GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 19, 2025

Delissa Payne
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

RE: License #: AS410289784
Investigation #: 2025A0467023
Blythefield Home

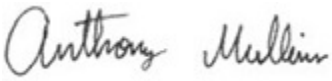
Dear Mrs. Payne:

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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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.

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 (616) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410289784
Investigation #:	2025A0467023
Complaint Receipt Date:	02/18/2025
Investigation Initiation Date:	02/18/2025
Report Due Date:	04/19/2025
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Delissa Payne
Licensee Designee:	Delissa Payne
Name of Facility:	Blythefield Home
Facility Address:	3485 Rogue River Rd. NE Belmont, MI 49306
Facility Telephone #:	(616) 447-9380
Original Issuance Date:	06/25/2007
License Status:	REGULAR
Effective Date:	12/29/2023
Expiration Date:	12/28/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Ahmed Jibril left residents home alone.	Yes

III. METHODOLOGY

02/18/2025	Special Investigation Intake 2025A0467023
02/18/2025	Special Investigation Initiated - Letter Email to recipient rights officer, Michael Kuik
02/19/2025	Inspection completed – Onsite
02/19/2025	APS referral not necessary due to no residents being hurt as a result of being left home alone.
02/19/2025	Contact – telephone call made to AFC staff member, Ahmed Jibril
02/19/2025	Exit conference with Associate Director, Jordan Walch on behalf of licensee designee, Delissa Payne

ALLEGATION: Staff member Ahmed Jibril left residents home alone.

INVESTIGATION: On 2/18/25, I received a complaint from Kent County Recipient Rights Officer, Michael Kuik. The complaint alleged that Mr. Jibril left residents home alone and unsupervised for an unknown amount of time on 02/16/2025.

On 2/18/25, I communicated with Mr. Kuik via email and he shared that he spoke to staff member, Regan Paige regarding this incident. Ms. Paige informed Mr. Kuik that after the residents were left alone on 2/16/25, one of the residents attempted to call her, but she never saw the missed call on her phone. The following morning (2/17/25), Ms. Paige stated that she went to the home and several residents informed her that Mr. Jibril had left them at the home after saying he was going to get Subway. Per Ms. Paige, the residents were left unsupervised at the home for approximately one hour, starting around 6:30-6:40pm. Ms. Paige stated that Mr. Jibril was working a double shift on the day in question.

On 2/19/25, I made an unannounced onsite investigation at the facility. Upon arrival, staff member, Jordan Vanover answered the door and allowed entry into the home. Introductions were made with Resident A and he was offered to be interviewed privately. However, Resident A gave consent to be interviewed at the dining room table. Resident A confirmed his DOB and stated that he has lived at the home since October 2024 and “things are going great. I’m actually pretty happy here.” Resident A confirmed that this past Sunday (2/16/25), staff member Ahmed Jibril left him and

other residents' home alone for approximately one hour. Resident A stated that Mr. Jibril told residents that he was going to Subway and he would be back in 5 to 6 minutes, which did not occur. During the hour that Mr. Jibril was away, Resident A stated that no one else showed up to the home and none of the residents were hurt or injured. Since this incident occurred, Resident A stated that he has not seen Mr. Jibril at the home.

After speaking to Resident A, introductions were made with Resident B at the dining room table. Resident B confirmed his DOB and stated that he has been at the home for approximately one year. Resident B confirmed that things are going well for him at the home and staff are doing a good job of taking care of him. Resident B confirmed that this past Sunday (2/16/25), the staff member working at the home left him and the other residents' home alone for approximately one hour. Resident B was unable to recall the staff member's name who was working. While being home alone, Resident B stated that he went to his room and took a nap. Resident B confirmed that he and other residents were not harmed or injured while home alone. Aside from this isolated incident, Resident B denied being left home alone.

AFC staff member, Jordan Vanover did not work on the day of the incident, but he shared that when he worked at the home yesterday, Resident C told him that Mr. Jibril left him and other residents' home alone this past Sunday for approximately 2 hours, which was long enough for the residents to finish a movie before he returned. Resident C told Mr. Vanover that Mr. Jibril was reportedly going to get Subway and he would be back in 5 to 6 minutes. Mr. Vanover confirmed that since this incident, Mr. Jibril has not worked in this home. Prior to concluding my home visit, staff member Marta Houser provided me with contact information for Mr. Ahmed.

On 2/19/25, I called Mr. Jibril. However, his phone went directly to voicemail. I then sent him a text message requesting a call to discuss the allegation. As of the conclusion of this investigation, Mr. Jibril has not returned my call or text.

On 2/19/25, I spoke to associate director, Jordan Walch regarding this incident. Mrs. Walch confirmed that she received a statement from Mr. Jibril, and he thought it was okay for him to leave residents home alone because they told him he could go. Mrs. Walch agreed to send me the statement from Mr. Jibril via email. Mrs. Walch stated that Mr. Jibril has been suspended pending the outcome of the investigation. However, he will be terminated because of this incident. I conducted the exit conference with Mrs. Walch during this call, and she denied having any questions and agreed to complete a Corrective Action Plan within 15 days of receipt of this report.

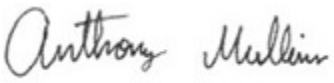
On 2/19/25, I received an email from Mrs. Walch that included staff member, Ahmed Jibril's statement regarding this incident. Mr. Jibril stated that on Sunday, 2/16/25, he went to pick-up food around 5pm to 6pm. When Mr. Jibril arrived at the restaurant, his food was not ready, so he waited approximately 25 minutes before returning to the home. Mr. Jibril stated that he did this "upon the request from the people in the

house," referring to residents. Due to receiving Mr. Jibril's statement, I will not need to interview him.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Mr. Jibril, Resident A, and Resident B all confirmed that Mr. Jibril left residents home alone on Sunday, 2/16/25. There is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



02/19/2025

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Anthony Mullins Date
Licensing Consultant

Approved By:

02/19/2025

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Jerry Hendrick Date
Area Manager