STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2026

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

RE: License #: AS790368897
Investigation #: 2026A0623029
Stoney Brooke

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 #:	AS790368897
Investigation #:	2026A0623029
Complaint Receipt Date:	04/15/2026
Investigation Initiation Date:	04/16/2026
Report Due Date:	06/14/2026
Licensee Name:	The Lighthouse, Inc.
Licensee Address:	1655 East Caro Road Caro, MI 48723
Licensee Telephone #:	(989) 673-2500
Administrator:	Brant Wilson
Licensee Designee:	Tristan Schramke
Name of Facility:	Stoney Brooke
Facility Address:	1570 Lighthouse Lane Caro, MI 48723
Facility Telephone #:	(989) 673-2500
Original Issuance Date:	06/22/2015
License Status:	REGULAR
Effective Date:	12/22/2025
Expiration Date:	12/21/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A reported that on 04/12/2026, Staff Drew Howard was verbally abusive to him.	Yes
Additional Findings	No

III. METHODOLOGY

04/15/2026	Special Investigation Intake 2026A0623029
04/16/2026	APS Referral An APS referral was completed.
04/16/2026	Special Investigation Initiated - Telephone I contacted APS worker Gerald Edwards.
04/30/2026	Inspection Completed On-site Observation and Interviews.
05/01/2026	Contact - Document Received I received AFC documents.
05/06/2026	Contact - Telephone call made I contacted APS worker Gerald Edwards.
05/15/2026	Contact - Telephone call made I contacted Staff Drew Howard.
05/15/2026	Contact - Telephone call made I contacted Guardian A.
05/18/2026	Contact - Telephone call made I contacted Staff Drew Howard.
05/18/2026	Contact - Document Received I received an email from Licensee Designee Tristan Schramke.
05/18/2026	Inspection Completed–BCAL Sub. Compliance
05/19/2026	Exit Conference I conducted an exit conference with Licensee Designee Tristan Schramke.

05/19/2026	Contact - Face to Face I conducted an unannounced onsite visit and met with Resident A.
05/22/2026	Contact - Telephone call received I received a phone call from Guardian A.
06/02/2026	Contact - Telephone call made I contacted Guardian A.
06/02/2026	Contact - Telephone call made I contacted APS Gerald Edwards.
06/04/2026	Contact – Telephone call made I contacted Social Worker Leandra Jahr.

ALLEGATION:

Resident A reported that on 04/12/2026, Staff Drew Howard was verbally abusive to him.

INVESTIGATION:

On 04/16/2026, An Adult Protective Service (APS) referral was completed. Information was shared with APS.

On 04/16/2026, I contacted APS worker Gerald Edwards. APS Edwards stated that he interviewed Resident A at his home. APS Edwards stated that he was told that this was the only time Staff Drew Howard spoke to him this way and that he (Drew) apologized to him.

On 04/30/2026, I made an unannounced onsite inspection of the facility. I interviewed Resident A and Staff Nickalas Burcham.

On 04/30/2026, I interviewed Resident A in his bedroom. Resident A is alert and oriented x4 (person, place, time and situation). Resident A confirmed that Staff Drew Howard swore at him and made him feel like he was being talked down to. Resident A stated that Staff Drew (Howard) was impatient with him and talked down to him as if he didn't understand. Resident A stated that Staff Drew (Howard) had been impatient with him before but not verbally abusive like this time. Resident A stated that he and Staff Drew Howard, were the only ones in the van and no one at church heard him.

On 04/30/2026, I interviewed Staff Nickalas Burcham. Staff Nickalas "Nick" Burcham stated that he does not know what exactly happened over that weekend as he works with Resident A during the week. Staff Burcham stated that he has not witnessed or heard any staff talk inappropriately to Resident A.

On 05/01/2026, I received and reviewed AFC documents. I reviewed the Incident Report dated 4/14/2026 *Resident A reported that staff Drew Howard was treating him inappropriately at church by calling him an "a**hole" and informing him that "nobody f**king cares if you can't stand". Resident A also stated that staff Drew Howard continued to yell at him on the drive back to the home. Drew was removed from working with Andy pending a report from APS and possibly licensing.*

I reviewed a signed statement dated 04/15/2026, from Staff Drew Howard. *While at church (Resident A) told the usher he wasn't going to be standing up at service the usher replied that was fine and walked away. I [Staff Howard] asked [Resident A] why he told the usher that and he responded with "because they will worry about why I'm not standing". Staff (Howard) prompted him [Resident A] that the usher and everyone else at church are there to worship. [Resident A] began trying to start an argument and since service was about to start, I patted him on the shoulder and said okay that's fine and (Resident A) whipped out his arm almost hitting me in the face. I prompted him that he nearly just hit me and that acting like that was inappropriate, especially in church. After Church, I took him out to eat despite the outburst. Prompting him to sit up and not talk with food in his mouth. Later during N/R (night routine) I had to catch [Resident A] from falling during a transfer and after N/R (night routine) [Resident A] apologized for the way he behaved that day. I prompted him to do better the next day.*

I reviewed Resident A's Health Care Appraisal showing his diagnoses; TBI (traumatic brain injury) and Spastic Quadriplegia with contractures which requires a wheelchair for mobility. I reviewed Resident A's Assessment Plan and Behavior Plan which addresses verbal aggression and impulsivity due to his TBI.

On 05/06/2026, I contacted APS worker Gerald Edwards. APS Edwards stated that he interviewed Staff Drew Howard. Staff Drew Howard stated that Resident A needed to practice common courtesy and not be so demanding and that he shouldn't have to tell him to do things. APS Edwards stated that staff Drew Howard was treating Resident A like a peer not like a resident that he supervised.

On 05/18/2026, I contacted Staff Drew Howard. I left a voice mail message.

On 05/15/2026, I contacted Guardian A. I left a voice mail message.

On 05/18/2026, I contacted Staff Drew Howard. I left a voice mail message.

On 05/18/2026, I received an email from Licensee Designee (LD) Tristan Schramke. LD Schramke stated that Staff Drew Howard was transferred to a different building pending investigation result. LD Schramke stated that Staff Drew Howard used paid time off (PTO) the first and 2nd week and then the last week he did not report to any of his scheduled shifts, nor did he call in to state he would not be reporting. LD Schramke stated that after 3 no call/no show it is considered an abandonment of position and Staff Drew Howard's employment at the Lighthouse Inc. ended as of today.

On 05/19/2026, I made an unscheduled facility visit and met with Resident A. Resident A was getting ready to eat lunch. Resident A stated he knows Drew (Staff Drew Howard) isn't working at The Lighthouse anymore and he is glad that he quit.

On 05/22/2026, I received a phone call from Guardian A, he left a voice mail message.

On 06/02/2026, I contacted Guardian A. Guardian A stated that he was notified of the incident between Resident A and the staff person. Guardian A stated that Resident A is very religious and church is very important to him. Guardian A stated that usually the staff are very good with the residents.

On 06/02/2026, I contacted APS Gerald Edwards. APS Edwards stated that he did not substantiate his case because Resident A told him it was the first time he acted like that with him.

On 06/04/2026, I contacted Social Worker (SW) Leandra Jahr. SW Jahr stated that Resident A disclosed to her how Staff Drew Howard had sworn at him and treated him in a dismissive and disrespectful manner. SW Jahr stated that Resident A was concerned that Staff Drew Howard would retaliate against him for telling other people what happened. SW Jahr stated that she found Resident A's account to be credible.

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:	The allegation stated that Resident A reported that on 04/12/2026, Staff Drew Howard was verbally abusive to him. Resident A consistently reported feeling disrespected, sworn at, and talked down to during the incident at the church and on the ride home. Multiple interviews were conducted, including Resident A, Guardian A, APS Worker Gerald Edwards, Social Worker Leandra Jahr, facility staff and Licensee Designee Tristan Schramke. Supporting documentation, including an Incident Report and statements from the social worker reinforced Resident A's account. Staff Drew Howard's own statement acknowledged conflict, though he described the situation differently and did not admit to verbal abuse.

	I attempted several times to interview Staff Drew Howard. According to Licensee Designee Tristan Schramke, Staff Howard did not come to work or call in so after 3 no call/no show he was terminated from his employment at The Lighthouse Inc.as of 05/18/2026. I conclude there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/19/2026, I conducted an exit conference with Licensee Designee (LD) Tristan Schramke. I explained my investigation and findings. LD Schramke will contact this consultant if he has any questions.

IV. RECOMMENDATION

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

06/05/2026

Cynthia Badour Date
Licensing Consultant

Approved By:

06/05/2026

Mary E. Holton Date
Area Manager