GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 19, 2023

Dorothea Wilson
The Lighthouse, Inc.
PO Box 289
Caro, MI 48723

RE: License #: AM790311143
Investigation #: 2024A0580009
Southern Cross

Dear Dorthea 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 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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM790311143
Investigation #:	2024A0580009
Complaint Receipt Date:	11/22/2023
Investigation Initiation Date:	11/27/2023
Report Due Date:	01/21/2024
Licensee Name:	The Lighthouse, Inc.
Licensee Address:	1655 East Caro Road Caro, MI 48723
Licensee Telephone #:	(989) 673-2500
Administrator:	Tristan Schramke
Licensee Designee:	Dorothea Wilson
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:	01/05/2022
Expiration Date:	01/04/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
On 11/18/2023, Resident A suffered an injury due to taking a hot shower.	Yes

III. METHODOLOGY

11/22/2023	Special Investigation Intake 2024A0580009
11/22/2023	APS Referral This complaint was denied by APS for investigation.
11/27/2023	Special Investigation Initiated - Telephone Call to Detroit Wayne Integrated Health Network (DWIHN), office of Recipient Rights.
11/28/2023	Contact - Telephone call received Call from Sherrie Underwood, Recipient Rights.
12/12/2023	Contact - Face to Face Interview with staff, Jacob Vandercook.
12/12/2023	Inspection Completed On-site Unannounced onsite. Contact with Logan Morningstar, Home Manager.
12/13/2023	Contact - Telephone call made Call to Sherrie Underwood, Recipient Rights.
12/18/2023	Contact - Telephone call made Call to Racheal Springer, Home Manager.

12/18/2023	Contact - Telephone call made Spoke with direct staff, Derick Culver
12/18/2023	Contact - Document Received Email receipt documentation received.
12/18/2023	Contact - Telephone call made Call to Joeancy Rivera, Wayne Center Supports Coordinator assigned to Resident A.
12/18/2023	Contact - Face to Face Facetime video observation of Resident A.
12/19/2023	Exit Conference Exit conference with Brant Wilson, Licensee Designee.

ALLEGATION:

On 11/18/2023, Resident A suffered an injury due to taking a hot shower.

INVESTIGATION:

On 11/22/2023, I received a complaint via BCAL Online complaints. This complaint was denied by APS for investigation.

On 11/27/2023, I placed a call to Detroit Wayne Integrated Health Network (DWIHN), office of Recipient Rights. Sherrie Underwood was identified as the assigned Recipient Rights Investigator in Wayne County.

On 11/28/2023, I spoke to Sherrie Underwood, assigned Recipient Rights Investigator in Wayne County. Sherrie Underwood shared that she spoke with the human resources manager at the home who indicated that there had been problems regulating the water heater in the home. The hot water heater is in the process of being replaced. Derick Culver is identified as the staff showering the resident on this day.

On 12/12/2023, I conducted an onsite inspection at Southern Cross AFC. Contact was made with Logan Morningstar, home manager. Logan Morningstar stated that he was not working on the day in question, however, he was informed regarding the incident. Logan Morningstar stated that there had been some issues with the water recently

which involved the health department. Logan Morningstar also shared that Resident A is provided with 1:1 staffing, from 7am-11pm. Home manager, Logan Morningstar also shared that the hot water heater was replaced. Upon observing the new hot water heater, the date of 11/28/2023 was written on the side, as the date of installation. While onsite, I also tested the water temperature in both resident bathroom sinks and showers. The water tested within the 105–120-degree range.

Resident A is currently out of the facility at an appointment in Ann Arbor, MI. Other residents in the home were observed in the living room, dining room and in their bedrooms. The residents were adequately dressed and groomed. They appeared to be receiving adequate care.

A copy of the AFC Assessment Plan and IPOS (Individual Plan of Service) for Resident A were reviewed. The AFC assessment plan I observed for Resident A indicates that Resident A requires full staff assistance and the use of a Bariatric Shower Chair for bathing. The IPOS I observed for Resident A indicates that Resident A will be monitored by staff while bathing to prevent injury.

The incident report reviewed states that on 11/18/2023, at 9:30am, while staff was showering Resident A, the water became really hot. Staff immediately turned the water temp down. Staff noticed while washing him up, his skin was peeling in 2 separate spots. Left upper chest (2 x2 inches in diameter) and center lower chest (2 x2 inches in diameter). In charge was notified. Nursing was contacted and advised to use cold compress's and burn cream (maximum strength Alocane) as a verbal order. Corrective measures listed on the incident report state that staff will continue to monitor and follow Resident A's Treatment/PCP/Behavior Program.

I reviewed the 11/18/2023 Verbal Order from Physician, indicating that wounds sustained from hot water in shower to be treated with Alocane Ointment. I also reviewed the Medication Change Order, dated 11/20/2023, changing Resident A's burn treatment from Alocane to Silvadine Wound Gel. Logan Morningstar reports that Resident A did not require outside medical treatment or hospitalization for the wounds.

On 12/12/2023, while onsite at the facility, I interviewed staff Jacob Vandercook, listed on the incident report. Staff Vandercook stated that he assisted staff, Derick Culver getting Resident A in the shower, using the 2-person Hoyer lift. Staff Vandercook stated that he remained in the bathroom, talking with staff Culver when the water got hot. Staff Vandercook was not assigned to Resident A. Staff Vandercook believed that maintenance had tampered with the hot water heater on that day.

On 12/13/2023, I spoke with Sherrie Underwood, Recipient Rights Investigator. Sherrie Underwood stated that she would be substantiating the case for resident safety.

On 12/18/2023, I spoke with home manager Racheal Springer who shared that Resident A's wound is healed and his treatment was discontinued effective 12/13/2023.

On 12/18/2023, I spoke with direct staff Derick Culver. Staff Culver recalled that on the day in question, after having gotten Resident A in his shower chair, Staff Culver turned on the water and began to wet Resident A down. Another resident began having a behavior and burst into the bathroom. While trying to get the other resident out of the bathroom, Staff Culver handed Resident A the shower head to allow him to wet himself as he usually likes to run the warm water on himself. After getting the other resident out of the bathroom, he noticed Resident A had turned the shower head away from himself. Staff Culver then felt the water, while wearing shower gloves, and realized the water was too hot.

On 12/18/2023, I received an emailed copy of a receipt from Shelter Plumbing and Heating Inc. It indicated that old hot water heaters removed, and 2 new water heaters were installed, effective 11/28/2023.

On 12/18/2023, I spoke with Wayne Center Supports Coordinator assigned to Resident A, Joeancy Rivera. She shared that Resident A is a log-time resident of the AFC home. When she visited with Resident An onsite, she observed very caring staff where everyone takes care of each other. Joeancy Rivera is satisfied with the care he is receiving in the home. Joeancy Rivera believed the incident with Resident A being burned was an accident.

On 12/18/2023, I conducted a Facetime video observation of Resident A. I observed Resident A while he was sitting at the kitchen table, coloring in his coloring book. Resident A is non-verbal. He did make noises acknowledging my presence on camera. He was adequately clothes and groomed. He appeared to be receiving proper care.

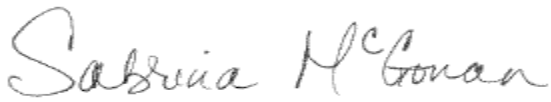
APPLICABLE RULE	
R400.14305	**Resident protection**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A suffered an injury due to taking a hot shower. Logan Morningstar, home manager, stated that there had been some issues with the water recently which involved the health department. The hot water heater was replaced. The AFC assessment plan for Resident A indicates that Resident A requires full staff assistance and the use of a Bariatric Shower Chair for bathing. The IPOS for Resident A indicates that Resident A will be monitored by staff while bathing to prevent injury. The incident report dated 11/18/2023, was reviewed.

	The Verbal Order from Physician dated 11/18/2023 indicated that Resident A was being treated for wounds sustained due to hot water. Staff Jacob Vandercook stated that he assisted staff, Derick Culver getting Resident A in the shower, using the 2-person Hoyer lift. He believes that maintenance had tampered with the hot water heater on that day. Staff Derick Culver stated that he handed Resident A the shower head to allow him to wet himself as he usually likes to run the warm water on himself. After getting the other resident out of the bathroom, he noticed Resident A had turned the shower head away from himself. He then felt the water, while wearing shower gloves, and realized the water was too hot. Residents in the home were observed in the living room, dining room and in their bedrooms. Resident A was observed separately, during a Facetime video. He and the residents were adequately dressed and groomed. They appeared to be receiving adequate care. Recipient Rights Investigator, Sherrie Underwood, stated that she would be substantiating the case for resident safety. Joeancy Rivera, assigned Supports Coordinator for Resident A, stated that she is satisfied with the care he is receiving in the home. She believes the incident with Resident A being burned was an accident. Based on a review of the incident report dated 11/18/2023, both the AFC Assessment Plan and IPOS for Resident A, Physician's Order for burn treatment, and interviews conducted with Recipient Rights Investigator, Sherrie Underwood, staff members, Logan Morningstar, Derick Culver, and Jacob Vandercook, and assigned Supports Coordinator for Resident A, Joeancy Rivera, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/19/2023, I conducted an exit conference with the licensee designee, Brant Wilson. He was informed of the findings of this investigation.

IV. RECOMMENDATION

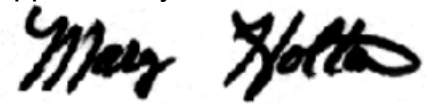
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



December 19, 2023

Sabrina McGowan — Date
Licensing Consultant

Approved By:



December 19, 2023

Mary E. Holton — Date
Area Manager