GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR


November 16, 2021

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

RE: License #: AM790384301
Investigation #: 2021A0871044
Promised Land

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 (989) 732-8062.

Sincerely,

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**
**THIS REPORT CONTAINS QUOTED PROFANITY**

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AM790384301 |
| | |
| **Investigation #:** | 2021A0871044 |
| | |
| **Complaint Receipt Date:** | 09/30/2021 |
| | |
| **Investigation Initiation Date:** | 09/30/2021 |
| | |
| **Report Due Date:** | 11/29/2021 |
| | |
| **Licensee Name:** | The Lighthouse, Inc. |
| | |
| **Licensee Address:** | 1655 East Caro Road<br>Caro, MI 48723 |
| | |
| **Licensee Telephone #:** | (989) 673-2500 |
| | |
| **Administrator:** | Dorothea Wilson |
| | |
| **Licensee Designee:** | Tristan Schramke |
| | |
| **Name of Facility:** | Promised Land |
| | |
| **Facility Address:** | 1890 Hope Drive<br>Caro, MI 48723 |
| | |
| **Facility Telephone #:** | (989) 673-3099 |
| | |
| **Original Issuance Date:** | 11/21/2016 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 05/21/2021 |
| | |
| **Expiration Date:** | 05/20/2023 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

| | AGED<br>TRAUMATICALLY BRAIN INJURED |
|---|---|

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff Kaitlyn Lunch was tapping Resident A on his head because he was biting himself. Ms. Lynch should have been using a blocking technique or something other than tapping his forehead. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/30/2021 | Special Investigation Intake<br>2021A0871044 |
| 09/30/2021 | Special Investigation Initiated - Letter<br>Received statements from staff members |
| 10/20/2021 | Inspection Completed On-site<br>Interviewed Staff Dylan Bates, Staff Liz Sagash, observed Resident A |
| 10/20/2021 | Contact - Telephone call made<br>Interviewed Staff Kaitlyn Lynch via telephone |
| 10/20/2021 | Exit Conference |
| 11/03/2021 | Contact - Telephone call made<br>Interviewed Resident A's Guardian 1 via telephone |
| 11/04/2021 | Contact - Telephone call made<br>Interviewed Staff Dylan Bates via telephone |

**ALLEGATION:**

Staff Kaitlyn Lunch was tapping Resident A on his head because he was biting himself. Ms. Lynch should have been using a blocking technique or something other than tapping his forehead.

**INVESTIGATION:**

On September 27, 2021, I received an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Licensee Tristan Schramke on September 27, 2021. It indicates what happened on September 25, 2021 @ 8:30 pm, “Kaitlyn was tapping [Resident A] on his head because he was biting himself. Kaitlyn should

have been using a blocking technique or something other than tapping his forehead." Action taken indicates reported to R/S, statements given." Corrective measures stated, "Per on call Wilson (Tristan) staff is unable to work in a CMH building until further notice."

On October 20, 2021, I conducted an onsite investigation and interviewed Staff Dylan Bate. Mr. Bates stated that Staff Michael Vandecar was in the living room and noticed that Resident A had not gone to the bathroom all shift and he is supposed to be toileted every two hours. Mr. Bates stated that Mr. Vandecar took Resident A to the bathroom and then to his bedroom. Mr. Vandecar told Staff Kaitlyn Lynch that she was supposed to take Resident A to bathroom and then get him ready for bed.

Mr. Bates said he also went into Resident A's bedroom and Ms. Lynch was putting Resident A in the middle of the bed. Mr. Bates indicated Resident A "was kicking his feet and rolled out of bed." Ms. Lynch than picked Resident A up under his arms set him towards the pillow. Mr. Bates stated Ms. Lynch said, "she didn't want to deal with it" and that she "was sick and tired of it." Mr. Bates said Ms. Lynch "palmed him on the forehead." Mr. Bates said she did it "three or four times, it was loud on his forehead," and it was loud enough for other staff to hear it. Mr. Bates stated Ms. Lynch "then stormed off and went outside."

I then interviewed Staff Liz Sagash on October 20, 2021. Ms. Sagash said around 4pm on the shift, she noticed that Ms. Lynch "didn't do any work." Ms. Sagash said around 8 pm, she noticed that Resident A had not been toileted all day. Ms. Sagash said Staff Michael Vandecar mentioned that at 8 pm, he took Resident A to the bathroom. Ms. Sagash said, "Kaitlyn [Ms. Lynch] was just sitting and not doing anything all day, playing videos, and eating all day." Ms. Sagash said as Mr. Vandecar was bringing Resident A out of the bathroom, Ms. Lynch was passing meds. Ms. Sagash said Resident A "started getting upset." Ms. Sagash said Ms. Lynch completed passing meds and was assigned to Resident A. Ms. Sagash stated Ms. Lynch started to help with Resident A and said, "If you don't knock that shit off, I'm not going to take care of you." Ms. Lynch then went into Resident A's bedroom and Ms. Sagash also went into Resident A's bedroom and was concerned about Resident A. Ms. Sagash said Resident A pulled his bed out from the wall. Ms. Sagash said Ms. Lynch put her arms under his and picked him up. Ms. Sagash told Ms. Lynch to put Resident A's bed rail up. Ms. Sagash said Ms. Lynch then "started slapping his forehead" and "she did it about three or four times." Ms. Sagash told Ms. Lynch "knock it off." Ms. Sagash was really upset and did not leave Ms. Lynch alone with Resident A. Ms. Sagash said Ms. Lynch walked out of the room and then she put the bed rails up. Ms. Sagash said Resident A calmed down. There was not a bruise or mark on Resident A but "you could still her it, it was loud enough."

On October 20, 2021, I interviewed Staff Kaitlyn Lynch via telephone. Ms. Lynch reported that she worked second shift, which was 3 to 11pm on September 25, 2021. Ms. Lynch indicated she had Resident A assigned to her. Ms. Lynch said she

was helping new staff and at 4:30pm, she took Resident A to the bathroom and got him back into his chair. Ms. Lynch said she gave Resident A dinner between 5:20 – 6:15 pm. Ms. Lynch said another resident wanted to go for a golf cart ride, so she took that resident for a ride from 6:15-6:45 pm. Ms. Lynch reported that she did not take Resident A to the bathroom at 6:30 pm. Ms. Lynch said Staff Mike Vandecar would have known to take Resident A to the bathroom at 6:30 and no one said anything to her about no toileting Resident A at 6:30pm. Ms. Lynch stated the other resident again asked her to take him for another golf cart ride and she took him from about 7-7:40 pm and came back to the building. Ms. Lynch said she gave the residents their meds at 8 pm. Ms. Lynch reported Resident A was in the bedroom when she got back from the golf ride and "it was a normal transfer to bed." Ms. Lynch said other staff helped her and she thanked them for it. Ms. Lynch said Mr. Vandecar "made a rude comment" and she just walked away. Ms. Lynch stated she pushed Resident A's head back so he would not bite his wrist and "tapped him on the forehead with two fingers" and he stopped biting himself. Ms. Lynch said Resident A covered his head up and there were no more incidents.

On October 20, 2021, I observed Resident A. Resident A is severely cognitively impaired and unable to provide any information. There were no bruises or marks noted on Resident A.

On November 4, 2021, I telephoned Resident A's Guardian 1. Guardian 1 said she "had no other concerns about the care [Resident A] receives." Guardian 1 said Resident A gets violent and his behavior has gotten worse. Guardian 1 indicated it was inappropriate for Staff Kaitlyn Lynch to tap him on the head and she should have used other measures. Guardian 1 stated she has no worries about the staff providing care for Resident A.

On November 9, 2021, Licensee Tristan Schramke emailed me a copy of Resident A's 'Social Work Behavior Program' that was signed and dated on 03/16/2021 by Carley Walker, LMSW. Ms. Walker wrote in the 'Methodology/Individual Needs' section for Resident A:

1. 'When transitioning to a new activity, help [Resident A] with this transition. Plan enough time that you do not have to rush [Resident A] if at all possible.'
2. 'Keeping Active: Offer going for walks, games, puzzles, or other positive distracting activities.'
3. 'Coping skills: Encourage [Resident A's] music as a coping skill. Other options are utilizing the rocking chair when upset.'
4. 'Whenever possible, offer choices to promote [Resident A's] ability to make decisions regarding various aspects of his life. This can include, but is not limited to preferred activities.'
5. 'When [Resident A] becomes upset, avoid saying 'no,' 'stop,' etc. Instead, redirect him to what he can do. Attempt to soothe him and assure him that he is safe. Suggest that [Resident A] take deep breaths. Praise him for doing it.'

On October 20, 2021, I conducted a fac-to-face exit conference with Licensee Tristan Schramke. I advised Licensee Schramke that there would be a rule cited with this complaint.

| APPLICABLE RULE | |
|---|---|
| **R 400.14303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.** |
| **ANALYSIS:** | Staff Dylan Bates and Staff Liz Sagash witnessed Staff Kaitlyn Lynch tap Resident A on the forehead. Mr. Bates and Ms. Sagash said it was loud enough to hear the taps. Ms. Lynch stated she tapped Resident A on the forehead with her two fingers. 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).

Kathryn Huber 11/16/2021

Kathryn A. Huber Date
Licensing Consultant

Approved By:

Mary Holton 11/16/2021

Mary E Holton Date
Area Manager