GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 23, 2024

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

RE: License #: AM790384301
Investigation #: 2024A0623005
Promised Land

Dear Tristan 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 (517) 643-7960.

Sincerely,

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(517) 648-8877

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 #:	2024A0623005
Complaint Receipt Date:	07/09/2024
Investigation Initiation Date:	07/10/2024
Report Due Date:	09/07/2024
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:	Promised Land
Facility Address:	1890 Hope Drive Caro, MI 48723
Facility Telephone #:	(989) 673-3099
Original Issuance Date:	11/21/2016
License **Status:**	REGULAR
Effective Date:	05/21/2023
Expiration Date:	05/20/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Kaylei Jackson was witnessed throwing Resident A to the ground. Resident A has bruising on their arms.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/09/2024	Special Investigation Intake 2024A0623005
07/10/2024	APS Referral
07/10/2024	Contact - Telephone call made Contact with APS worker Gerald Edwards
07/10/2024	Special Investigation Initiated - Telephone Contact with AFC home lead worker Anthony Gimple
07/11/2024	Inspection Completed On-site Interview at AFC home.
07/24/2024	Contact - Document Received AFC
07/25/2024	Contact - Telephone call made I contacted APS worker Gerald Edwards
07/25/2024	Contact - Telephone call made I contacted guardian
07/25/2024	Contact - Telephone call made I contacted Recipient Rights
07/30/2024	Contact – Telephone call made I contacted Resident A’s guardian
7/30/2024	Contact – Telephone call made I contacted DCW Theresa Childers
7/30/2024	Contact – Telephone call made I contacted Witness A

7/30/2024	Contact – Telephone call made I contacted Witness B
7/30/2024	Contact – Telephone call made I contacted RN Carly Teachout
7/30/2024	Contact – Telephone call made I contacted DCW Heidi Smith
08/09/2024	Exit Conference
08/22/2024	Inspection Completed-BCAL Sub. Compliance
08/22/2024	Corrective Action Plan Requested and Due on 09/05/2024

ALLEGATION: Staff Kaylei Jackson was witnessed throwing Resident A to the ground. Resident A has bruising on their arms.

INVESTIGATION: On 7/10/2024, I contacted APS worker Gerald Edwards. I discussed the allegations with APS Edwards and received contact information for the home and staff.

On 7/10/2024, I contacted Promised Land AFC and spoke with Lead worker Anthony Gimple. Anthony Gimple provided information regarding Resident A. On 7/11/2024 I completed an onsite inspection. I observed and interviewed Resident A. I observed that Resident A has 1:1 supervision and due to her behavioral issues which are a combination of mental illness and developmental disabilities she appeared unable to directly answer my questions. Resident A appeared clean, groomed and moved around their room having difficulty focusing. I observed small areas of bruising on Resident A's arms however they appeared to be very faint, pale and yellow. When I questioned Resident A about the incident they stated, "Kaylie pushed me." After this Resident A appeared agitated, so I concluded my interview.

On 7/16/2024, I contacted Direct Care worker (DCW) Kaylei Jackson. DCW Jackson stated that they grabbed Resident A's arms because Resident A was hitting them. Resident A then fell back on the ground and DCW Jackson held Resident A down until Resident A calmed down and helped them stand up. DCW Jackson stated that Resident A then started to hit and bite at staff when Resident A fell back by themselves on the ground hitting and kicking. DCW Jackson stated that another staff showed up to assist (DCW Heidi Smith) and Resident A was taken back to the home. DCW Jackson stated that Resident A continued to attempt to hit, bite and kick at both DCW Jackson and DCW Smith. DCW Jackson denied pushing or holding Resident A down.

On 7/24/2024, I received AFC documents. I reviewed the following staff notes in regard to Resident A:

- I assessed [Resident] A at 8:30 pm this evening after being notified of abuse allegations. When I inquired about the contusions, staff reported that they do not know if the ones on her arms are from today or from her PI [Physical Intervention] on Monday June 10th. The bruise on her right leg appears to be aged as it is yellowing. No other injuries noted. [Resident A] did not verbalize anything alarming/wavering from baseline. Carly Teachout BSN, RN
- Update, I saw [Resident A] this morning at 11:30 am to check on/follow-up on her sore buttock (on-going). The HM reported to me that it was also mentioned that Sarah "hit her head" yesterday. So, during my assessment of her sore I also assessed her head. I looked at her head and there is no bruising, or any bumps noted. [Resident A] denies headache. There is no change in her LOC (level of consciousness). She is at baseline in relation with alertness and orientation. Thelma P. Dicks LPN

I also reviewed Resident A's plan regarding behaviors and how to address them. Resident A's plan included the following:

- Resident A requires 1:1 staffing during waking hours and 2:1 staffing when being transported due to their history of impulsivity, self-injurious behavior, and physical aggression.
- Resident A can get over-stimulated easily and requires staff remain quiet, calm and re-direct when possible. Staff should allow Resident A to learn how to regulate their emotions and compose themself.

On 7/25/2024, I contacted APS Edwards. APS Edwards stated that he will not be substantiating his case.

On 7/25/2024, I contacted North Country Community Mental Health-Recipient Rights (RR) and spoke with Michael Wolf. RR Wolf reported that his associate Brandy Marvin substantiated for Abuse II and for Dignity and Respect violations.

On 7/25/2024, I contacted Resident A's guardian. Guardian reported no prior concerns with staff. Guardian reported that Resident A has always had 1:1 supervision in the AFC home due to her many challenging behaviors.

On 7/30/2024, I contacted DCW Theresa Childers from Binkley House. DCW Childers observed the incident while transporting a consumer. DCW Childers did not know the name of the offending staff person, however they were able to describe the staff person and the consumer. The description provided identified DCW Jackson and Resident A. DCW Childers observed the staff physically take down Resident A twice and Resident A hit their head on the ground. DCW Childers observed the staff yelling at Resident A however did not hear what was being said. DCW Childers observed the staff step away from Resident A who was on the ground. DCW Childers stated she reported what she witnessed to her home manager. DCW Childers stated that it was not an appropriate way to physically manage a consumer.

On 7/30/2024, I contacted Witness A that stated they noticed a couple of people coming out of the Lighthouse building. Witness A noticed a woman who appeared to be a "patient" waving their arms around, not hitting anyone, and appeared agitated. Witness A noticed another woman with short black hair shoved the "patient" to the ground, which they did it twice. Witness A stated they observed the "patient" hit their head on the ground.

On 7/30/2024, I contacted Witness B. Witness B stated they could hear yelling 100-150 yards away. Witness B stated that they saw the "patient" swing once toward the worker's head, did not make contact and then he saw the worker push with both hands against the "patient's" chest and the "patient" fell back and hit their head. Witness B stated they were with Witness A and observed the incident at the same time.

On 7/30/2024, I contacted Registered Nurse (RN) Carly Teachout regarding Resident A. RN Teachout stated that they observed and assessed Resident A at 8:30 pm on the evening of the incident. R.N. Teachout reported that Resident A appeared stable, and she could not determine if the bruises were from the incident that day.

On 8/9/2024, I conducted an exit conference with Licensee Designee (LD) Tristan Schramke. I discussed the investigation findings and which rule violations I am substantiating. LD Schramke stated that DCW Kaylei Jackson was terminated from employment on 7/19/24. I asked LD Schramke to complete and submit a corrective action plan upon receipt of my investigation report.

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. **(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:** **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	On 6/13/2024 multiple witnesses observed DCW Kaylei Jackson forcibly push Resident A onto the ground twice which caused

	Resident A's head to hit the ground. DCW Childers stated that it was not an appropriate way to physically manage a consumer. Resident A was able to say that "Kaylei pushed me". DCW Jackson denied pushing Resident A stating that Resident A "fell back". Resident A's plan indicates staff are required to remain calm, quiet and redirect when possible, allowing Resident A to learn to self-regulate their emotions and compose themself. RN Teachout was unable to verify that Resident A received the bruises from this incident as they appeared, "aged and yellowing." I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While conducting this investigation upon interviewing DCW Heidi Smith, she admitted to swearing and threatening Resident A.

On 7/30/2024 I contacted Witness A. Witness A stated that a 2nd person came in a golf cart, they didn't hit the "patient" however they said, "You fucked up little girl".

On 7/30/2024 I contacted DCW Heidi Smith. DCW Smith stated that she was on her way in a golf cart to pick up her consumer when DCW Jackson asked for her help with Resident A. DCW Smith stated she did not see anything physical happen between DCW Jackson and Resident A. DCW Smith stated that when she pulled up Resident A was on the ground and DCW Jackson was standing off to the side. DCW Smith stated that she does not remember swearing at or threatening to take away Resident A's ear buds, however she stated that she admitted to HR that if others said she did it she must have done it even if she does not remember it. DCW Smith stated she apologized to Resident A.

On 8/9/2024 I conducted an exit conference with Licensee Designee (LD) Tristan Schramke. Discussed the investigation findings and which rule violations I am substantiating. LD Schramke stated that DCW Heid Smith was disciplined by completing Recipient Rights training and documentation that any further incidents will result in termination. I asked LD Schramke to complete and submit a corrective action plan upon receipt of my investigation report.

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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	An incident occurred on 6/13/2024 involving Resident A and DCW Heidi Smith. DCW Smith admitted to swearing and threatening Resident A. Witness A reported hearing DCW Smith swear at Resident A. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

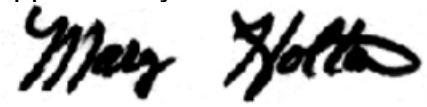
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

8/23/2024

Cynthia Badour Date
Licensing Consultant

Approved By:



8/23/2024

Mary E. Holton Date
Area Manager