



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 21, 2026

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

RE: License #: AS820014549  
Investigation #: 2026A0116009  
Salem Residence

Dear Ms. 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 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 feel free to 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 (313) 456-0439.

Sincerely,

A handwritten signature in blue ink that reads "Pandrea Robinson". The signature is written in a cursive style with a large initial 'P'.

Pandrea Robinson, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 319-9682

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820014549
<b>Investigation #:</b>	2026A0116009
<b>Complaint Receipt Date:</b>	12/08/2025
<b>Investigation Initiation Date:</b>	12/09/2025
<b>Report Due Date:</b>	02/06/2026
<b>Licensee Name:</b>	Spectrum Community Services
<b>Licensee Address:</b>	Suite 700 185 E. Main St Benton Harbor, MI 49022
<b>Licensee Telephone #:</b>	(734) 458-8729
<b>Administrator:</b>	Donna McBride
<b>Licensee Designee:</b>	Donna McBride
<b>Name of Facility:</b>	Salem Residence
<b>Facility Address:</b>	28595 Huron River Drive Flat Rock, MI 48134
<b>Facility Telephone #:</b>	(734) 782-5607
<b>Original Issuance Date:</b>	03/25/1991
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/24/2024
<b>Expiration Date:</b>	04/23/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
On 12/06/25, at 7:00am staff, Samuel Udeozor, arrived at the home for his shift. Mr. Udeozor found the five residents home alone. Staff, Janai Rice, left the residents home alone, after the midnight staff failed to show for her shift.	Yes

## III. METHODOLOGY

12/08/2025	Special Investigation Intake 2026A0116009
12/09/2025	Special Investigation Initiated - On Site Staff, Samuel Udeozor, visually observed Residents A-C.
12/09/2025	Contact - Telephone call made Home manager, Ashley Smith.
12/09/2025	Contact - Document Received Received and reviewed the individual plans of service (IPOSs)for Residents A-E.
12/17/2025	Contact - Telephone call made Staff, Janai Rice.
01/07/2026	Referral - Recipient Rights
01/07/2026	APS Referral Made.
01/12/2026	Contact - Telephone call made Guardian D1.
01/12/2026	Contact - Telephone call made Guardian E1.
01/12/2026	Inspection Completed-BCAL Sub. Compliance
01/12/2026	Exit Conference Licensee designee, Donna McBride.

## **ALLEGATION:**

**On 12/06/25, at 7:00am staff, Samuel Udeozor, arrived at the home for his shift. Mr. Udeozor found the five residents home alone. Staff, Janai Rice, left the residents home alone, after the midnight staff failed to show for her shift.**

## **INVESTIGATION:**

On 12/09/25, I conducted an unscheduled onsite inspection and interviewed staff, Samuel Udeozor, and visually observed Residents A-C. Mr. Udeozor reported that on the morning of 12/06/25, he arrived to the home at 7:00 a.m. He reported that when he walked in, he immediately felt something was off. He reported that the only light on was the hallway light and the home was silent. Mr. Udeozor reported that when he gets to work in the mornings the residents are up and at the kitchen table getting ready for breakfast. He reported that he walked around the home and soon realized that there was no staff there. He reported he called the home manager, Ashley Smith, to inform her, and she instructed him to take the five residents to urgent care to be evaluated. Mr. Udeozor reported that Resident E is the only verbal resident, and he was unaware that staff, Janai Rice, had left the home as he was asleep. Mr. Udeozor reported that all of the residents were fine and likely unaware that they had been left alone. Mr. Udeozor reported that according to the home manager, Ashley Smith, she was able to confirm that staff, Janai Rice, punched out and left the home at 1:00 a.m. He reported that the midnight staff did not show up for her shift. Mr. Udeozor reported she is a newer staff and he could not recall her name.

I visually observed Residents A-C as they are non-verbal and unable to be interviewed. They were neatly dressed and groomed sitting in the living room. Resident D was in school and Resident E was at his workshop program.

On 12/09/25, I interviewed home manager, Ashley Smith, and she reported that on the morning of 12/06/25, she woke up to one missed call and text from staff, Janai Rice, informing her that the midnight staff, Angela Onyemuche-Ihebom, did not report for her shift and she needed to leave. Ms. Smith reported that Ms. Rice knows that if she is unable to get in contact with her, she has to call up the chain of command so that they can get a staff sent to the home to relieve her. Ms. Smith reported that Ms. Rice did not do that and made the decision to leave. Ms. Smith reported that she reviewed the payroll system and saw that Ms. Rice punched out at 1:00 a.m. leaving the residents home alone for six hours. Ms. Smith reported that at 6:50 a.m. she received a call from staff, Samuel Udeozor, informing her that the residents were all still in bed asleep and no staff was in the home. Ms. Smith reported that she instructed Mr. Udeozor to take the residents to urgent care to be evaluated to make sure they were okay as they are vulnerable and totally dependent

on staff for all of their needs. Ms. Smith reported to date staff, Janai Rice, has been suspended.

Ms. Smith reported that she reported the incident to APS and ORR.

On 12/09/25, I received and reviewed the IPOSs for Residents A-E and they document the following;

- Resident A requires 24-hour staffing as well as visual checks every 45 minutes during sleeping hours.
- Resident B requires visual checks every 30 minutes during sleeping hours.
- Resident C requires visual checks every 30 minutes.
- Resident D requires 24-hour supervision and in line of sight care at all times.
- Resident E requires visual checks every 30 minutes.

On 12/17/25, I interviewed staff, Janai Rice, and she reported that in the early morning hours of 12/06/25, she left the residents alone. Ms. Rice reported that she was scheduled to work the afternoon shift from 4:00 p.m. to 12:00 a.m. She reported that the midnight staff, Angela Onyemuche-Ihebom, did not show up so at about 12:27 a.m. she sent a text and called home manager, Ashly Smith, to see who was going to relieve her. Ms. Smith reported that she also texted the staff group chat and got no response. Ms. Rice reported that she has another job and that she could not stay over and work another shift and she needed to ensure she got home so that her children would not be alone. Ms. Rice reported that she waited and after no one responded she made the decision to leave. She reported she believed it was around 2:00 a.m. when she left. Ms. Rice reported that she is fully trained and knows that the residents require 24-hour supervision and should not be left alone, however, the midnight staff failing to show up for work put her in a bind, so she made the decision to leave. I informed Ms. Rice that although I understand the inconvenience this may have caused, it was a decision that placed five very vulnerable people at risk of harm. She reported understanding but reported she had to do what she had to do. Ms. Rice reported that she did not contact upper management or follow the chain of command because she thought that her manager was the person she needed to contact.

On 01/12/26, I interviewed Guardian D1 and she reported that home manager, Ashley Smith, informed her that the residents had been left alone overnight. Guardian D1 reported that she was thankful that all of the residents were okay and no harm was brought to them. She reported that she has had some concerns regarding Resident D's hygiene and has addressed it with the home manager and staff.

On 01/12/26, I interviewed Guardian E1 and she reported that home manager, Ashley Smith, informed her of the incident and she is not happy about it. She reported she is just glad that the residents were unharmed. Guardian E1 reported

that overall, this is a good home, and the staff have provided good care to Resident E.

On 01/12/26, I conducted the exit conference with licensee designee, Donna McBride, and informed her of the findings of the investigation. Ms. McBride reported that she was immediately made aware of the situation by home manager, Ashley Smith. Ms. McBride reported that staff, Janai Rice, has been terminated. Ms. McBride reported that the midnight staff, Angela Onyemuche-Ihebom, who did not report for her shift on 12/06/25, was moved to another home that is in closer proximity to where she lives as the distance was creating a barrier for her to get to work. Ms. McBride reported that she would submit an acceptable corrective action plan upon receipt of the report.

<b>APPLICABLE RULE</b>	
<b>R 400.633</b>	<b>Staffing requirements.</b>
	<p><b>(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following:</b></p> <p><b>(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.</b></p> <p><b>(b) 12 residents for small group and family homes.</b></p>
<b>ANALYSIS:</b>	<p>Based on the findings of the investigation, which included interviews of staff, Samuel Udezor, home manager, Ashley Smith, staff, Janai Rice, and my review of Residents A-E IPOSs, there is a preponderance of evidence to substantiate the allegations that on 12/06/25 there was not sufficient staff on duty for the supervision, personal care, and protection of the residents</p> <p>Residents A-E were left home alone for 6 hours (1:00 a.m. to 7:00 a.m.) after staff, Janai Rice, left. Residents A-E IPOSs document and require staff to conduct visual checks on each of them during sleeping hours, in addition to them requiring 24-hour supervision.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



Pandrea Robinson  
Licensing Consultant

01/20/26  
Date

Approved By:



01/21/26

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Ardra Hunter  
Area Manager

Date