GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 21, 2025

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

RE: License #: AM790311143
Investigation #: 2025A0623021
Southern Cross

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

I. IDENTIFYING INFORMATION

License #:	AM790311143
Investigation #:	2025A0623021
Complaint Receipt Date:	02/11/2025
Investigation Initiation Date:	02/12/2025
Report Due Date:	04/12/2025
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:	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:	01/05/2024
Expiration Date:	01/04/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Justin Traster was observed throwing hot coffee on Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

02/11/2025	Special Investigation Intake 2025A0623021
02/12/2025	APS Referral
02/12/2025	Special Investigation Initiated - Telephone I contacted Oakland County Recipient Rights Officer Rachel Moore
02/25/2025	Inspection Completed On-site Observation and interviews
02/25/2025	Contact - Document Received AFC Documents
03/12/2025	Contact - Telephone call made I contacted APS worker Gerald Edwards.
03/12/2025	Contact - Telephone call made I contacted staff Justin Traster.
03/12/2025	Contact - Telephone call made I contacted Licensee Designee (LD) Tristan Schramke.
03/12/2025	Inspection Completed-BCAL Sub. Compliance
03/12/2025	Exit Conference I contacted Licensee Designee (LD) Tristan Schramke.
03/20/2025	Contact - Telephone call made I contacted Guardian A.

ALLEGATION: Staff Justin Traster was observed throwing hot coffee on Resident A.

INVESTIGATION: On 2/12/2025, I completed an Adult Protective Services (APS) complaint. I shared the allegation with APS Centralized Intake.

On 2/12/2025, I contacted Oakland County Recipient Rights Officer (RRO) Rachel Moore. RRO Moore stated that she is substantiating Abuse II against staff Justin Traster. Staff Traster admitted to throwing his cup of hot coffee on Resident A because they were bothering him about it.

On 2/25/2025, I completed an unscheduled onsite inspection of the facility. I interviewed 2nd shift Home Manager Logan Morningstar. HM Morningstar stated that he was present when the incident occurred with staff Justin Traster throwing his coffee on Resident A. HM Morningstar stated he immediately notified 1st shift home manager Racheal Springer and staff Justin Traster was asked to leave the home pending the investigation.

On 2/25/2025, I attempted to interview Resident A. I observed Resident A laying on their bed covered up to their neck with a blanket. I asked Resident A how they were doing. However, he has difficulty with communication and appeared agitated, so I ceased the attempt to interview them. I did observe Resident A's face and neck area and there did not appear to be any visible marks, bruises or burns.

On 2/25/2025, I reviewed the Incident Report and written staff statement.

Date of Incident 2/11/2025, 7:15 am. It was reported shortly after the 7am shift change that Resident A was in the kitchen obsessing over coffee. Staff Justin Traster prompted Resident A 3-4 times to sit down at the table. When Resident A didn't comply, staff Justin Traster threw a cup of coffee at Resident A. Resident A was checked over by staff and noted no marks. Home staff will continue to monitor Resident A. Staff Justin Traster told HM Rachel Springer that he was frustrated and threw coffee at Resident A. Staff Justin Traster was given a written review and sent home. Nurse April came over to assess Resident A.

On 2/11/2025, Staff Justin Traster completed a written statement.

I was not thinking in the moment. I was frustrated from prior events and I should have taken better care and process my emotions as I have failed today to live up to the standard of Lighthouse staff. I hope this is an example as what not to do, but more importantly I hope that you can forgive me as I'm disgusted by my act as well. Sincerely sorry. I hope to be better for you in the future.

On 2/25/2025, I reviewed the following staff notes regarding Resident A.

I assessed (Resident A) around 9am this morning. Upon my arrival, (they) were calm laying in (their) bed with TV on. I did not note any redness or burn marks on (their) skin. *There is a red mark/rash area on the left side of (their) face. This area has been there as (they) dig/pick at it. (Resident A) has been seen by family

doctor and dermatologist for this however, this specific is related to self-injury. April Coutcher RN

On 2/25/2025, I reviewed Resident A's behavior plan regarding behaviors and how to address them. Resident A's diagnoses include Autism, Impulse Control disorder, tremors, headaches, seizure disorder. The behavior plan included the following. Use Resident A's name often. Be polite and courteous. Offer prompts and encouragement. Do not argue, command, demand, disagree or say no. Say "later" or "after we finish". Approach calmly and speak in a low quiet voice. Be consistent. Stay firm. Don't appear afraid. Be supportive.

On 3/12/2025, I contacted APS worker Gerald Edwards. APS Edwards stated that they interviewed staff Justin Traster, and he admitted to throwing the hot coffee on Resident A. APS Edwards stated that they did not observe any marks or burns on Resident A following the incident. APS Edwards stated that they are substantiating their case.

On 3/12/2025, I contacted staff Justin Traster. Staff Traster admitted to throwing the hot coffee on Resident A because he was frustrated and tired. Staff Traster stated that he wrote a written statement for Home Manager Racheal Springer and was sent home. Staff Traster stated that he was called today and fired from the Lighthouse.

On 3/12/2025, I contacted Licensee Designee (LD) Tristan Schramke. LD Schramke Stated that Justin Traster's employment with the facility has been terminated as of today. I inquired about any disciplinary actions, trainings and background checks for Justin Traster. LD Schramke stated that Justin Traster had completed all his trainings, background checks were up to date and Behavior Management training update completed on 12/13/2024.

On 3/20/2025, I contacted Resident A's guardian, Guardian A. I left a voicemail message.

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:	On 2/11/2025, staff Justin Traster was observed throwing hot coffee on Resident A. Staff Justin Traster admitted throwing the hot coffee on Resident A. Staff Justin Traster completed a written statement and was sent home. Home Manager Racheal Springer contacted nurse April Coutcher who assessed

	Resident A found that they did not have any marks or burns from the incident. Resident A's behavior plan indicates staff are required to remain calm, quiet, encouraging and consistent. On 3/12/2025, I interviewed Staff Justin Traster, and he admitted to throwing hot coffee on Resident A because he was frustrated. On 3/12/2025, Staff Justin Traster was terminated from his employment at The Lighthouse. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/12/2025, I conducted an exit conference with Licensee Designee (LD) Tristan Schramke. I discussed my findings and which rule violation I am substantiating. I asked LD Schramke to complete and submit a corrective action plan upon receipt of my investigation report.

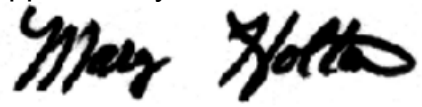
IV. RECOMMENDATION

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

3/21/2025

Cynthia Badour — Date
Licensing Consultant

Approved By:



3/21/2025

Mary E. Holton — Date
Area Manager