GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 24, 2021

Matthew Dennis
The Lighthouse, Inc.
PO Box 289
Caro, MI 48723

RE: License #: AS790368897
Investigation #: 2022A0871001
Stoney Brooke

Dear Mr. Dennis:

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 #:	AS790368897
Investigation #:	2022A0871001
Complaint Receipt Date:	10/13/2021
Investigation Initiation Date:	10/14/2021
Report Due Date:	12/12/2021
Licensee Name:	The Lighthouse, Inc.
Licensee Address:	1655 East Caro Road Caro, MI 48723
Licensee Telephone #:	(989) 673-2500
Administrator:	Dorothea Wilson
Licensee Designee:	Matthew Dennis
Name of Facility:	Stoney Brooke
Facility Address:	1570 Lighthouse Lane Caro, MI 48723
Facility Telephone #:	(989) 673-2500
Original Issuance Date:	06/22/2015
License **Status:**	REGULAR
Effective Date:	12/22/2019
Expiration Date:	12/21/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Austin Dennis reported that Staff Brian Ewald utilized an unapproved physical management technique on Resident A. According to Staff Austin Dennis, Staff Brian Ewald pushed Resident A in the chest to get Resident A to move out of his personal space, causing Resident A to trip and fall.	Yes

III. METHODOLOGY

10/13/2021	Special Investigation Intake 2022A0871001
10/14/2021	Special Investigation Initiated - Letter Received statements from Staff Caleb Montei, Jeremy Burley, Thelma Dicks
11/23/2021	Inspection Completed On-site Interviewed Resident A and Staff Brian Ewald
11/23/2021	Exit Conference Face-to-face exit conference with Licensee Matthew Dennis
11/23/2021	Inspection Completed-BCAL Sub. Compliance
11/24/2021	Contact - Telephone call made Telephone call to Staff Austin Dennis, he did not answer, and his mailbox is full. Could not leave message.
11/24/2021	APS Referral Through Central Intake to Tuscola County MDHHS

ALLEGATION:

Staff Austin Dennis reported that Staff Brian Ewald utilized an unapproved physical management technique on Resident A. According to Staff Austin Dennis, Staff Brian Ewald pushed Resident A in the chest to get Resident A to move out of his personal space, causing Resident A to trip and fall.

INVESTIGATION:

On October 12, I received an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Licensee Designee Tristan Schramke. What happened indicates "It was reported by Austin Dennis (staff) that Brian Ewald (staff) utilized an unapproved physical management technique on [Resident A]. According to Austin, Brian pushed [Resident A] in the chest to get [Resident A] out of personal space, causing [Resident A] to trip and fall." Action taken indicates "The matter was reported to Licensing and Brian Ewald was removed from working directly with [Resident A]."

On October 11, 2021, Staff Jeremy Burley was called to Stoney Brooke by Nurse Thelma Dicks. Mr. Burley wrote a statement that indicates "The third shift nurse called me to Stoney Brooke, she needed help ASAP due to a resident being agitated. I got to SB (Stoney Brooke) and [Resident A] was agitated, swearing at staff, and calling them liars. [Resident A] picked up the end of the table and slammed it on the ground and broke the support. [Resident A] said he was not trying to take off, he was extremely upset with Brian and said that he continued to be put up at Stoney Brooke that he would have problems every night. [Resident A] didn't take his PRN right away after he started to calm down some, he finally took the PRN. The staff that were at SB were moved, Brian was moved to HL (Harbor Light) an Austin was moved to NS (North Star). Caleb replaced Brian at SB and Chase replaced Austin at SB. [Resident A] was more calm and relaxed after the staff were changed out that was done to further de-escalate the situation."

I also received a statement that was written by Nurse Thelma Dicks on October 11, 2021. It indicates "This morning around 1am while I was on the phone with other building I heard 'yelling/commotion' outside in the common area. I know it would be [Resident A] since the staff told me few minutes prior to that [Resident A] has a headache and I said you will be giving a Tylenol. I had to drop the call to who I was talking to come out to the living area and seen [Resident A] on the floor, he was yelling nurse! Nurse! He pushed me (pointing to Staff Brian E.). I called staff Jeremey Burley to come here. [Resident A] stood up really fast from sitting position and came towards me, saying he has no right to do that. I encouraged [Resident A] to have a seat and we will find out exactly what happened. I offered him a Tylenol for his headache and also offered Xanax to help calm him down. He did not take it right away, but Jeremy explained and encouraged hm to take it to help. [Resident A]

is crying at this time. I had the in charge look at his upper body ([Resident A] ripped his shirt off) for marks. I visually did not see any from 5-6 feet apart from him."

On October 12, 2021, I received a statement that was written by Staff Austin Dennis on October 11, 2021. It indicates "[Resident A] woke up at 2:30 am and asked if he could get a yogurt. In charge (Staff Brian Ewald) informed him he could not get one himself because he had been stealing food. This made [Resident A] very upset and he told IN charge 'I don't steal mother fucker. In charge then repeatedly asked [Resident A] 'what did you call me.' [Resident A] continued to ignore the question and said, 'you don't wanna pick a fight with me' and then he got in the IN charges' face which made IN charge push him away. [Resident A] got even more upset and said, 'fuck this I'm out of here' and he made his way toward the door. IN charge blocked [Resident A] from exiting the building and [Resident A] started to get aggressive with IN charge and putting his hands on IN charge which made in charge grab [Resident A] by the shirt up by his throat and he pushed him back and [Resident A] fell over the arm of the recliner on to the floor. [Resident A] screamed for the nurse and told the nurse IN charge grabbed him by the throat. [Resident A] called me and IN charge 'fucking liars.' Nurse and supervisor prompted [Resident A] to take PRN to calm down. [Resident A] started to cry and stated, 'get me out of here or don't let that fucking IN charge back in this building.' [Resident A] called me a 'punk' and said, 'come at me and see what happens."

On November 24, 2021, I interviewed Staff Austin Dennis via telephone. Mr. Dennis indicated that Resident A got up and wanted something out of the refrigerator. Mr. Dennis said Staff Brian Ewald told him 'you can't get something out of the fridge.' Resident A then called Mr. Ewald a 'mother fucker.' Mr. Dennis indicated Mr. Ewald "should have left if alone" and that Mr. Ewald kept asking Resident A 'what did you call me.' Mr. Dennis reported that Resident A got more upset and then walked to the door. Mr. Dennis said, "there was a lot of pushing and shoving." Mr. Dennis indicated that Resident A fell over the chair. Mr. Dennis also said Mr. Ewald grabbed Resident A by the shirt and not the neck. Mr. Dennis stated the nurse came out and Resident A yelled for her. Mr. Dennis feels that if Mr. Ewald would have left Resident A alone, the incident would not have escalated.

On October 11, 2021, I received a statement that was written by Staff Brian Ewald. Mr. Ewald wrote "at 2:15 [Resident A] came out of his room asking for Tylenol for a headache. In charge staff asked the nurse if it was ok to give [Resident A] Tylenol for a headache, nurse approved PRN of Tylenol. As [Resident A] is not allowed to be in the refrigerator at all times per his program, in charge staff told [Resident A] to stay out of the refrigerator. In charge staff then proceeded to get [Resident A] a blueberry yogurt. [Resident A] then said he did not want that kind of yogurt and preferred another kind. In charge staff did not see any blueberry yogurt in the other side. [Resident A] reached in the refrigerator and flipped all the yogurts around with his hand and found a blueberry yogurt on that side. In charge staff told him I was sorry that I did not see the blueberry on that side. [Resident A] then yelled out 'you mother fucker' at in charge staff and headed in his direction. In charge told him he

was not allowed to speak to staff that way. [Resident A] headed towards the front door and said he was leaving the building. In charge staff blocked the doorway and was redirected. [Resident A] became verbally and physically aggressive. Staff protected himself and performed safety care by bringing [Resident A] to the floor with no known injuries. When [Resident A] was on the floor staff continued to block him. [Resident A] got up and continued to be verbally aggressive towards staff. Nurse tried to redirect [Resident A] and asked if he wanted a PRN of Xanax with his Tylenol. Home manager arrived to help de-escalate [Resident A] as he was still verbally agitated. Threats were made toward in charge staff until he left the building."

On October 23, 2021, I interviewed Staff Brian Ewald at the facility. Mr. Ewald stated that [Resident A's] behaviors have been escalating regarding going into the refrigerator. Mr. Ewald indicated Resident A came out of his room and went to the refrigerator and he told him not to go into the refrigerator. Mr. Ewald stated Resident A wanted a yogurt and when Mr. Ewald looked in the refrigerator, he did not see the kind of yogurt Resident A wanted. Resident A told Mr. Ewald "yes, it is" and he opened the refrigerator and found it. Mr. Ewald indicated Resident A went back over to the table and stood by the counter. Mr. Ewald told Resident A that he is not allowed in the refrigerator. Mr. Ewald report Resident A "exploded and went to the front door." Mr. Ewald got up and blocked the door because he did not want Resident A to elope. Mr. Ewald said the first safety care was to block the door but Resident A then "bolted toward the door." Mr. Ewald said Resident A had "his right hand in my face, looking like a threatening situation." Mr. Ewald grabbed his sweatshirt with one hand and moved him away. Resident A started going to the floor while Mr. Ewald was holding him. Mr. Ewald reported that later Resident A said, "I should have hit you." Resident A started going to the floor and "I was keeping him safe." Mr. Ewald said he was holding his sweatshirt with one hand while he went to the floor and was trying to keep him safe. Mr. Ewald said proper safety care was not possible because "it happened so fast, and I was trying to keep myself and [Resident A] safe." Mr. Ewald said Resident A "never tried to attack him anymore." Mr. Ewald said he could see this coming because Resident A "had a lot of pent-up anger."

On October 12, 2021, I received a written statement from Staff Caleb Montei who interviewed Resident A on October 11, 2021. Mr. Montei noted ([Resident A] was very insistent on not having a physical copy of this note in his book. I told him I would only send it as an email and wouldn't print a physical copy. He also wanted to be certain the hand printed notes were shredded.) Mr. Montei indicates the statement given by Resident A was written @330 on 10-11-21. The statement written by Mr. Montei verbalized by [Resident A] indicates "I got out of bed to get a yogurt and Tylenol for a headache. Brian said, 'You can't get in the fridge, you're a thief.' Resident A said 'Fuck you! I haven't stolen in some time, you're a fucking asshole! Brian grabbed me by the throat, he had some skin and my shirt. I told him 'Get your fucking hands off me!' Brian said "you ain't leaving!' I said, 'I already know that!' Brian said, 'You're trying to leave!' I said, 'You're fucking crazy!' Brian

then started shoving me backwards, he let go of my neck and shoved/hit me in the face. He shoved me backwards into the recliner, I tripped over the right arm and hit the back of my head on the coffee cart as I fell to the floor. I landed on my back. He grabbed me again by the chest/shirt and held me down saying, 'Stay down! Stay down! You're not leaving!' While he was doing that, I'm yelling, 'HELP! HELP! Nurse!' I don't know when or why he let me go. I got up and moved to Thelma (Nurse) saying, 'I wasn't leaving!' She offered me my PRN. I didn't want it right then. During all of that, the other staff (Austin) didn't do or say anything. I sat at the table trying to calm down. Afterward, Brian and Austin talked about what happened, Brian was telling Austin what to say, coaching him. When I tried to interrupt to correct them, they both would say, 'You're lying.' I will admit that I was wrong in the begining, but I didn't do anything to deserve what he did. I don't like him, I hate the man, I despise him and don't want him here. And that kid Austin is a punk, he ain't nothing but a punk. I don't want him here either."

On November 23, 2021, I also interviewed Resident A at the facility. Resident A said, "I personally don't care for him (Brian)." Resident A said he has ignored his abuse for a long time but did not say what the abuse was. Resident A told Mr. Ewald "fuck you" and Mr. Ewald said, 'what did you say?' Resident A again said, "fuck you." Resident A said, "he thought I was going out the door but did not mean that I was leaving." Resident A said I was not going to leave and all I wanted to do is get the nurse. Resident A said Mr. Ewald "kept grabbing me and I tried to push him off." Resident A said Mr. Ewald would not let go. Resident A said Mr. Ewald "grabbed me by the throat and I was screaming for the nurse." Resident A Resident A said Mr. Ewald tried to take him down and tripped him. Resident A said he was near the door and Mr. Ewald "thought I was going to elope." Resident A said he again grabbed me by the throat and tried to get me on the ground. Resident A said Mr. Ewald pushed him by the chair and Mr. Ewald got on top of him. Resident A said when he took him to the ground, he tried grabbing and pushed him by the neck.

Resident A said when he saw Mr. Ewald at the facility today, he was going to apologize to him, but staff told him to stay away. Resident A said he "wanted to work through it."

On November 24, 2021, Licensee Matthew Dennis gave me a copy of Resident A's Behavioral Program which was written on 10/04/2019 and has been continued. An addendum to Resident A's Behavioral Program was updated on 01/21/2021 and on 05/11/2021, and was written by Psychologist Michelle Culton-Ekstrom. It indicates "Any snack [Resident A] is making at night (regardless of whether it is his or Lighthouse food) must be prepared, consumed and any mess cleaned up by 10:45 PM. If cleanup extends beyond 10:45 notify psychologist to determine if the privilege will be permitted the next opportunity." It also indicates "If [Resident A] is demonstrating behavior, which in the staff's opinion constitutes a risk to self or others or is behavior which is not deemed appropriate for the community, there will be no community outing." In the privileges section of Resident A's Behavior Program indicates "In order to maintain his out-of-town position, [Resident A] must engage in

safe actions. If [Resident A] has a physical aggression toward self or others in any setting, the following step is to be implemented:
*[Resident A] will be suspended from his position for 7 days."

I also received pictures of bruising and an assessment of the bruising from Registered Nurse Carly Teachout that she observed on October 12, 2021. Nurse Teachout reported "I assessed [Resident A's] arm. He has the bruise (that's clearly a bruise) on his upper left bicep. The one on his forearm (left), however does have a 'rash' like appearance, but a mark like that could also be caused by friction with applied pressure. Similar to a rug burn for example."

On November 23, 2021, I conducted a face-to-face exit conference with Licensee Matthew Dennis. I advised Licensee Dennis there would be a rule violation cited with this complaint.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Staff Austin Dennis observed Staff Brian Ewald push Resident A, and Resident A fell and did have bruising on him. Staff Brian Ewald admitted he did not follow Resident A's Behavioral Program. Resident A did have bruising that resulted from the fall. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

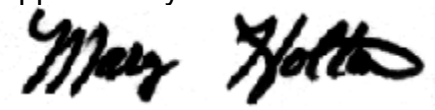
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

11/29/2021

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



11/29/2021

Mary E Holton — Date
Area Manager