GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 20, 2025
Michelle Helmuth-Charles
LADD, Inc.
300 Whitney Dr.
Dowagiac, MI 49047

RE: License #: AS140010484
Investigation #: 2025A1030047
Country Manor Home

Dear Ms. Helmuth-Charles:

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.

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,

Nile Khabeiry, LMSW

Nile Khabeiry, 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 #:	AS140010484
Investigation #:	2025A1030047
Complaint Receipt Date:	08/14/2025
Investigation Initiation Date:	08/14/2025
Report Due Date:	10/13/2025
Licensee Name:	LADD, Inc.
Licensee Address:	300 Whitney Dr. Dowagiac, MI 49047
Licensee Telephone #:	(269) 240-1473
Administrator:	Michelle Helmuth-Charles
Licensee Designee:	Michelle Helmuth-Charles
Name of Facility:	Country Manor Home
Facility Address:	23250 Hospital Road Cassopolis, MI 49031
Facility Telephone #:	(269) 445-2462
Original Issuance Date:	11/01/1992
License Status:	REGULAR
Effective Date:	05/02/2024
Expiration Date:	05/01/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
McKenzi Hyche slapped and pushed Resident A.	Yes
Additional Findings	No

II. METHODOLOGY

08/14/2025	Special Investigation Intake 2025A1030047
08/14/2025	APS Referral APS referral made
08/14/2025	Special Investigation Initiated - Telephone Interview with Allison Robles
08/14/2025	Contact - Document Received Received and reviewed Incident Report
08/15/2025	Contact - Telephone call made Interview with Jazmin Lee
08/18/2025	Contact - Face to Face Face to face with Resident A
08/19/2025	Contact - Telephone call made Interview with Tyelurson Stanford
08/19/2025	Contact - Telephone call made Interview with McKenzi Hyche
08/20/2025	Exit Conference Exit conference by phone

ALLEGATION:

McKenzi Hyche slapped and pushed Resident A.

INVESTIGATION:

On 8/14/25, I received and reviewed an Incident Report (IR) regarding an incident that occurred on 8/13/25. The IR indicated direct care staff member (DCSM) McKenzi Hyche slapped Resident A's arms away from her when she tried to embrace Ms. Hyche. The IR also indicated that Resident A attempted to embrace her again and Ms. Hyche yelled "don't touch me" and then pushed Resident A in the chest to push her away.

On 8/14/25, I interviewed facility supervisor Allison Robles by phone. Ms. Robles reported that Ms. Hyche was suspended pending the outcome of the investigation. Ms. Robles reported Resident A did not suffer any physical injuries and that she is non-verbal.

On 8/15/25, I interviewed DCSM Jasmin Lee by phone. Ms. Lee reported that she was coming into work at the time the incident occurred. Ms. Lee reported Resident A tried to hug Ms. Hyche and in response Ms. Hyche pushed her and yelled at her to go back to bed. Ms. Lee reported she has never witnessed Ms. Hyche put her hands on a resident but frequently yells at them. Ms. Lee reported another staff member told Ms. Hyche that she should not put her hands on any of the residents.

On 8/18/25, I conducted an on-site investigation. Resident A was unable to be interviewed as she is non-verbal but was home and appeared to be doing well at the facility.

On 8/19/25, I interviewed DCSM Tyelurson Stanford by phone. Ms. Stanford reported she was working on 8/13/24 when the incident occurred between Resident A and Ms. Hyche. Ms. Stanford reported Resident A was already awake and they were getting her some banana bread to eat. Ms. Stanford that Ms. Hyche was coming into work for the morning shift and Resident A went to give her a hug and Ms. Hyche responded by pushing her and yelling "don't touch me and get off me." Ms. Standford reported another staff member told her that it's not ok to push one of the residents and Ms. Hyche ignored her. Ms. Stanford reported Ms. Hyche has yelled at residents in the past but has never pushed or hit them.

On 8/19/25, I interviewed DCSM McKenzi Hyche by phone. Ms. Hyche reported she was coming into work at about 6:20am on 8/13/25 and noted that Resident A was awake. Ms. Hyche reported she went to clock in for her shift and Resident A came up beside her and put her in a choke hold with her arm as a way to hug her. Ms. Hyche reported she gently took Resident A's arm from around her neck and put it by her side. Ms. Hyche reported she also politely told Resident A not to touch her and then walked

away. Ms. Hyche reported she would never slap or push a resident as it would be disrespectful. Ms. Hyche also denied yelling at Resident A.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged that a staff member slapped and pushed Resident A. Based on interviews and review of an incident report, this violation will be established. On 8/13/25 three staff members witnessed McKenzi Hyche slap and push Resident A when she tried to hug Ms. Hyche. In addition, Ms. Hyche was overheard being verbally disrespectful to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/20/25, I shared the findings of my investigation with licensee designee Michelle Helmuth-Charles by phone. Ms. Helmuth-Charles acknowledged the findings and agreed to submit a corrective action plan.

III. RECOMMENDATION

Contingent upon the submission of an acceptable corrective action plan, I recommend no change in the current license status.

Nile Khabeiry, LMSW

8/20/25

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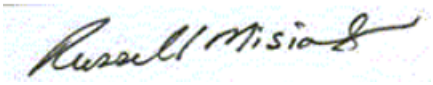
Nile Khabeiry Date
Licensing Consultant

Approved By:



8/20/25

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Russell B. Misiak Date
Area Manager