Andrew Beckrow) came in. Joshua (Staff Durussell) was just watching as Resident A does not like him. Joshua (Staff Durussell) does not know the reason why Resident A doesn't like him. The other staff had Resident A against the wall as Resident A's trying to fight them. Joshua (Staff Durussell) told the staff to do safety care. I asked what safety care was. Joshua (Staff Durussell) said it's a holding position on the ground. One person on each arm, one-two on the legs and a person on the head. The staff was telling him no and that they should wait it out. Joshua (Staff Durussell) has worked there longer than any of them. He has been working there 2 ½ years. Joshua (Staff Durussell) tried attempting and grabbed Resident A's leg. The staff agreed to put Resident A on the ground. Joshua (Staff Durussell) doesn't know if he helped getting Resident A on the ground. Joshua (Staff Durussell) had Resident A's head but was not touching Resident A's head. Resident A starts spitting and started blocking with his arm. Joshua (Staff Durussell) used a towel to hold above Resident A's head so spit wouldn't get on him. Laura (Staff Laura Brigham-Tuttle) left to get medications. The staff let go of Resident A and Resident A rose to his feet. Resident A threw the medications and started to hit the staff again. The staff did a two-person transfer to the bedroom. Joshua (Staff Durussell) believes he was holding the

towel around Resident A's waist because Resident A was still naked. Hayden (Staff Hayden Martin) and Andrew (Staff Andrew Beckrow) were in the room with Resident A and Joshua (Staff Durussell). Joshua (Staff Durrusell) stated they put him back on the ground using physical interaction because that is what they agreed to. Joshua (Staff Durrusell) had a book to hold over Resident A's face with one arm. Joshua's (Staff Durrusell) arm got tired, so he put it on Joseph's face and didn't put it in his mouth. Joshua (Staff Durussell) used the other arm to pick up the book. The staff did a safety release and left. I (Deputy Tiffany Reynolds) asked if there are reports for every physical interaction. Joshua (Staff Durussell) stated there was. Joshua (Staff Durussell) stated that is only the second physical interaction from being there 6-7 months. I (Deputy Tiffany Reynolds) asked why Joshua (Staff Durussell) was moved from the other building. Joshua (Staff Durussell) stated he was fired in June for falling asleep but was rehired in July.

In addition, I observed in Staff Joshua Durussell's statement that he denied anything happening with using a washcloth or socks on Resident A. Staff Durussell denied that Resident A was unable to breathe with the book placed on their face. Staff Durussell denied spitting back at Resident A.

On 3/18/2025, I observed the public website, MiCourt Case search 2025-25-0216SM-SM, 71B District Court Caro. State of Michigan vs. Durussell. Hearing Scheduled 4/25/2025 8am scheduled for review. Charge: Vulnerable Adult Abuse 4th degree (750145N4)

On 3/24/2025, I contacted Resident A's guardian, Guardian A. Guardian A stated that he has not had any concerns about the care Resident A received in the home, prior to this incident. Guardian A stated that they go to the home on a weekly basis. Guardian A stated that the home manager, Chris Lowery, is very communicative and caring. Guardian A stated that he had met Staff Durussell previously and did not observe any abusive or neglectful behavior toward Resident A when they were there.

On 3/24/2025, I contacted Lapeer County Recipient Rights Officer (RRO) Lisa Jolly. RRO Jolly stated that she is substantiating Abuse II.

On 3/24/2025, I conducted an exit conference with Licensee Designee (LD) Tristan Schramke. I explained my findings and the rule violations I am citing. LD Schramke agreed to complete a corrective action plan to address the violations.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee,

	visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 2/14/2025, Staff Joshua Durussell was Resident A's 1:1 staff and Physical Intervention was utilized. An Incident Report was completed. On the evening of 2/17/2025, staff Martin Hayden approached Home Manager Chris Lowery and stated that Staff Joshua Durussell used excessive force on Resident A on 2/14/2025. A 2nd Incident Report was completed regarding this information and reported to the required agencies. Staff Joshua Durussell had been removed from working with Resident A until 2/18/2025, when he was suspended from his employment with The Lighthouse Inc. during the investigation. On 2/14/2025 after the Physical Intervention, Resident A had a small abrasion in the middle top portion of head. Nursing assessed and said to monitor as long as they are in baseline, no concerns at this time. Resident A received PRN diazepam 5mg total. APS Gerald Edwards substantiated for physical abuse. Recipient Rights Officer Lisa Jolly substantiated Abuse II. The Tuscola County Sheriff's Department arrested Staff Joshua Durussell, and he was arraigned on 3/11/2025 in 71-B District Court in Caro charged with Vulnerable Adult Abuse 4. Resident A continues to reside in the home with no contact from Staff Joshua Durussell. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**

ANALYSIS:	On 2/14/2025, Staff Joshua Durussell was Resident A's 1:1 staff and Physical Intervention was utilized. An Incident Report was completed. On the evening of 2/17/2025, Staff Martin Hayden approached Home Manager Chris Lowery and stated that Staff Joshua Durussell used excessive force on Resident A. A 2nd Incident Report was completed regarding this information and reported to the required agencies. Staff Joshua Durussell had been removed from working with Resident A until 2/18/2025, when he was suspended from his employment with The Lighthouse Inc. during the investigation. On 2/14/2025 after the Physical Intervention, Resident A had a small abrasion in the middle top portion of head. Nursing assessed and said to monitor as long as they are in baseline, no concerns at this time. Resident A received PRN diazepam 5mg total. APS Gerald Edwards substantiated for physical abuse. Recipient Rights Officer Lisa Jolly substantiated Abuse II. The Tuscola County Sheriff's Department arrested Staff Joshua Durussell, and he was arraigned on 3/11/2025 in 71-B District Court in Caro charged with Vulnerable Adult Abuse 4. Joshua Durussell is not suitable to be employed as staff due to pending criminal charge of Vulnerable Adult Abuse 4. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

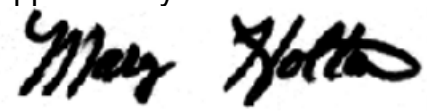
IV. RECOMMENDATION

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

3/28/2025

Cynthia Badour — Date
Licensing Consultant

Approved By:



3/28/2025

Mary E. Holton — Date
Area Manager