GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 1, 2026

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

RE: License #: AS820315575
Investigation #: 2026A0993013
Freedom Residence

Dear Ms. McBride:

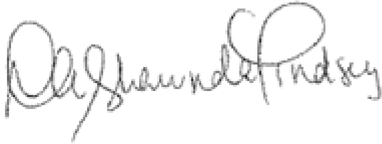
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 456-0380.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820315575
Investigation #:	2026A0993013
Complaint Receipt Date:	05/22/2026
Investigation Initiation Date:	05/22/2026
Report Due Date:	07/21/2026
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St 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:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 05/12/2026, Resident A was not administered his medication Latuda.	Yes

III. METHODOLOGY

05/22/2026	Special Investigation Intake 2026A0993013
05/22/2026	APS Referral Received allegations from Adult Protective Services (APS). APS denied the intake.
05/22/2026	Referral - Recipient Rights Forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
05/22/2026	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation. I interviewed staff, Ross Henderson. I attempted to interview Resident A with no success.
05/22/2026	Inspection Completed-BCAL Sub. Compliance
05/26/2026	Contact - Telephone call made Telephone call made to DWIHN recipient rights officer, Phoenicia Jackson
05/26/2026	Contact - Telephone call made Telephone call made to home manager, Lawrence Faulk. Left a message.
05/26/2026	Contact - Telephone call made Telephone call made to supports coordinator, Belsheda Blakey. Left a message.
05/26/2026	Contact - Telephone call made Telephone call made to Guardian A1. Left a message.
05/26/2026	Contact - Telephone call received Telephone call received from Guardian A1

05/26/2026	Contact - Telephone call received Telephone call received from home manager, Lawrence Faulk
05/27/2026	Contact - Telephone call made Telephone call made to supports coordinator, Belsheda Blakey
05/29/2026	Contact - Document Received Received a copy of Mr. Henderson's training transcript
05/29/2026	Contact - Telephone call made Telephone call made to staff, Eric Julks
05/29/2026	Exit Conference Held with licensee designee, Donna McBride

ALLEGATION:

On 05/12/2026, Resident A was not administered his medication Latuda.

INVESTIGATION:

On 05/22/2026, I received allegations from Adult Protective Services (APS). APS denied the intake.

On 05/22/2026, I forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights.

On 05/22/2026, I conducted an unannounced onsite investigation. I interviewed staff, Ross Henderson. I attempted to interview Resident A with no success. Resident A did not wish to talk with me.

Mr. Henderson acknowledged he did not administer Latuda to Resident A at 6:00 p.m. on 05/12/2026. Mr. Henderson stated, on that day, he popped Resident A's medication out of the bubble pack and signed the Medication Administration Record (MAR). While administering medications, staff, Eric Julks, was having trouble redirecting another resident back into the facility. Mr. Henderson stated he put Resident A's medication back in the bubble pack, locked the medication in the cabinet, and assisted Mr. Julks with redirecting the resident. Mr. Henderson stated he simply forgot to administer the medication to Resident A afterwards. Mr. Henderson confirmed he completed medication administration training.

While at the facility, I observed Resident A's medications and MAR. I observed the following:

- The Latuda was still in the bubble pack for 05/12/2026.

- Staff initialed the MAR to show administration of Latuda at 6:00 p.m. on 05/12/2026.
- Staff did not initial the MAR to show administration of Trazadone HCl 50mg at 8:00 p.m. on 05/21/2026.
- Resident A is prescribed Clozapine 50mg at bedtime. The medication was not listed on the MAR. Per the bubble pack, staff administered the medication to Resident A from 05/03/2026 to 05/21/2026.

On 05/26/2026, I conducted a telephone interview with DWIHN recipient rights officer, Phoenicia Jackson. She confirmed she is also investigating the allegations. Her investigation is pending.

On 05/26/2026, I conducted a telephone interview with Guardian A1. She confirmed she was aware staff did not administer Resident A's medication to him on 05/12/2026. Per Guardian A1, there are a few good staff at the facility, but there are also some lazy staff.

On 05/26/2026, I conducted a telephone interview with home manager, Lawrence Faulk. He confirmed Mr. Henderson did not administer Resident A's Latuda to him on 05/12/2026. He confirmed all staff who administer medications have completed medication administration training.

On 05/27/2026, I conducted a telephone interview with supports coordinator, Belsheda Blakey. She confirmed that staff did not administer Latuda to Resident A on 05/12/2026. She stated staff could benefit from additional training as well as the importance of documentation.

On 05/29/2026, I reviewed a copy of Mr. Henderson's training transcript, confirming he completed medication administration training.

On 05/29/2026, I conducted a telephone interview with staff Eric Julks. He confirmed he was working in the facility with Mr. Henderson when he did not administer one of Resident A's medications to him. Per Mr. Julks, while administering medications, Mr. Henderson assisted him with redirecting one of the other residents. Mr. Henderson forgot to administer the medication afterwards. Mr. Julks stated he does not administer medications. He also stated all staff who administer medications have been trained to do so.

On 05/29/2026, I contacted licensee designee, Donna McBride, and conducted an exit conference. I informed her of the department's recommendation.

APPLICABLE RULE	
R 400.675	**Resident medications.**

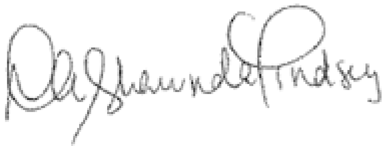
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Mr. Henderson did not administer Latuda to Resident A at 6pm on 05/12/2026. Evidence supports that a medication was not given, taken or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	Staff initialed Resident A’s MAR to show administration of Latuda at 6:00 p.m. on 05/12/2026. Although the medication was not administered. Staff did not initial Resident A’s MAR to show administration of Trazadone HCl 50mg at 8:00 p.m. on 05/21/2026. Resident A is prescribed Clozapine 50mg at bedtime. The medication is not listed on Resident’s MAR. Per the bubble pack, staff administered the medication to Resident A from 05/03/2026 to 05/21/2026.

	Evidence supports that a licensee, administrator, or direct care did not complete the Resident's medication log when administering the medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



05/29/2026

DaShawnda Lindsey Date
Licensing Consultant

Approved By:

06/01/2026

Ardra Hunter Date
Area Manager