GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 13, 2025

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

RE: License #: AS410316526
Investigation #: 2025A0467038
Alima Home AFC

Dear Mrs. Payne:

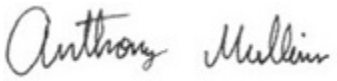
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with 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 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 (616) 356-0100.

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 #:	AS410316526
Investigation #:	2025A0467038
Complaint Receipt Date:	05/06/2025
Investigation Initiation Date:	05/06/2025
Report Due Date:	07/05/2025
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:	Alima Home AFC
Facility Address:	547 60th Street Kentwood, MI 49548
Facility Telephone #:	(616) 827-9902
Original Issuance Date:	03/21/2012
License Status:	REGULAR
Effective Date:	09/20/2024
Expiration Date:	09/19/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 4/28/25, Resident A was at the park for 3-4 hours with staff resulting in him sustaining sunburn on his hands and head.	Yes

III. METHODOLOGY

05/06/2025	Special Investigation Intake 2025A0467038
05/06/2025	APS Referral Not necessary based on allegations
05/06/2025	Special investigation initiated – On site
05/06/2025	Contact – Face to Face with Resident A at Moka Day Program
05/06/2025	Contact – telephone call made with Ben Winford, home manager and Sam Johnson, Associate Director
05/06/2025	Contact – document received from Sam Johnson
05/07/2025	Contact – telephone call made to Resident A's guardian, Deb Kiefer
05/12/2025	Exit conference with executive director, Jordan Walch on behalf of licensee designee, Delissa Payne

ALLEGATION: On 4/28/25, Resident A was at the park for 3-4 hours with staff resulting in him sustaining sunburn on his hands and head.

INVESTIGATION: On 5/6/25, I received a LARA-BCHS online complaint stating that Resident A sustained "bad sunburns" to his face, hands, and arms. As a result, Resident A's skin is "bright red, oozing, and his skin on his hand is split open." Resident A was reportedly transported to the park for an outing and sunscreen was not applied.

On 5/6/25, I made an unannounced onsite investigation at the facility. Upon arrival, home manager, Ben Winford answered the door and informed me that he was conducting a staff meeting, which was evident by the driveway having multiple vehicles present. Mr. Winford informed me that Resident A is currently at MOKA's Day Program and provided me with the address. Mr. Winford also provided me with his phone number and he was made aware that I would call him after his staff meeting concludes to discuss the complaint.

On 5/6/25, I made an unannounced visit to MOKA's Day Program in Wyoming, MI. Upon arrival, program supervisor Jenny Shumard introduced me to Resident A and provided us with a conference room to discuss the allegation. Resident A confirmed that last week Monday (4/28/25), home manager Ben Winford transported him and another resident to a park. While at the park, Resident A confirmed that he sustained a sunburn on his hands, face, and head. Resident A was unable to state how long he was at the park. However, he shared that staff typically applies sunscreen when necessary but he believes that Mr. Winford forgot to do so on the day in question. Resident A shared that it was an accident by Mr. Winford but the sunburn caused his head to bleed. Since sustaining the sunburn, Resident A stated that staff at the home and Day Program have been applying Aloe on his burns when needed. Aside from this incident, Resident A denied any other concerns in the home and reported that he feels safe and his needs are being met. It should be noted that Resident A is diagnosed with cerebral palsy and wheelchair bound, making it impossible for him to apply sunscreen to himself.

After speaking to Resident A, I spoke to the Day Program supervisor again, Jenny Shumard. Ms. Shumard stated that that the day after Resident A went to the park (Tuesday, 4/29/25), a staff member showed her pictures of the sunburn that Resident A sustained. Ms. Shumard eventually made her way to the building and observed the burns herself. Ms. Shumard stated that staff at the Day Program contacted Resident A's mother/guardian to inform her of this and she made her way to the office and observed the sunburns. Resident A's mother applied Aloe to Resident A's skin to treat the burns. Ms. Shumard stated that she received a doctor's note from Resident A's physician, which allows staff at Day Program to treat his sunburns. Ms. Shumard provided me with a copy of the doctor's note, which was authored on 5/2/25. The note explained recommendations to treat the sunburns, which included "cool compresses to area, can also take Tylenol as needed for pain." The recommendations also included staying out of the sun and wearing sunscreen. The note stated that Resident A can also use aloe vera gel and to keep the areas clean with soap and water. Ms. Shumard was thanked for her time as this interview concluded.

On 05/06/25, I spoke to home manager, Ben Winford via phone. Present on the phone with him was associate director, Sam Johnson. Mr. Winford confirmed that on 4/28/25, he took Resident A and another resident to Wabasis Park in Greenville, MI. Mr. Winford stated that everyone was at the park for approximately 3-4 hours. While there, Mr. Winford confirmed that Resident A did sustain sunburn on his hands and his head. Prior to this incident occurring, Mr. Winford stated that he did not have any knowledge that Resident A needed sunscreen applied to him on outings. Moving forward, Mr. Winford stated that SP100 sunscreen will be applied to Resident A to prevent a similar incident from occurring. Associate Director Sam Johnson intervened and stated that Mr. Winford started his employment at the home in mid-September 2024. Therefore, Mr. Winford had not had the opportunity to take Resident A anywhere in the community that he would need sunscreen prior to this incident. Ms. Johnson stated that she saw pictures from the outing and Resident A

was in the shade the whole time. Ms. Johnson also clarified that she is not stating that it is not possible to get sunburned in the shade, but she wanted to make it known that Resident A was not sitting in the sun for the duration of the outing.

Mr. Winford stated that he was “thrown off guard” by this incident. Mr. Winford and Ms. Johnson denied Resident A having anything documented in his assessment plan or other paperwork that would indicate Resident A requires sunscreen. Ms. Johnson also denied Resident A having a history of being photosensitive. Ms. Johnson agreed to send me a copy of Resident A’s assessment plan and biopsychosocial to review. Ms. Johnson stated that nothing is on Resident A’s annual orders other than applying sunscreen “as needed” when going out in the community. Ms. Johnson stated that Resident B had no injuries/sunburn although Resident A did. Ms. Johnson stated that she plans to follow-up with Resident A’s medical providers to see if he has a medication that is making him sensitive to the sun. Ms. Johnson confirmed that Resident A has been diagnosed with cerebral palsy, which limits his hands movements and makes him unable to apply sunscreen himself.

While Mr. Winford was at the park with Resident A and Resident B, Mr. Winford denied Resident A complaining about being too hot or his skin burning. Mr. Winford stated that he noticed redness on Resident A’s skin later in the day on Monday, 4/28/25, or the following day. Mr. Winford stated that Resident A had an appointment with palliative nurses yesterday at the home for a prescheduled appointment and believes they made a note about the burns to his skin. Mr. Winford added that Resident A’s guardian/mother communicated the concerns to his PCP (primary care physician), Alison Fabian and believes that the PCP likely made a note regarding this incident. Mr. Winford stated that the AFC staff are treating Resident A’s sunburns with pain reliever (Tylenol), putting Aloe on burns, as well as petroleum jelly, lotion and other skin protective ointments. Mr. Winford and Ms. Johnson were thanked for their time.

On 5/6/25, I received a copy of Resident A’s assessment plan and biopsychosocial. Resident A’s assessment plan confirmed that he is 100% dependent on staff to address his personal care needs, including assistance moving his wheelchair. His assessment plan and biopsychosocial did not make any mention of Resident A using sunscreen.

On 5/7/25, I spoke to Deb Kiefer, guardian/mother for Resident A via phone. Ms. Kiefer confirmed that Resident A was sunburned on his hands and head after going to a park on Monday, 4/28/25 with home manager, Ben Winford. Ms. Kiefer stated that she had no idea that Resident A went to the park on 4/28/25 until staff at MOKA Day Program called her the next day to come to the building to observe the sunburn that Resident A sustained. Ms. Kiefer stated that she told the Day Program staff to put cold compresses and aloe on the sunburn and she would contact Resident A’s doctor. Ms. Kiefer stated that she hopes Adult Protective Services does not get involved in this incident since it was an accident. Despite this being an accident, Ms.

Kiefer acknowledged that this shouldn't have happened. Ms. Kiefer stated that Resident A's sunscreen was "right on the side of his bag." Although Resident A having sunscreen applied to him when going out in the community may not be documented, Ms. Kiefer confirmed that this has been discussed with staff in the past. Ms. Kiefer stated, "I guess it's a rule that they have sunscreen when they go out." Ms. Kiefer stated that Resident A always wears a hat so she is unsure why he went to the park without one.

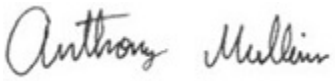
Ms. Kiefer confirmed that Resident A is unable to apply sunscreen to himself due to limitations of his cerebral palsy. Ms. Kiefer stated that Mr. Winford "is not a careless person. He's done an amazing job" at the home since taking over as the manager in the fall of 2024. However, she doesn't understand why this incident happened with Resident A. Ms. Kiefer stated, "why would you put someone in a wheelchair in the sun, even if they did have sunscreen on?" Ms. Kiefer then acknowledged that Resident A could have been sunburned with sunscreen, but she feels that it is unlikely that his burns would have been to the extent that they currently are. Ms. Kiefer stated that Resident B was also at the park and he was not sunburned. Ms. Kiefer stated that Resident A has psoriasis, but he doesn't take medications for this. Ms. Kiefer stated that she communicated with Resident A's PCP and she confirmed that Resident A has been on the same medications for an extended period of time and none of the medications would have caused this issue. Ms. Kiefer stated that she has since spoken to staff at the home and they have informed her that Resident A is looking better daily and they are treating his sunburn with aloe and lotion and it continues to improve.

On 05/12/2025, I conducted an exit conference with Jordan Walch on behalf of licensee designee, Delissa Payne. She was informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A went to the park for an outing with staff on 4/28/25 for 3-4 hours. As a result, he was sunburned on his hands and head. Staff confirmed that sunscreen was not applied to Resident A prior to going to the park. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend no changes to the current license status.



05/12/2025

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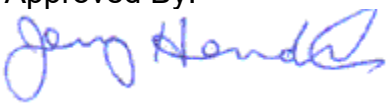
Anthony Mullins Date
Licensing Consultant

Approved By:



05/13/2025

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Jerry Hendrick Date
Area Manager