GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 17, 2025

Michael & Miranda LaBarge
1357 Terrace
Muskegon, MI 49442

RE: License #:	AF610320384
Investigation #:	2025A0356011
	Light House Retreat

Dear Michael & Miranda:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AF610320384
Investigation #:	2025A0356011
Complaint Receipt Date:	11/15/2024
Investigation Initiation Date:	11/15/2024
Report Due Date:	01/14/2025
Licensee Name:	LaBarge, Miranda & Michael
Licensee Address:	1357 Terrace Muskegon, MI 49442
Licensee Telephone #:	(231) 747-7751
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Light House Retreat
Facility Address:	1357 Terrace Muskegon, MI 49442
Facility Telephone #:	(231) 747-7751
Original Issuance Date:	10/09/2012
License Status:	REGULAR
Effective Date:	04/09/2023
Expiration Date:	04/08/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not allowed to return to the AFC home during the day.	Yes

III. METHODOLOGY

11/15/2024	Special Investigation Intake 2025A0356011
11/15/2024	Special Investigation Initiated - Telephone MOKA staff
11/15/2024	APS Referral denied for investigation.
11/21/2024	Contact - Telephone call made Leah Feenstra, MOKA.
12/13/2024	Contact - Telephone call made Monique Winters, Club Interactions.
12/13/2024	Contact - Telephone call received Club Interactions, Nicole Norman.
12/19/2024	Contact - Face to Face Resident B
01/03/2025	Contact - Face to Face Resident C
01/03/2025	Contact - Telephone call made Life Circles left message for social worker Yvonne.
01/06/2025	Contact - Face to Face Ben Barritt, Life Circles, social worker, Resident D.
01/06/2025	Inspection Completed On-site No answer at door, left contact information.
01/06/2025	Contact - Telephone call received Mike LaBarge, LD.
01/06/2025	Contact - Telephone call made Michael LaBarge, LD.

01/06/2025	Contact - Face to Face Resident A still in hospital, possibly in GR, unable to interview.
01/07/2025	Contact-Telephone call received. Miranda LaBarge, licensee.
01/09/2025	Contact-Telephone call made. Hartford Terrance- Angela Mayeaux, manager.
01/10/2025	Contact-Telephone call made. Relative #4.
01/16/2025	Exit Conference Miranda LaBarge, Licensee.

ALLEGATION: Residents are not allowed to return to the AFC home during the day.

INVESTIGATION: On 11/15/2024, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) complaint. The complainant reported Resident A was working in the yard outside over the past weekend and now Resident A is sick. The complainant reported it is unknown what Resident A is sick with, but Resident A was then at a day program during the week, and he was too sick to be there. The complainant reported Licensee, Mike LaBarge was contacted by staff from the day program, and he refused to allow Resident A to return to the AFC home. The complainant reported that Mr. LaBarge said the rule of the facility is that residents must be gone during the day. The complainant reported eventually, Mr. LaBarge allowed Resident A back in the home, but this has been an ongoing issue.

On 12/13/2024, I interviewed Nicole Norman at Club Interactions, day program. Ms. Norman stated Resident A is a new resident to this facility. He is currently in the hospital at Spectrum Butterworth in Grand Rapids and is extremely ill. Ms. Norman reported on 11/25/2024, Resident A “looked horrible” and was so ill at the day program that he was laying on the floor, curled up in a ball and if he sat at the table, his head was down on the table. Ms. Norman stated she called Mr. LaBarge but did not get an answer so she called him from another telephone number, and he answered the telephone. Ms. Norman stated she asked Mr. LaBarge about administering Zofran for nausea to Resident A and Mr. LaBarge stated he had already given Resident A Zofran that morning and he could only have that medication every 6 hours so he could not take any more at that time. Ms. Norman stated she informed Mr. LaBarge that Resident A was ill and should not be at the day program. Ms. Norman stated Mr. LaBarge reported he had a meeting with Health West (Community Mental Health) and could not be at home for Resident A and suggested Ms. Norman call Resident A’s relative. Ms. Norman stated she called

Relative #1 but Relative #1 was unable to accommodate Resident A. Ms. Norman stated she contacted Mr. LaBarge and informed him that Relative #1 was unable to get Resident A and that Resident A needed to go home now. Ms. Norman stated Mr. LaBarge said he would have to hire someone to be at the house because he was in a meeting with Health West. Ms. Norman stated she and Mr. LaBarge began to text one another, Ms. Norman read the texts stating, “(Ms. Norman): hey, any updates? (Mr. LaBarge): What’s the address there? (Ms. Norman): is someone coming to pick him up? (Mr. LaBarge): yes (Ms. Norman): who? (Mr. LaBarge): ambulance.” Ms. Norman stated once the ambulance arrived, she gave them Resident A’s medication list and sent him off in the ambulance, Resident A did not attend day programming the following day, 11/26/2024 and they have not seen Resident A since. Ms. Norman added that in another, previous incident, Resident A had been raking leaves over the Veteran Day weekend (11/09/2024-11/10/2024) and was ill. He attended day program on that Monday (11/11/2024) and was sick and wanted to go home. Ms. Norman reported she contacted Mr. LaBarge and asked if she could drop Resident A off at home and Mr. LaBarge told her he was not home. Ms. Norman asked if he was refusing to allow Resident A to come home and Mr. LaBarge told her she was using the wrong wording, that he would be home in approximately 10 minutes and Ms. Norman dropped Resident A off at the facility.

On 12/19/2024, Resident A is currently in the hospital and unavailable to participate in an interview.

On 12/19/2024, I interviewed Resident B. Resident B stated he spends his day out of the facility at a day program. Resident B stated Mr. LaBarge “has things to do, he has to shop and do paperwork, so we have to go to clubhouse until 3:00p.m.” Resident B then stated if Mr. LaBarge could get Ms. Betty or Terri to stay with him if he wanted to stay at home during the day then he could but Mr. LaBarge is not at the house until 3:00p.m. Resident B stated if he was sick and Mr. LaBarge couldn’t find anyone to sit with him at the facility, he would be at his day program. Resident B stated Resident A was “really sick” at the day program and had been “throwing up” at the facility and Mr. LaBarge “gave him cough syrup because he thought he had a cold.” Resident B stated another day, in the morning, Resident A was sick and throwing up and Mr. LaBarge called an ambulance that came and picked Resident A up at the facility.

On 12/19/2024, I interviewed Monique Lee, day program staff. Ms. Lee stated Resident A attended day program on several days despite being sick prior to having an ambulance pick him up at the day program because he was so ill. Ms. Lee stated Resident A stated he had been raking leaves over the weekend of 11/09/2024-11/10/2024 with Mr. LaBarge and Resident A was sick, yet he still attended day programming that Monday. Ms. Lee stated staff called Mr. LaBarge and he said he would not be home for an hour. They (day program staff) dropped Resident A off at the facility when Mr. LaBarge was home and then Mr. LaBarge called an ambulance and sent him to the hospital. Ms. Lee stated on 11/25/2024, Resident A was at the day program and was not himself. He was laying on the floor, pale and did not feel

well and that is when Ms. Norman called Mr. LaBarge. He told them he had an appointment with Health West and to try and see if his relative would come and pick him up. Ms. Lee continued and reiterated the same information reported by Ms. Norman regarding contacting Mr. LaBarge and the ambulance picking Resident A up from day programming.

On 01/03/2025, I interviewed Resident C at his day program. Resident C stated he is required to be at his day program and cannot return to the facility until 3-3:30p.m. when Mr. LaBarge is home. Resident C stated this is during weekdays only and on the weekends, he can stay at home. Resident C stated on Sundays, Mr. LaBarge goes to church and Resident C goes to his own church and then to a friend's house until he knows Mr. LaBarge is home. Resident C stated Resident A was sick, coughing and turning red during the night, the next day, the ambulance picked him up at the facility and Resident C stated he saw Resident A on the stretcher. Resident C stated the ambulance took Resident A to the hospital, and he has not seen Resident A since. Resident C stated Resident A was at the day program when he was sick, but stated he never saw Resident A lying on the floor at day program as reported by staff. Resident C stated in August or September 2024, his sugar dropped while he was at work. He went to the facility and could not get in, so he went back to work and sat until an ambulance came to take him to the hospital. Resident C stated he attempted to call and text Mr. LaBarge after he was in the hospital but never received an answer from Mr. LaBarge, so he had to return to work and sit until 3:30p.m. when Mr. LaBarge was back at the facility. Resident C stated this happened again a different time. His boss transported him to the hospital but when he (Resident C) went to the facility after he was discharged, Mr. LaBarge was there.

On 01/06/2025, I interviewed Resident D at his day program. Resident D stated he wants to go to day program every day because he has a job there and does not want to miss his job. Resident D stated he does not want to stay home but he could go home if he wanted to. Resident D stated if he is sick at day program, Relative #2 picks him up and he stays at Relative #2's house until day program is over. Resident D stated on the weekends he does not go to day program and is at the facility. Resident D stated on Sundays, he goes to Relative #2 & #3's home while Mr. LaBarge attends church and stated he likes to go to his relatives house each Sunday.

On 01/06/2025, Resident A remains in the hospital and is unavailable to participate in an interview.

On 01/06/2025, I interviewed Mr. LaBarge via telephone. Mr. LaBarge stated Resident A was ill, but he insisted that he was "fine, alright and ok" and went to his programming each day except for 11/26/2024, when he (Mr. LaBarge) called an ambulance for the third time to transport Resident A from the facility to the hospital due to continued illness. Mr. LaBarge stated Resident A moved into the facility in October 2024 and was not well the entire time he lived there but always said he was

fine. Mr. LaBarge stated on Sunday, 11/24/2024, Resident A was ill at the facility, he threw up on his dinner plate and threw up during the night. Mr. LaBarge stated this was not completely unusual because Resident A was sickly the entire time he resided in the facility. Mr. LaBarge stated on 11/24/2024, he called an ambulance, and Resident A was transported to the hospital. He was sent home with no explanation that Mr. LaBarge received. Mr. LaBarge stated he sent Resident A to the hospital again on Monday, 11/25/2024, from the day program when staff called and said he was sick and needed to come home. Mr. LaBarge stated he responded to staff and called an ambulance to pick him up at the day program because he knew something was wrong that required professional medical attention, but the hospital kept sending him back to the facility. Mr. LaBarge stated Resident A was sent home again from the hospital on 11/25/2024 and then finally, on 11/26/2024, Resident A did not attend day programming due to illness, he remained at the facility, continued to throw up and was “collapsing,” so he (Mr. LaBarge) called an ambulance again. Mr. LaBarge stated on 11/26/2024, Resident A was admitted to the hospital and has not returned to the facility. Mr. LaBarge stated earlier in the month when staff called about Resident A, he initially suggested that day program staff take Resident A to the Health West doctor, but when they said they could not do that, he returned home so Resident A could come home. Mr. LaBarge stated once he got home, Resident A acted as if nothing was wrong and stated that he felt ok. Mr. LaBarge stated he would be at home when Resident A or any resident needed to return to the facility.

On 01/09/2025, I interviewed Angela Mayeaux, Resident C’s supervisor at work. Ms. Mayeaux stated Resident C returned to her office one day because he (Resident C) could not get back into the facility when he thought his sugar was low, but it turned out his blood pressure dropped. Ms. Mayeaux stated she spoke to Ms. Lee at the day program, who attempted to call Mr. LaBarge and when he did not answer her call, Ms. Mayeaux called an ambulance to pick Resident C up from the workplace and then she (Ms. Mayeaux) picked Resident C up from the hospital and took him back to her office where he sat until 3:30p.m. when he was able to get back into the facility. Ms. Mayeaux reported this occurred in August or September 2024 and happened twice in a 60-day period. Ms. Mayeaux supported the information Resident C provided in his interview.

On 01/10/2025, I interviewed Relative #4 via telephone. Relative #4 stated more than once she has picked Resident A up at the day program because he was too sick to be there, yet he was still sent to the program from home and was not permitted to return to the facility until 3:30p.m. Relative #4 stated on the last day staff at the program called her to pick Resident A up, she had a doctor’s appointment and could not pick him up. Relative #4 stated other times, when Resident A got to her house, he got in bed because he was vomiting and so sick. Relative #4 stated this has been going on since he moved into this facility and Relative #4 was adamant that even though Resident A was ill, he was not permitted to stay at the facility during the day. He had to go elsewhere and usually it was her house.

Note: On 05/14/2024, Rule 400.1409 (1)(p) (Special Investigation Report 2024A0356028) was substantiated stating a preponderance of evidence was established that residents at the facility are not allowed or they believe they are not allowed to remain in the home during the day by the licensee and a corrective action plan was requested.

On 06/07/2024, Miranda and Michael LaBarge, licensees submitted a corrective action plan that documented the following: *'Resident's will be fully informed of their ability to come home if he/she is feeling sick. It is acknowledged in the admission packet that residents can come home if they are ill and if they need medical attention, their case managers and guardians will also be notified of their medical attention that may require a doctor attention. Upon admission this home has also let all client's case managers and guardians be aware that the client needs a day program M-F from 8a.m.-3p.m. It is also understood that if they don't want to attend a day program then this may not be the home for them. For future clients coming into the home, and the client's that are there now, we will make sure everyone knows they have access to their rooms and if not feeling well, they have the right to stay home, if at any time, client's do not want to participate in a day program M-F they will fully understand that they can give the home a discharge notice.'*

On 1/10/2025, Ms. LaBarge stated upon admission, residents review the home guidelines and are given a written copy of their rights.

On 01/16/2024, I conducted an exit conference with, Licensee, Miranda LaBarge via telephone. Ms. LaBarge stated they do allow residents to stay at the facility and arrange for them to do so if they are ill or do not want to attend day programming. Ms. LaBarge stated the day program wants Mr. LaBarge to pick the residents up however, they do not transport and that is an issue. However, Mr. LaBarge is available and willing to be at the facility if the residents need to come home and are transported home from their programs. Ms. LaBarge stated they will review the report and submit a corrective action plan.

APPLICABLE RULE	
R 400.1409	**Resident rights; licensee responsibilities.**
	Resident rights; licensee responsibilities. (1) Upon a resident's admission to the home, the licensee shall inform and explain to the resident or the resident's designated representative all of the following resident rights: (p) The right of access to his or her room at his or her own discretion. (2) A licensee shall provide the resident and the resident's designated representative with a written copy of the rights outlined in subrule (1) of this rule upon a resident's admission to the home.

ANALYSIS:	The complainant reported Resident A was at a day program, and he was too sick to be there. Licensee, Mike LaBarge was contacted by staff from the day program and refused to allow Resident A to return to the AFC home. Ms. Norman and Ms. Lee reported difficulty contacting Mr. LaBarge and difficulty from Mr. LaBarge with returning residents to the facility if they are ill or need to go home between 8:00a.m. and 3:30p.m. Resident B & C stated they are required to be out of the home during the week and cannot come home until day programming is done. Resident D stated if he leaves his program early, Relative #2 picks him up and he stays with Relative #2 until day program is over. Relative #4 stated she has been called more than once by staff at Resident A's Day program to pick him up because he was ill and not able to return to the facility as Mr. LaBarge was not available or at home to accommodate Resident A. Mr. LaBarge stated he would come home if Resident A or any resident needed to return to the facility from day programming, yet day program staff reported difficulty getting him to respond or make accommodations to residents that need to leave day programming due to illness. Resident B, C & D stated they are required to be out of the house until 3:30p.m. every weekday with little exception and while Resident A claimed he was "fine, alright, ok" to Mr. LaBarge, he was exhibiting signs of illness by vomiting multiple times, over several days, and was in and out of the emergency room and yet still at his day program. On 05/14/2024, Rule 400.1409 (1)(p) was substantiated stating a preponderance of evidence was established that residents at the facility are not allowed or they believe they are not allowed to remain in the home during the day by the licensee. On 06/07/2024, a corrective action plan was received that documented the Licensees would make sure everyone knows they have access to their rooms and if they were ill, they have the right to stay home.

	There is a preponderance of evidence to show that Mr. LaBarge does not allow the residents the right to access their home and room at their own discretion and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license is changed to a 6-month provisional status based on repeated quality of care violations.

01/17/2025

Elizabeth Elliott Date
Licensing Consultant

Approved By:

01/17/2025

Jerry Hendrick Date
Area Manager