



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 19, 2025

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

RE: License #: AM790311143
Investigation #: 2025A0623045
Southern Cross

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.
- 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,

A handwritten signature in cursive script that reads "Cynthia Badour". The signature is written in black ink on a white background.

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 #:	AM790311143
Investigation #:	2025A0623045
Complaint Receipt Date:	07/31/2025
Investigation Initiation Date:	07/31/2025
Report Due Date:	09/29/2025
Licensee Name:	The Lighthouse, Inc.
Licensee Address:	1655 East Caro Road Caro, MI 48723
Licensee Telephone #:	(989) 673-2500
Administrator:	Dorothea Wilson
Licensee Designee:	Tristan Schramke
Name of Facility:	Southern Cross
Facility Address:	1770 Hope Drive Caro, MI 48723
Facility Telephone #:	(989) 673-4004
Original Issuance Date:	07/01/2011
License Status:	REGULAR
Effective Date:	01/05/2024
Expiration Date:	01/04/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
<ul style="list-style-type: none"> On 7/19/2025 and 7/20/2025 Resident A was given a discontinued dose of Prozac on 7/19 and 7/20. 	Yes
<ul style="list-style-type: none"> On 8/12/2025 Resident A was not given his required dose of Linzess. 	Yes

III. METHODOLOGY

07/31/2025	Special Investigation Intake 2025A0623045
07/31/2025	APS Referral I completed an APS referral
07/31/2025	Special Investigation Initiated - Letter I completed an APS complaint.
07/31/2025	Contact - Document Received AFC documents received.
08/05/2025	Inspection Completed On-site Observation and interviews.
08/14/2025	Contact - Document Received AFC documents received.
08/26/2025	Inspection Completed-BCAL Sub. Compliance
08/26/2025	Contact - Face to Face Observation and interview.
08/26/2025	Exit Conference Exit conference completed with Licensee Designee Tristan Schramke.
08/28/2025	Contact - Telephone call made I contacted staff Damon Lane.
08/28/2025	Contact - Telephone call made I contacted Wayne County Recipient Rights investigator Michele Libos.
09/18/2025	Contact - Telephone call made I contacted staff Maria Ball.

09/18/2025	Contact - Telephone call made I contacted Guardian A.
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ALLEGATION:

- On 7/19/2025 and 7/20/2025 Resident A was given a discontinued dose of Prozac on 7/19 and 7/20.
- On 8/12/2025 Resident A was not given his required dose of Linzess.

INVESTIGATION:

On 07/31/2025, I completed an Adult Protective Services (APS) compliant. I shared the allegation with APS Centralized Intake. The complaint was denied for investigation.

On 07/31/2025, I received AFC documents. On 07/31/2025, I reviewed the following Incident Reports dated 07/19/2025 and 07/20/2025. Resident A received an additional 10mg more Prozac than prescribed. Nurse was notified once error was found. Will continue to monitor Resident A and follow up with staff that administer the wrong doses (Staff Mackenzie Schmidt and Staff Damon Lane). The additional 10mg of Prozac was discontinued on 07/18/2025 but was not removed from the medication cart, the blister pack was removed when the error was discovered on 07/21/2025 by Home Manager Racheal Springer. Nursing was notified immediately and staff given written reprimands that will be placed in their permanent employment files and required to complete post med-error training.

On 07/31/2025, I reviewed the note from Nurse April Coutcher dated 07/21/2025 which stated that Dr. Movva saw Resident A last week and had increased Prozac to 40mg plus 20mg daily. The change started on Saturday; however, they did not pull out the 10mg card that was discontinued, and it appears (based off the popped pills) that he was administered the additional 10mg on Saturday and Sunday. Max dose on psychotropic consent form is 80mg daily. Resident A would have received 70mg 2 days. Med error written.

On 08/05/2025, I conducted an unannounced onsite inspection of Southern Cross. I observed Resident A and interviewed staff Mackenzie Schmidt and Home Manager (HM) Racheal Springer.

On 08/05/2025, I observed Resident A as he was being supervised at the dining room table. Resident A severe cognitive deficits. Due to his cognitive limitations which also impacted on his speech, I was unable to interview him. I did observe that Resident A appeared to be clean, neatly groomed and dressed.

On 08/05/2025, I interviewed staff Mackenzie Schmidt. Staff Schmidt stated that the med wasn't scanning for Resident A, so she went to the lead worker in charge, staff Maria Ball, and she told her to go ahead and give it to him.

On 08/05/2025, I interviewed Home Manager (HM) Racheal Springer. HM Springer stated that the new computer system for medication started on May 29, 2025. HM Springer stated that staff are med trained to scan meds and if they do not scan, they contact nursing. HM Springer stated that she discovered the med errors on 7/21/2025 and an additional incident report was written due to the discontinued Prozac card still being in the medication cart. HM Springer stated that the medication error and review write ups stated that Resident A was only to receive 60mg total with the med change and 70mg were administered. HM Springer stated to please pay attention and only pass meds that scan to prevent errors. I inquired if HM Springer had talked with staff Maria Ball telling staff Mackenzie Schmidt to go ahead and give Resident A their medication even if it wouldn't scan and was told that having talked with staff Maria Ball, she did not tell staff Mackenzie Schmidt to give Resident A his medication despite it not scanning.

On 08/14/2025, I received AFC documents. On 08/14/2025, I reviewed an Incident Report dated 08/09/2025. Staff Derick Culver failed to scan Resident A's meds while preparing to administer, resulting in a missed dose of Linzess 145 mg at 8 am. Nurse was notified, med error written for staff Culver and Resident A was monitored. Staff Culver will follow up with HR about med error.

On 08/14/2025, I reviewed Medication Error and Review document dated 08/11/2025. Signed by staff Derick Culver and Home Manager Racheal Springer. Staff failed to scan Resident A's meds while preparing to administer resulting in a missed dose. Staff Culver stated that it is not going to happen again and that he will scan them all.

On 08/14/2025, I reviewed Medication Pass Observation Review, Post Med-Error Training document which was satisfactorily completed and signed on 08/12/2025 by staff Derick Culver.

On 08/14/2025, I reviewed the note from nurse April Coutcher stating that the missed dose of Linzess is given every other day for constipation and Resident A has been having regular bowel movements with no assist needed.

On 08/14/2025, I reviewed an email from Licensee Designee Tristan Schramke. *As you are aware from your recent visit to Harbor Light, we have recently switched over to a new pharmacy with electronic M.A.R.'s, all staff that are med passers went through the training provided by Pharma script. The training is clear that med should be scanned and not checked, however the option to check the meds is still there as a back-up, such as if the scanner is malfunctioning. However, if staff are utilizing the check feature they will need to follow the three-check procedure manually. When these errors happened, the scanner was functioning properly, they were just being lazy. As for the question regarding why the staff was told to pass them anyway after the scanner didn't recognize the bar code, Mackenzie had explained to me that the error should not be her fault as she went to the person in charge at the time (Maria Ball) and was told that she should pass it anyway. I asked her if she had followed the 3 check process as she had been trained to do so and she stated that she did not, I reminded her that had she followed*

that three step process she would have noticed that 10mg dose had been D/C'ed, so the error is still her fault because she still failed to follow proper procedures. Additionally, part of the med training is to contact nursing anytime there is a problem/questions regarding medications, which she failed to do. Had she done that she would have discovered the 10mg dose had been D/C'ed. I also spoke with Maria, and she stated that she never was approached by Mackenzie that day, in fact she reminded Mackenzie in the past to utilize the scanner and not take short cuts.

Since these errors have happened, we have reached out to Pharma script and asked for guidance, they explained to the manager (Racheal Springer) how to access detailed administration reports which track how meds were signed for (either scanned or checked) previous to that conversation we were unaware of that feature. Now the managers can do random checks to make sure that staff are following proper procedures and utilizing the scan tool.

On 08/26/2025, I completed a face-to-face contact with Resident A at Southern Cross. I interviewed staff Derick Culver. Due to severe cognitive and speech deficits, I observed Resident A since he was unable to engage in an interview. I observed Resident A appeared clean, neatly groomed and dressed as he sat on the couch in the living room.

On 08/26/2025, I interviewed staff Derick Culver. Staff Culver stated that he is med trained. Staff Culver stated he missed a dose as it didn't scan. Staff Culver stated that he took responsibility for it and said it wouldn't happen again and that he would scan everything.

On 08/28/2025, I contacted staff Damon Lane. I left a voice mail message.

On 08/28/2025, I contacted Wayne County Recipient Rights (RR) investigator Michele Libos. RR Libos stated that the med errors are rights violations which would be substantiated and documented in employee files along with med re-training.

On 09/18/2025, I contacted staff Maria Ball. Staff Ball denied being approached by staff Mackenzie Schmidt and did not give verbal permission to give the Prozac medication to Resident A without scanning. Staff Ball stated that staff Schmidt did not ask her for assistance. Staff Ball stated that when meds are passed now, they must use the scanner only and cannot bypass the scanner by using the computer mouse to put a checkmark in the box located next to the medication. Staff Ball stated that she is not aware of any further med errors since scanning only has been implemented.

On 09/18/2025, I contacted Resident A's guardian, Guardian A. I left a voice mail message.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	<p>On 07/19/2025 and 07/20/2025, Resident A received an additional 10 mg of Prozac, when they were supposed to receive 60 mg, however, 70 mg was administered. The additional 10 mg of Prozac was discontinued on 07/18/2025, but was not removed from the medication cart, the blister pack was removed when the error was discovered on 07/21/2025. Nursing was notified immediately. There was no known harm to Resident A as the dose was below the maximum recommended level of 80 mg. An incident report was completed, and agencies and guardian were notified. Staff Mackenzie Schmidt and Damon Lane were given written reprimands that are placed in their permanent employment files and completed post-med error training.</p> <p>On 08/09/2025 staff Derick Culver failed to scan Resident A's meds while preparing to administer, resulting in a missed dose of Linzess 145 mg at 8 am. Nurse was notified, med error written for staff Culver and Resident A was monitored. The medication is for constipation, and a check of Resident A's bowel movements show no harm to him for the missed dose. An Incident Report was completed, and agencies and guardian were notified. Staff Derick Culver received a written reprimand placed in his permanent employment file and completed post-med error training.</p> <p>Nurse April Coutcher assessed Resident A and found no negative effects from the incorrect or missed doses. Staff monitored Resident A to ensure his continued well-being.</p> <p>The new computer system for medication was implemented on May 29, 2025. Medication errors occurred due to staff overriding the scanning feature and will be addressed by retraining and discipline.</p> <p>I conclude that there is sufficient evidence to substantiate this rule violation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 08/26/2025, I completed an exit conference with Licensee Designee (LD) Tristan Schramke. I discussed my findings and which rule violation I am substantiating. I asked LD Schramke to complete and submit a corrective action plan upon receipt of my investigation report.

IV. RECOMMENDATION

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



09/19/2025

Cynthia Badour
Licensing Consultant

Date

Approved By:



09/19/2025

Mary E. Holton
Area Manager

Date