GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 19, 2022

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

RE: License #: AS790366587
Investigation #: 2022A0871053
North Star

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 115 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

I. IDENTIFYING INFORMATION

License #:	AS790366587
Investigation #:	2022A0871053
Complaint Receipt Date:	08/31/2022
Investigation Initiation Date:	09/01/2022
Report Due Date:	10/30/2022
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:	North Star
Facility Address:	1801 Hope Drive Caro, MI 48723
Facility Telephone #:	(989) 673-2500
Original Issuance Date:	03/11/2015
License **Status:**	REGULAR
Effective Date:	09/11/2021
Expiration Date:	09/10/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
During a social work session, Resident A reported that during a physical management on 08/28/22, that the "old man punched him in the face after Resident A kicked him."	No
Additional Findings	Yes

III. METHODOLOGY

08/31/2022	Special Investigation Intake 2022A0871053
08/31/2022	APS Referral Through Central Intake to Tuscola County MDHHS
09/01/2022	Special Investigation Initiated - Letter Received information from Licensee Tristan Schramke
09/15/2022	Inspection Completed On-site Interviewed Licensee Tristan Schramke, Staff Members Brian Ewald, Jeremy Burley, Mike Lamb, Chase Whitfield, and Resident A.
10/18/2022	Exit Conference Face-to-face exit conference with Licensee Tristan Schramke

ALLEGATION:

During a social work session, Resident A reported that during a physical management on 08/28/22, that the "old man punched him in the face after Resident A kicked him."

INVESTIGATION:

On August 29, 2022, I received an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Licensee Tristan Schramke on August 29, 2022. The date and time of the incident indicates 08/28/22 @ 4:00 am. What happened indicates "During a social work session today (08/29/22), [Resident A] reported to his SW that during the physical management on 8-28-22 that the "old man" punched him in the face after he [Resident A] kicked the "old man" in the face." Action taken indicates "Initiated an investigation, reported to APS and Licensing."

On September 15, 2022, I conducted an onsite investigation and interviewed Staff Brian Ewald. Mr. Ewald reported that he worked third shift on August 28, 2022, from 11 pm to 7 am and the incident happened about 3:30 or 4 am. Mr. Ewald said he prompted Resident A throughout the night to turn off his electronics. Mr. Ewald said all of Resident A's electronics need to be shut off at 11 pm. Resident A was in his room with his tv on and he would not turn it down. Mr. Ewald went into his room and Resident A "was throwing stuff in his room." Resident A was angry because the tv (video game) was talking back to him. Resident A "frequently wants to do things that he is not allowed to do" and he was supposed to have his tv off. Mr. Ewald reported Resident A "already had a PRN" and he was keeping the resident in the next room awake. Mr. Ewald indicated Resident A threatened to hit another resident and Resident A was picking on that resident all day. Mr. Ewald turned the tv off and Resident A grabbed his legs and pulled him down on him. Mr. Ewald said he hit Resident A's face when he pulled him down on him. Mr. Ewald reported that he tried to get up but Resident A "rolled over and spit on me." Resident A hit Mr. Ewald's face and his nose was bleeding. Staff Josh James came in and they tried to get him in control, and Mr. James was blocking Resident A. Mr. Ewald stood up and Resident A grabbed his groin. Mr. Ewald was able to get free and called the neighboring AFC for help. Mr. Ewald said Resident A "assaulted me numerous times." I asked Mr. Ewald if he punched Resident A in the face and he denied that he punched Resident A.

I then interviewed Staff Jeremy Burley. Mr. Burley reported that he was called over from Harbor Light by Mr. James. Mr. Burley reported when he came over, Resident A was "in the hallway kicking and hitting" and they went into a three-person supine home. Mr. Burley was on Resident A's right arm, Mr. Ewald was on his left, and Mr. James was on his legs. Mr. Burley reported Resident A "was still trying to punch Brian in the head." Staff Chase Whitfield came over as well and released Mr. Ewald. Resident A slid into his closed and was still attempted to kick at staff. Resident A slide out of the closed and "punched Chase in the groin." Staff Mike Lamb also came over to help and they released his hold. Mr. Burley indicated Resident A wanted to speak to third shift Manager Tabitha Smith and she did go into Resident A's room. Manager Smith was able to calm Resident A down and Staff Chase Whitfield got Resident A to go back to bed.

On September 15, 2022, I then interviewed Staff Mike Lamb. Mr. Lamb reported he was working at Southern Cross, and he got called to the home by a manger to come to North Star to help. When Mr. Lamb arrived, he came in the front door and Resident A was in the hallway. Mr. Lamb relieved Staff Jeremy Burley doing the three-person supine hold on Resident A. As Mr. Lamb was holding Resident A, "he swung at Chase." Resident A then asked to talk to Manager Smith and Mr. Chase Whitfield and Manager Smith stayed with Resident A. Mr. Lamb does not know what happened prior that made Resident A so upset. Mr. Lamb did not see anyone hit or punch Resident A.

Mr. Chase Whitfield was then interviewed at the onsite investigation. Mr. Whitfield indicated he was called to come over and when he got there, Resident A was in a supine hold in the hallway. Mr. Ewald was on Resident A's left arm and Mr. Whitfield relieved him. Mr. Whitfield reported that Resident A "was trying to him (Brian) in the head." Mr. Whitfield stated Resident A "reached over and punched me" and he kept trying to spit in his face. Manager Tabitha Smith came into the room and talked to Resident A. Manager Smith calmed him down and "I laid Resident A in bed and tucked him in." Resident A finally went to sleep, and he stayed outside of Resident A's room, as he has a good rapport with Resident A. Mr. Whitfield reported no one punched Resident A and everything was done as it should have.

On October 18, 2022, I interviewed Resident B, the Resident that occupies the room right next to Resident A's room. Resident B said, "I heard a thump in the next room." Resident B then said he had nothing else to say. I also observed Resident A's room and he is the only occupant of the bedroom, and it can only have one resident. Resident B is in the room next to Resident A.

On September 15, 2022, Licensee Tristan Schramke said Resident A does not have a roommate but the resident in the next bedroom could hear Resident A throwing and banging things.

On September 15, 2022, I interviewed Resident A. I asked Resident A how he is doing, and he said he "is doing good but he don't like staff." When I asked Resident A who punched him in the face he replied, "I don't want to snitch" and said it was the only time he got punched. Resident A then said he was punched before "on my right eye" and he "don't like any of them." Resident A said he does what they (staff) say just to please them.

Licensee Tristan Schramke gave me a copy of Resident A's 'Social Work Behavior Plan' that was signed and dated on September 17, 2021, by Carley Walker, MSW. The Methodology/Individual Needs indicates '1. Music: [Resident A] should listen to music at an appropriate volume. If his music is disrupting others, encourage him to listen to it outside or in the back room of North Star. If [Resident A] is playing loud music at inappropriate times, such as on 3rd shift, staff will take away the music device until morning.' Section 3 indicates 'Electronics: All electronics should be turned off at shift change (11:00 PM). If they are used throughout the night, they will be locked up in the office the following night."

I also received a copy of Resident A's 'Behavior Management Plan' which was signed and dated by Resident A's Guardian A1 on September 21, 2022. It indicates for 'Emergency Physical Management' the following:

'The Lighthouse does utilize personal restraint as defined by Act 116, 722.112b(h). In response to emergency safety situations, personal restraint is defined as "the application of physical force without the use of a device, for the purpose of restraining the free movement of a resident's body." In any emergency situation,

only a single staff member may utilize physical restraint until other staff can be of assistance.'

'Physical management may be utilized in emergency situations to prevent a resident from injuring self or others. Physical management is not utilized as a means of "coercion, discipline, convenience or retaliation.'

On September 27, 2022, I asked Licensee Tristan Schramke for a copy of the *AFC Licensing Division – Incident/Accident Report* regarding the physical aggression of Resident A towards Staff Brian Ewald. Licensee Schramke indicated there was no other *AFC Licensing Division – Incident/Accident Report* completed.

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:	Staff Brian Ewald denied punching Resident A in the face. Staff Jeremy Burley said Resident A was trying to punch Mr. Ewald in the face and Mr. Ewald did not punch him in the face. Staff Mike Lamb and Staff Chase Whitfield, both said no one hit or punched Resident A. Resident A did not provide any information about who punched him. There is not substantial evidence to confirm violation of this rule.
CONCLUSION:	**VIOLAITON NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On September 27, 2022, I asked Licensee Tristan Schramke for a copy of the *AFC Licensing Division – Incident/Accident Report* regarding the physical aggression of Resident A towards Staff Brian Ewald. Licensee Schramke indicated there was no other *AFC Licensing Division – Incident/Accident Report* completed.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (c) Incidents that involve any of the following: (iii) Attempts at self-inflicted harm or harm to others.
ANALYSIS:	An *AFC Licensing Division – Incident/Accident Report* was not completed for the aggression and harm that Resident A did to Staff Brian Ewald. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On October 14, 2022, I conducted a telephone exit conference with Licensee Tristan Schramke. Licensee Schramke was advised that an *AFC Licensing Division – Incident Accident Report* must be completed when a resident is aggressive toward a staff or other resident.

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).

Kathryn Huber 10/19/2022

Kathryn A. Huber Date
Licensing Consultant

Approved By:

Mary Holton 10/19/2022

Mary E. Holton Date
Area Manager