STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

February 8, 2023

Brant Wilson
The Lighthouse-Traverse City LLC
4040 Beacon St
Kingsley, MI 49649

RE: License #: AM280286819
Investigation #: 2023A0230018
Beacon of the North

Dear Mr. Wilson:

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 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 (231) 922-5309.

Sincerely,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM280286819
Investigation #:	2023A0230018
Complaint Receipt Date:	01/18/2023
Investigation Initiation Date:	01/18/2023
Report Due Date:	03/19/2023
Licensee Name:	The Lighthouse-Traverse City LLC
Licensee Address:	1655 East Caro Road, Caro, MI 48723
Licensee Telephone #:	(231) 263-1350
Administrator:	Rebecca Noffke
Licensee Designee:	Brant Wilson
Name of Facility:	Beacon of the North
Facility Address:	4160 Beacon Street, Kingsley, MI 49649
Facility Telephone #:	(231) 263-1353
Original Issuance Date:	09/04/2008
License Status:	REGULAR
Effective Date:	04/08/2021
Expiration Date:	04/07/2023
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS, TRAUMATICALLY BRAIN INJURED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's finger was sprained when staff grabbed her hand forcibly.	Yes

III. METHODOLOGY

01/18/2023	Special Investigation Intake 2023A0230018
01/18/2023	Special Investigation Initiated - On Site Interview with Administrator Jackie Davis, Resident A, and Staff member Tammy Hartsell
01/19/2023	APS Referral
01/31/2023	Contact - Telephone call made staff member Allyssa Deloach
01/31/2023	Contact - Telephone call made staff member Lillian Molholland
02/07/2023	Exit Conference With Administrator Rebecca Noffke

ALLEGATION: Resident A's finger was sprained when staff grabbed her hand forcibly.

INVESTIGATION: On 01/18/2023, I conducted an unannounced on-site investigation at the facility and interviewed staff members Jackie Davis, Tammy Hartsell and Resident A regarding the above allegation.

Ms. Davis stated that staff member Tammy Hartsell had received a written disciplinary action for grabbing a granola bar out of Resident A’s hand on 01/10/2023. Resident A stated her hand hurt. She was assessed by the facility nurse and sent to urgent care for evaluation. She was diagnosed at urgent care with a sprained finger. Ms. Davis stated this was an uncharacteristic action on the part of Ms. Hartsell, but she and the other management team members felt it was unacceptable. Ms. Hartsell is still currently working at the facility however she is not working directly with Resident A.

Ms. Hartsell stated that on 01/10/2023, Resident A had walked over to the unlocked snack cupboard and grabbed a granola bar out of her tote. She explained all

residents have individual totes in the pantry with their own snacks. She stated there are designated snack times and this was outside the designated time as dinner was to be served within the next 45 minutes. She asked Resident A what she was doing, and Resident A would not answer her. She stated she asked Resident A twice to give her the snack to which Resident A replied, “You can’t make me give it to you.” Ms. Hartsell stated she asked one more time for the snack and Resident A refused. Ms. Hartsell stated she then stuck her finger into Resident A’s hand and “popped it out of her hand.” She stated Resident A then became angry and tried to hit her. At this time another staff member stepped in between her and Resident A, blocked the snacks and locked the snack cupboard. Resident A then became upset, walked back to her room, and called her mother. Ms. Hartsell stated she was not intentionally trying to hurt Resident A but was just trying to get the snack from her hand.

Resident A stated that on 01/10/2023, she woke up from a nap and it was nearly 4:00 p.m., which was about an hour prior to dinner. She stated she went to go get a snack but did not ask staff. Resident A stated, “I took it out of my tote, a simple, healthy, plain granola bar when Tammy physically, and forcibly took the granola bar out of my hand.” Resident A stated Ms. Hartsell told her, “You can’t have that It’s just an hour before dinner.” Resident A stated after the incident she stated that her hand hurt so Ms. Hartsell went over to another building and got the nurse, who looked it over and advised she go to Urgent Care. Resident A stated, “At Urgent Care they gave me a splint and said it was not broken but it was sprained.” She was not wearing her splint at the time of the interview and stated it no longer hurt.

On 01/31/2023, I interviewed staff members Alyssa Deloach and Liliian Molholland who were both working at the time of the incident. Ms. Deloach stated that Resident A went to the pantry, got into it, and grabbed a snack. Ms. Hartsell asked Resident A what she was doing several times and Resident A ignored her. Ms. Hartsell then walked over to the pantry asking one more time when Resident A stated, “I am getting a snack.” Ms. Hartsell stated it was not snack time so Resident A needed to give her the snack. Resident A became angry and began to shout at Ms. Hartsell telling her, “You can’t make me give it to you.” Ms. Deloach then stepped into the pantry between Resident A and Ms. Hartsell. At this time Ms. Hartsell took the snack by placing her finger between the snack and Resident A’s hand. Ms. Hartsell handed the snack to Ms. Deloach. Resident A became angry and attempted to hit Ms. Hartsell, then went to her room, slammed her door, and called her mother,

Ms. Molholland stated that she observed Resident A walk over to the pantry when Ms. Hartsell asked her what she was doing. Resident A ignored her several times and proceeded to get her snack. Ms. Hartsell told her it was no longer snack time and to either put the snack back or give it to Ms. Hartsell. Resident A stated, “You can’t make me give it to you.” Ms. Hartsell then stuck her finger into Resident A’s hand and removed the snack. Resident A eventually went to her room after attempting to hit Ms. Hartsell.

On 02/07/2023, I conducted an exit conference with Administrator Rebecca Noffke. She stated she would provide a plan of correction, which will include retraining of staff member Tammy Hartsell on appropriate behavior intervention techniques. Ms. Hartsell also will not be allowed to work directly with Resident A.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on statements from Resident A, two staff members as well as Ms. Hartsell it was determined that physical force was used on Resident A by staff member Tammy Hartsell. This physical force resulted in a sprain of Resident A's finger.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction I recommend the status of this license remain unchanged.

02/08/2023

Rhonda Richards — Date
Licensing Consultant

Approved By:

02/08/2023

Jerry Hendrick — Date
Area Manager