GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 10, 2025

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

RE: License #: AM280286819
Investigation #: 2025A0230006
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 #:	2025A0230006
Complaint Receipt Date:	11/21/2024
Investigation Initiation Date:	11/21/2024
Report Due Date:	01/20/2025
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:	04/08/2023
Expiration Date:	04/07/2025
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, ALZHEIMERS, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was lifted improperly in a Sara Lift which caused his foot to slip and resulted in a sprain to his knee.	Yes

III. METHODOLOGY

11/21/2024	Special Investigation Intake 2025A0230006
11/21/2024	APS Referral
11/22/2024	Inspection Completed On-site Interview Resident A, Administrator Rebecca Noffke and staff member Olga Bakunets.
11/22/2024	Physical therapist Emily Chiabattoni was present and consulted.
01/10/2025	Exit Conference With Licensee Designee Rebecca Knoffke

ALLEGATION: Resident A was lifted improperly in a Sara Lift which caused his foot to slip and resulted in a sprain to his knee.

INVESTIGATION: On 11/22/2024, I conducted an on-site investigation at the facility and interviewed staff member Olga Bakunets, Resident A, and Administrator Rebecca Noffke regarding the above allegation.

Ms. Noffke stated that she had received notice from staff at the facility on 11/19/2024 that Resident A had injured his knee during a transfer in a Sara Lift (a standing lifting aid that assists in moving residents between beds, chairs, and toilets). Ms. Noffke stated Resident A was transported to the Emergency Department where he was diagnosed with a sprain to his right knee.

I met with Resident A in his room. He stated he was comfortable at the moment. He stated he slipped down onto his knees in the Sara Lift when Ms. Bakunets was transferring him and the pressure on his right knee caused a sprain. He wasn't sure how it happened as this had never happened in the past.

Ms. Bakunets stated she has worked at the facility for over two years and had proper training on using various lifts to transfer residents. She was not certain how this happened but she expressed that she was upset that this happened to Resident A.

Ms. Bakunets stated she was transferring Resident A from his wheelchair to his bed using the Sara Lift. Ms. Bakunets lifted Resident A and changed his brief. Suddenly Resident A's feet slipped off the platform on the Sara Lift and hit his knees on the pad. Resident A yelled "Ouch". Other staff members then rushed in to assist and lowered Resident A and disconnected him from the lift. He was then tipped to his side onto the floor and rolled onto his back and another type of lift (Hoyer Lift) was used to lift him to his bed. At the time of the incident Resident A stated he had no pain. He also showed no sign of swelling or bruising to his knees. Approximately 5 hours later Resident A was complaining of pain. The on-call facility nurse was contacted. Instructions from the nurse were to reposition Resident A and administer ibuprofen. Later into the morning Resident A's Palliative nurse was contacted as he was still expressing that he was in pain. She advised the facility to have Resident A transported to the emergency room via ambulance.

I had Ms. Bakunets reenact the scenario with Ms. Noffke in the lift. Physical Therapist Emily Chiabatonni was present for this and provided an opinion. When Ms. Bakunets assisted Ms. Noffke getting into the Sara Lift she did not initially place leg safety belts on her. After she was prompted, she stated that she had them on Resident A but just then during the reenactment had forgotten. Ater Ms. Noffke was all set-up in the lift it was noted that she was able to slide her knees down and lower to the foot pad. After tightening the straps Ms. Noffke could barely touch the foot pad. Physical therapist Emily Chiabatonni weighed-in and stated it was her opinion that the straps were not on tight enough when the incident occurred.

On 01/10/2025, I conducted an exit conference with administrator Rebecca Noffke and reviewed the findings of the investigation. She stated that directly after this incident occurred Ms. Bakunets was re-trained in using lifts. She then had to complete a 30-day period of being supervised by management each time she used a lift to ensure that proper technique was used. Ms. Noffke stated there have been no further issues with Ms. Bakunets. She will provide a plan of correction.

APPLICABLE RULE	
R 400.14305	**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:	Resident A stated he slipped onto his knees while Ms. Bakunets was using the Sara Lift to transfer him and his right knee had been sprained as a result. He was unsure how it occurred and it had not happened in the past.

	Ms. Bakunets stated she had used proper protocol to transfer Resident A in the Sara Lift but his feet slipped out from under him and hit the foot pad. During the reenactment of the incident, initially Ms. Bakunets forgot to use safety straps but stated she used them during the actual incident with Resident A. As noted, Ms. Noffke slipped out of the straps and was able to touch the foot pad with her knees. After tightening the straps, it was difficult for her to touch the foot pad. It was Resident A's physical therapist's opinion that the straps likely were not tight enough on Resident A. Resident A was not safe and protected on 11/19/2024. Resident A's knee was sprained as a result of him slipping on the Sara Lift onto his knees and hitting the foot pad.
CONCLUSION:	**VIOLATION ESTABLISHED**

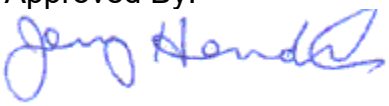
IV. RECOMMENDATION

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

01/10/2025

Rhonda Richards — Date
Licensing Consultant

Approved By:



01/10/2025

Jerry Hendrick — Date
Area Manager