GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 10, 2025

Donna McBride
Spectrum Community Services
185 E. Main St., Suite 700
Benton Harbor, MI 49022

RE: License #: AS820315575
Investigation #: 2025A0575023
Freedom Residence

Dear Mrs. McBride:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On April 4, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS820315575
Investigation #:	2025A0575023
Complaint Receipt Date:	04/04/2025
Investigation Initiation Date:	04/04/2025
Report Due Date:	05/04/2025
Licensee Name:	Spectrum Community Services
Licensee Address:	185 E. Main St., Suite 700 Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Donna McBride
Licensee Designee:	Donna McBride
Name of Facility:	Freedom Residence
Facility Address:	15980 Oak Drive Livonia, MI 48154-3448
Facility Telephone #:	(734) 744-5441
Original Issuance Date:	05/23/2012
License **Status:**	REGULAR
Effective Date:	12/05/2024
Expiration Date:	12/04/2026
Capacity:	5
Program Type:	DD; MI

II. ALLEGATION(S)

	Violation Established?
Staff Laquan Aikens-Kirkland left his shift before the next staff arrived at the facility.	Yes

III. METHODOLOGY

04/04/2025	Special Investigation Intake 2025A0575023
04/04/2025	Special Investigation Initiated – Telephone
04/04/2025	Contact - Telephone call made-(a) Donna McBride, licensee designee; and (b) direct care staffs (1) Laquan Aikens-Kirkland (2) Michael Teetteh.
04/04/2025	APS Referral
04/04/2025	Referral-Recipient Rights
04/04/2025	Inspection Completed-BCAL Sub. Compliance
04/04/2025	Corrective Action Plan Received
04/04/2025	Corrective Action Plan Approved
04/04/2025	Corrective Action Plan Requested and Due
04/04/2025	Exit Conference with Donna McBride, licensee designee
04/07/2025	Contact- Telephone call made-Resident A's guardian

ALLEGATION:

Staff Laquan Aikens-Kirkland left his shift before the next staff arrived at the facility.

INVESTIGATION:

An APS and ORR referrals were received.

None of the residents were interviewed because they were all asleep at the time of the incident.

On 4/4/2025, I interviewed staff Laquan Aikens-Kirkland. He stated that on 4/3/2025 his shift was supposed to last until midnight and the next staff was supposed to arrive at 11:00pm. When the next staff had not arrived at 11:45pm and his UBER ride had arrived at 11:45pm, he checked on all of the residents to ensure they were asleep and left the facility. He stated he did not know who he was supposed to notify and that he did not notify the facility manager.

On 4/4/2025, I interviewed staff Michael Teetteh. He stated that when he arrived at the facility at midnight on 4/4/2025 for his overnight shift, there was no staff at the facility. He stated he checked on all of the residents to be sure they were asleep and safe and he logged the incident and notified the main office the next morning.

On 4/4/2025, I interviewed the licensee designee, Donna McBride. She stated that staff Laquan Aikens-Kirkland's employment with the licensee was terminated on 4/4/2025. She submitted an acceptable corrective action plan.

On 4/4/2025, I conducted an exit conference with Donna McBride.

On 4/7/2025, I contacted one of the resident's guardians. She stated that she was aware of this incident and was satisfied with his placement.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Since Laquan Aikens-Kirkland left the facility residents unsupervised before the next staff had arrived, then the licensee did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the license status.

Jeffrey J. Bozsik Date: 4/8/2025
Licensing Consultant

Approved By:

Ardra Hunter Date: 4/10/2025
Area Manager