GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25, 2025

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

RE: License #: AM790311143
Investigation #: 2026A0623002
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 #:	2026A0623002
Complaint Receipt Date:	10/07/2025
Investigation Initiation Date:	10/08/2025
Report Due Date:	12/06/2025
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?
On 10/01/25, staff Nathan Rossbach was seen mistreating Resident A at Southern Cross AFC home.	Yes
On 10/1/2025 staff Nathan Rossbach was seen pouring water down Resident B's back.	Yes
On 10/05/2025, staff Shaun Hansen was observed using inappropriate physical intervention on Resident C.	Yes
Additional Findings	No

III. METHODOLOGY

10/07/2025	Special Investigation Intake 2026A0623002
10/08/2025	APS Referral
10/08/2025	Special Investigation Initiated - Letter An APS complaint was completed.
10/16/2025	Inspection Completed On-site Observations and interviews.
10/16/2025	Contact - Document Received I received AFC documents.
10/16/2025	Contact - Face to Face I met with Licensee Designee Tristan Schramke.
10/30/2025	Contact - Document Received I received AFC documents.
10/31/2025	Contact – Document Received I received an email from Licensee Designee Tristan Schramke.
11/04/2025	Contact - Document Received I received an email from Licensee Designee Tristan Schramke.
11/04/2025	Exit Conference I conducted an exit conference with Licensee Designee Tristan Schramke.
11/12/2025	Contact - Telephone call made

	I contacted Recipient Rights Officer Rachel Henry.
11/12/2025	Contact - Telephone call made I contacted Recipient Rights Officer Michelle McCormick.
11/17/2025	Contact - Telephone call made I contacted Guardian A.
11/17/2025	Contact - Telephone call made I contacted Guardian B.
11/17/2025	Contact - Telephone call made I contacted Guardian C.
11/17/2025	Contact - Telephone call made I contacted Recipient Rights Officer Johancy Rivera.
11/19/2025	Contact - Telephone call made I contacted Deputy Kile Arp.
11/19/2025	Inspection Completed-BCAL Sub. Compliance
11/21/2025	Contact – Telephone call made I contacted staff Shaun Hansen.
11/21/2025	Contact – Telephone call made I contacted staff Nathan Rossbach.
11/25/2025	Contact – Telephone call made I contacted staff Shaun Hansen.
11/25/2025	Contact – Telephone call made I contacted staff Alex Garrett.
11/25/2025	Contact – Telephone call made I contacted staff Mackenzie Schmidt.
11/25/2025	Contact – Telephone call made I contacted staff Nickole Huston.
11/25/2025	Contact – Telephone call made I contacted staff Derick Culver.

ALLEGATION:

- **On 10/01/25, staff Nathan Rossbach was seen mistreating Resident A at Southern Cross AFC home.**
- **On 10/1/2025 staff Nathan Rossbach was seen pouring water down Resident B's back.**

INVESTIGATION:

On 10/08/2025, I completed an Adult Protective Service (APS) referral. I shared information with APS. The referral was denied for APS investigation by Centralized Intake.

On 10/16/2025, I conducted an unannounced onsite inspection of Southern Cross. I attempted to interview Resident A and Resident B. I interviewed staff Racheal Springer.

On 10/16/2025, I attempted to interview Resident A. I observed Resident A sitting in a wheelchair at the dining room table. Resident A appeared clean, well-groomed and dressed. I was unable to interview Resident A due to his diagnoses of Pervasive Developmental Disorder. Resident A was not able to understand and respond to questions regarding his care.

On 10/16/2025, I attempted to interview Resident B. I observed Resident B sitting in a chair in the living room area. Resident B appeared clean, well-groomed and dressed. I was unable to interview Resident B due to his diagnoses of Autism and Intellectual Disability. Resident B was not able to understand and respond to questions regarding his care.

On 10/16/2025, I interviewed staff Racheal Springer. Staff Springer stated that staff Nathan Rossbach has been suspended from work and Recipient Rights is involved, as well as the Tuscola County Sheriff’s department.

On 10/16/2025, I received and reviewed AFC documents. Incident Report regarding Resident A with staff Nathan Rossbach, and Incident Report regarding Resident B with staff Nathan Rossbach. I received Staff Statements from Shaun Hansen, Alex Garrett and Nathan Rossbach.

On 10/16/2025, I reviewed the Incident Report dated 10/01/2025 at 8:00 pm. Staff Nathan Rossbach was seen mistreating Resident A by threatening to spray him with cold water, placing a frozen bag of corn on his back and hitting him with a book. Staff Alex Garrett and staff Shaun Hansen witnessed the incident. Licensing, Guardian A and Recipient Rights Wayne County notified. Nurse Kyra Enos completed a nursing assessment on Resident A on 10/02/2025. Nurse Enos found Resident A’s assessment findings to be within normal limits, skin integrity of his back and head was intact with no marks, swelling, cuts or scrapes.

On 10/16/2025, I reviewed the Incident Report dated 10/01/2025 at 8:00 pm. Staff Shaun Hansen saw staff Nathan Rossbach pour water down Resident B's back. Licensing, Guardian B and Recipient Rights Jackson County notified.

Statement from staff Shaun Hansen indicated the following: On 10/01/2025, he did witness Nathan Rossbach hit client (Resident A) with a book in the face and back of the head. Staff Hansen stated that the client (Resident A) was making a lot of noise at which time staff Nathan Rossbach poured water over the client (Resident A) head. At snack time Resident B was another client that was not following staff Nathan Rossbach's prompts regarding eating his snacks and he then poured water down Resident B's back.

Statement from staff Alex Garrett indicated the following: On 10/01/2025, I saw staff Nathan Rossbach hit a patient (Resident A) with a book in the face and threatened to dump water on him and he also put a bag of frozen corn on his bare back and thought it was funny.

Statement from staff Nathan Rossbach indicated the following: On 10/01/2025 I was working at Southern Cross, I had (Resident A), he was outside I brought him inside to cook dinner, after dinner he completed his treatment and then we sat in the kitchen until his mom call (Resident A) faked crying during the phone call and afterwards he ate a snack and we then completed his shower then I put him in bed and I sat with him until I left.

Staff Nathan Rossbach was suspended on 10/02/2025 because of similar allegations involving a different resident.

On 10/16/2025, I met with Licensee Designee (LD) Tristan Schramke. LD Schramke stated that staff Nathan Rossbach was up to date with all staff training including rights and safety care.

On 10/30/2025, I received and reviewed AFC documents for Resident A and Resident B.

On 10/30/2025, I reviewed Resident A's Health Care Appraisal dated 03/24/2025. Resident A has the following diagnoses of Pervasive Developmental Disorder with profound cognitive impairment.

On 10/30/2025, I reviewed Resident A's Behavior Plan. Resident A has the following behavioral concerns, physical aggression, self-abuse and temper tantrums. Resident A is non-verbal, displays limited eye contact and has difficulty following simple directions. Behavioral interventions include reinforcing positive behavior with an edible reinforcer (small piece of fruit, small piece of pretzel, etc.) paired with verbal praise for cooperating in ADL (Activities of Daily Living) skills, or participation in activities. Redirect to an alternative activity when Resident A exhibits physical aggression or other maladaptive

behaviors. Resident A requires 1:1 staffing; 16 hours a day for safety, self-injuring behavior, physical aggression and impulsiveness due to his diagnosis.

On 10/30/2025, I reviewed Resident B's Health Care Appraisal dated 03/24/2025. Resident B has the following diagnoses of Autism Spectrum disorder, Bipolar 1 disorder, moderate intellectual disability disorder and seizure disorder.

On 10/30/2025, I reviewed Resident B's Behavior Plan. Resident B has the following behavior concerns, physical aggression, verbal aggression, noncompliance, boundaries, property destruction and safety redirection. Resident B's behavior is marked by constant psychomotor restlessness and can be aggressive towards staff. Behavior interventions include redirection, verbally instructing to stop, verbally encourage and praise when Resident B is engaging in a leisure or group activity. Staff working with Resident B are to always model appropriate social behavior. Resident B needs to be reminded of personal space. Resident B has the following triggers, when asked to do things he does not want to do, when he dislikes a designated activity, overstimulation due to noise or busy environment, social situations, and being prompted to complete ADL's (Activities of Daily Living).

On 10/31/2025, I received an email from Licensee Designee Tristan Schramke. Staff Nathan Rossbach was terminated today because of the findings from Lifeways Recipient Rights regarding Resident B.

On 11/04/2025, I received an email from Licensee Designee Tristan Schramke. Staff Nathan Rossbach had the following formal disciplinary notes in his employee file for use of personal cell phone violation, sleeping on duty, company vehicle accident and separate company vehicle left running unattended.

On 11/12/2025, I contacted Recipient Rights Officer (RRO) Rachel Henry. RRO Henry stated that she substantiated Dignity and Respect violation for taunting/teasing Resident B. RRO Henry stated that she received a corrective action plan showing staff Nathan Rossbach had been terminated from his employment at the Lighthouse.

On 11/17/2025, I contacted Resident A's guardian, Guardian A. Guardian A stated that she was notified of the incident. Guardian A expressed disappointment with staff Nathan Rossbach and stated she wanted to know why he did what he did. Guardian A stated that she has not heard back from Wayne County or the Sheriff's Deputy. Guardian A stated that Resident A has lived at Lighthouse homes since November 2000. Guardian A stated that this facility is the only one capable of handling Resident A's behaviors.

On 11/17/2025, I contacted Resident B's guardian, Guardian B. Guardian B stated that Resident B has lived at the Lighthouse for 15 years. Resident B stated that they do a great job of taking care of the residents even though they have challenging behaviors. Resident B stated that she was notified of the incident and heard from Recipient Rights Lifeways that the staff responsible was terminated from the Lighthouse.

On 11/17/2025, I contacted Recipient Rights Officer (RRO) Johancy Rivera. RRO Rivera stated that she has met with Resident A and Guardian A as well as received relevant documentation. RRO Rivera stated that she will be substantiating a rights violation against staff Nathan Rossbach.

On 11/19/2025, I contacted Tuscola County Sheriff's Department Deputy Kile Arp. I left a voice mail message.

On 11/21/2025, I contacted staff Nathan Rossbach. Staff Rossbach denied doing anything to hurt any resident. Staff Rossbach stated that he wrote out a statement for his employer and talked with Recipient Rights. Staff Rossbach stated he was fired from the Lighthouse.

On 11/25/2025, I contacted staff Shaun Hansen and discussed the incidents regarding Resident A and Resident B. I was able to confirm that staff Hansen did provide the written statement.

On 11/25/2025, I contacted staff Alex Garrett and discussed the incident regarding Resident B. I was able to confirm that staff Garrett did provide the written statement.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Allegations stated that on 10/01/2025, staff Nathan Rossbach mistreated Resident A and at a separate time he was seen pouring water down Resident B's back. I reviewed multiple staff who wrote witness statements and reviewed staff Nathan Rossbach's disciplinary record and training. Staff Garrett and Staff Hansen provided a written statement of mistreatment of Resident A by Staff Rossbach. Staff Hansen further provided a written statement of mistreatment of Resident B by Staff Rossbach. I attempted to interview both Resident A and Resident B, however they are both unable to understand and answer questions regarding their care. On 10/02/2025, Nurse Kyra Enos completed a nursing assessment on Resident A on 10/02/2025. Nurse Enos found Resident A's assessment findings to be within normal limits, skin integrity of his back and head was intact with no marks, swelling, cuts or scrapes.

	Resident A's Behavior plan stated to reinforce positive behavior with an edible reinforcer (small piece of fruit, small piece of pretzel, etc.) paired with verbal praise for cooperating in ADL (Activities of Daily Living) skills, or participation in activities. Or redirect to an alternative activity. Resident B's Behavior Plan stated that staff working with Resident B are to always model appropriate social behavior. Jackson County Lifeways Recipient Rights Officer Rachel Henry substantiated Dignity and Respect violation against staff Nathan Rossbach for taunting Resident B. Wayne County Recipient Rights Officer Johancy Rivera stated that she has seen Resident A and with the information she has she will be substantiating a rights violation. Licensee Designee Tristan Schramke stated that staff Nathan Rossbach was terminated from the Lighthouse Inc. on 10/31/2025 as the result of the findings from Lifeways Recipient Rights regarding Resident B. I conclude there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 10/05/2025, staff Shaun Hansen was observed using inappropriate physical intervention on Resident C.

INVESTIGATION:

On 10/08/2025, I completed an Adult Protective Service (APS) referral. I shared information with APS. The referral was denied for APS investigation by Centralized Intake.

On 10/16/2025, I conducted an unannounced onsite inspection of Southern Cross. I attempted to interview Resident C. I interviewed staff Racheal Springer.

On 10/16/2025, I attempted to interview Resident C. Resident C was observed to be clean, neatly groomed and laying on his bed. I attempted to engage Resident C however he did not want to speak with me. Resident C has limited communication using body language, one word or gestures. Resident C was unable to understand and answer questions regarding his care.

On 10/16/2025, I interviewed staff Racheal Springer. Staff Springer stated that staff Shaun Hansen has been suspended from work and Recipient Rights is involved.

On 10/16/2025, I received and reviewed AFC documents. Incident Report regarding Resident C and staff Shaun Hansen. Staff statements from Shaun Hansen, Mackenzie Schmidt, Nickole Huston and Derick Culver.

On 10/16/2025, I reviewed the Incident Report dated 10/05/2025 at 12:45 pm. Staff Shaun Hansen was seen using inappropriate physical management techniques on Resident C. Staff witnesses include Mackenzie Schmidt, Nickole Huston, and Derick Culver. Licensing, Guardian A and Recipient Rights Oakland County were notified.

On 10/16/2025, I reviewed the email from the10/05/2025 regarding Nurse Jenifer Blackmer. Nurse Jennifer Blackmer completed a nursing assessment later that afternoon. Nurse Blackmer found client had full range of motion without pain, no signs of bruising, redness abrasions or injuries. Will continue to monitor.

On 10/16/2025, I received a written Statement from staff Shaun Hansen indicated the following: Staff Hansen stated that he held unto (Resident C's) wrist, holding it to his chest while Resident C laid on the ground fighting so I stayed on the ground with Mark…get him up and take him to the van, (Resident C) was still attacking me on the way to the van, trying to twist hands, pinch and bite so I held onto one arm with my hand on his wrist and the other on the center between his neck and head…Let go and just hold onto his other arm…(Resident C) and I made it back to the van and put his seatbelt on. This statement was signed and dated 10/06/2025.

On 10/16/2025, I received a written Statement from staff Mackenzie Schmidt indicated the following: While helping another staff bring out food, staff Shaun Hansen was seen over top of Resident C on the ground. I (Mackenzie Schmidt) told staff Shaun Hansen that he can not do that and asked him to get off him (Resident C) and redirect Resident C to the van to calm down and wait for his food while staff Shaun Hansen was walking with Resident C being complaint. Staff Shaun Hansen had Resident C by his arm and the back of his neck. I (Mackenzie Schmidt) told staff Shaun Hansen that it is not how you walk with clients and told him to cover over Resident C's arms instead.

On 10/16/2025, I received a written Statement from staff Nickole Huston indicated the following: Resident C was agitated when walking out to sit at the parade, he was yelling and staff Shaun Hansen grabbed Resident C from behind and wrapped his arms around him and took him down to the ground. I (Nickole Huston) tried to help and staff Shaun Hansen said he had it. Staff Mackenzie Schmidt came out of McDonalds yelling at staff Shaun Hansen to redirect Mark to the van. I (Nickole Huston) heard staff Mackenzie Schmidt tell staff Shaun Hansen to not grab him (Resident C) by the neck, however, did not see that happen.

On 10/16/2025, I received a written Statement from staff Derick Culver indicated the following: Staff Derick Culver stated he heard Resident C scream/yell and then staff pushed and swept the leg then held Resident C down.

On 10/16/2025, I met with Licensee Designee Tristan Schramke. LD Schramke stated that staff Shaun Hansen was up to date with all staff training including rights and safety care.

On 10/30/2025, I received AFC documents for Resident C. I reviewed Resident C's Health Care Appraisal dated 05/19/2025. Resident C is diagnosed with Autism, Impulse Control Disorder and Seizure Disorder. I reviewed Resident C's Behavior Plan. Resident C benefits from routine and positive interactions with staff. Resident C benefits from 2:1 staffing while in the community for safety reasons. Resident C's 1:1 staffing in the home has been reduced from 12 hours per day to 6 hours per day from 3:00-9:00 pm due to increased improvement with dysregulation, OCD behaviors, elopement, food waste, agitation and aggression. Positive intervention plan includes managing stimulation and environmental triggers, minimizing corrective language, calm supportive presence at all times. Staff are not to restrain Resident C and do not leave him alone when he is upset. Do remove social pressure from the situation or guide Resident C to a less stimulating environment.

On 11/04/2025, I received an email from Licensee Designee Tristan Schramke. Staff Shaun Hansen had no formal disciplinary notes in his employee file; at the beginning of his employment, he had substandard performance reviews that were addressed with him at that time. A Report of Investigative Findings (RIF) was received from Oakland County Recipient Rights and based on that report staff Shaun Hansen was terminated today.

On 11/12/2025, I contacted Recipient Rights Officer (RRO) Michelle McCormick. RRO McCormick stated that she substantiated Abuse II for staff Shaun Hansen using unreasonable force. RRO McCormick stated that staff Hansen also used unapproved physical management techniques. RRO McCormick stated that she received a corrective action plan showing staff Shaun Hansen had been terminated from his employment at the Lighthouse.

On 11/17/2025, I contacted Resident C's guardian, Guardian C. I left a voice mail message.

On 11/21/2025, I contacted staff Shaun Hansen. Staff Hansen's phone was not accepting calls.

On 11/25/2025, I contacted staff Shaun Hansen and discussed the incident regarding Resident C. I was able to confirm that staff Hansen did provide a written statement. Staff Hansen stated that he did hold Resident C's arm back and used his other hand on the back of Resident C's neck to guide him to the van. Staff Hansen denied any use of force and stated he had been trained in safety care, which is physical management.

On 11/25/2025, I contacted staff Mackenzie Schmidt. I left a voice mail message.

On 11/25/2025, I contacted staff Nickole Huston. I was able to confirm that staff Huston provided a written statement regarding the incident with Resident C. Staff Huston stated that she helped train staff Shaun Hansen and he did not use appropriate safety care techniques. Staff Huston stated that she offered to assist Shaun with Resident C and he told her he had it (Resident C under control on the ground).

On 11/25/2025, I contacted staff Derick Culver. I was unable to leave a voice mail message, as the phone was set not to take calls at this time. I sent a text message.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(1) A licensee shall ensure methods of behavior intervention are appropriate to the needs of the resident.
ANALYSIS:	The allegations stated that on 10/05/2025, staff Shaun Hansen was observed using inappropriate physical intervention on Resident C. Staff Shaun Hansen stated that he believed he was using appropriate physical intervention. Staff Shaun Hansen completed a written statement and was sent home. On 10/05/2025, Nurse Jennifer Blackmer completed a nursing assessment later that afternoon. Nurse Blackmer found client had full range of motion without pain, no signs of bruising, redness abrasions or injuries. Will continue to monitor. I attempted to interview Resident C; however, he was unable to understand and answer questions regarding his care. Resident C's behavior plan indicates staff are required to always have a calm supportive presence. Staff are not to restrain Resident C; they are to remove social pressure from the situation or guide them to a less stimulating environment. Staff Schmidt, Staff Huston, and Staff Culver all reported inappropriate physical intervention by Staff Hansen. Staff Shaun Hansen used inappropriate physical intervention on Resident C. Recipient Rights Officer Michelle McCormick stated she substantiated for Abuse II-staff Shaun Hansen used unreasonable force.

	Licensee Designee Tristan Schramke confirmed that staff Shaun Hansen was terminated from employment at the Lighthouse Inc. on 11/04/2024. I conclude there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/04/2025, I conducted an exit conference with Licensee Designee (LD) Tristan Schramke. I discussed my findings, and which rule violations I am substantiating. I asked LD Schramke to complete and submit a corrective action plan upon receipt of my investigation report. LD Schramke stated that he understood the findings and will submit a corrective action plan.

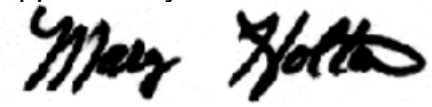
IV. RECOMMENDATION

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

11/25/2025

Cynthia Badour — Date
Licensing Consultant

Approved By:



11/25/2025

Mary E. Holton — Date
Area Manager