GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 6, 2026

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

RE: License #: AS820315575
Investigation #: 2026A0992044
Freedom Residence

Dear Donna 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,



Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 300-9922

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820315575
Investigation #:	2026A0992044
Complaint Receipt Date:	08/06/2026
Investigation Initiation Date:	08/07/2026
Report Due Date:	10/05/2026
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?
• Resident A experienced verbal abuse by a staff member, Chris Lacy and medication neglect. • There are concerns about Resident A missing day program due to the home being short staffed.	No Yes

III. METHODOLOGY

08/06/2026	Special Investigation Intake 2026A0992044
08/07/2026	Special Investigation Initiated - Telephone Office of Recipient Rights (ORR), Tiffany Burgess
08/11/2026	Inspection Completed On-site Direct care staff, Micheal Tetteh and Resident A.
08/12/2026	Contact - Telephone call made Home manager, Lawrence Faulk, was not available. Message left.
08/12/2026	Contact - Telephone call made Licensee designee, Donna McBride.
08/18/2026	Contact - Telephone call made Mr. Faulk
08/18/2026	Contact - Telephone call made Quality Coordinator, Daniella Graham
09/01/2026	Contact - Telephone call made Ms. Graham
09/01/2026	Contact - Telephone call made Resident A's guardian, Guardians A1 and A2 were not available. Message left.
09/01/2026	Contact - Document Received Resident A's medical documents.
09/11/2026	Contact - Face to Face Direct care staff, Ross Henderson and Resident C.
09/24/2026	Contact - Telephone call made

	Former direct care staff, Chris Lacy
09/28/2026	Contact - Telephone call made Guardians A1 and A2
09/29/2026	Contact - Telephone call made Ms. Burgess
09/29/2026	Contact - Telephone call made Ms. McBride was not available. Message left.
10/01/2026	Exit Conference Ms. McBride

ALLEGATION:

- **Resident A experienced verbal abuse by a staff member, Chris Lacy and medication neglect.**

- **There are concerns about Resident A missing day program due to the home being short staffed.**

INVESTIGATION: On 08/07/2026, I contacted Office of Recipient Rights (ORR), Tiffany Burgess regarding the allegation. Ms. Burgess stated based on her preliminary findings, it appears as though Resident A did miss a substantial amount of program for various reasons. She stated it was alleged that Resident A had scabies and could not attend program, but after a second opinion from the dermatologist, it was determined that Resident didn't have scabies. Ms. Burgess stated she is awaiting medical documentation to support that Resident A was examined at Urgent Care and dermatology. She stated there was also a staff issue that caused Resident A to miss program on one or two separate occasions. She stated staff called off and by the time coverage was secured, it was too late for Resident A to go to program because he must be there by a certain time, she believes he must be there by 9:00 a.m. or he cannot attend. As it pertains to medication, it appears the home switched pharmacies, so it wasn't that the medication wasn't given the direct care staff finished the medication in the blister pack from the pharmacy they were switching from before starting the medication from the new pharmacy; that's why the medication in the new blister pack was unused. She stated no concerns or discrepancies were found. Ms. Burgess stated she is still actively investigating the allegation. She stated she reported the allegations to adult protective services on 08/06/2026; she is unaware if the allegation was assigned for investigation.

On 08/11/2026, I completed an unannounced on-site inspection and interviewed direct care staff, Micheal Tetteh and Resident A. Mr. Tetteh denied having any

knowledge of direct care staff, Chris Lacy verbally abusing Resident A. Mr. Tetteh stated Mr. Lacy work midnights, and he has never worked with him. He stated to his knowledge Resident A receives his medication as prescribed. He stated administering medication has never been a concern to his knowledge. As it pertains to Resident A missing program, he confirmed that. He stated there have been instances when staff have called off and coverage wasn't secured in time for Resident A to attend program; he stated he believes he has to be there by 9:00 a.m.

It should be noted that Resident A was present and didn't attend program today due to staff calling off.

I interviewed Resident A. Resident A immediately stated he is stressed out. He stated he is having issues with his roommate, Resident B. I asked if he has made the staff aware of the issues he is having with his roommate and he said, yes. He stated one night when he was up late dealing with his roommate, staff Chris told him "to take his white motherfucking ass back in his room." Resident A stated Chris was the only staff on shift. He stated no one else heard him because the other residents were in their bedroom. Regarding program, Resident A stated he attends program regularly but there have been times when he didn't go because staff called off. He stated typically there are two staff on shift, but sometimes a staff calls off and there's only one staff on shift. Resident A stated if there is only one staff on shift, no one is available to take him to program but that doesn't happen too often. Resident A stated he receives his medication daily around the same time; he denied having any concerns regarding his medications.

I reviewed Resident A's medication administration records (MARs) and didn't observe any discrepancies.

On 08/12/2026, I contacted licensee designee, Donna McBride and interviewed her regarding the allegation. Ms. McBride denied having any knowledge of Chris Lacy making any derogatory statements towards Resident A. She stated no one reported that to her and she has no knowledge of medication neglect. As far as Resident A missing program, she stated she wasn't aware of him missing program other than when there was a concern of him possibly having scabies. She stated during that time he had several doctors' appointments which might have caused him to miss program. She stated it was later determined that he didn't have scabies, it was eczema. I explained that it was reported that due to insufficient staffing he missed several days; Ms. McBride stated she wasn't aware of that. I made her aware that I visited the home on 08/11/2026 and he didn't attend due to the lack of staff. Ms. McBride stated quality coordinator, Daniella Graham, is available to transport Resident A to program anytime there is a staffing issue and the home manager, Lawrence Faulk should be aware of that; she stated she will follow-up to make sure all staff are aware.

On 08/18/2026, I contacted home manager, Lawrence Faulk regarding the allegation. Mr. Faulk denied Resident A was verbally abused by Chris or any other

staff. He stated he works the midnight shift with Chris, and he did not hear him make any derogatory statements towards Resident A. I asked when Chris is scheduled to work, and he stated Chris quit last week. Mr. Faulk provided a contact number for Chris. Mr. Faulk denied Resident A's medication needs were neglected. He stated Resident A received his medication as scheduled. As far as unused medications being observed in the blister pack, he stated the home was in the process of changing pharmacies. He stated the staff initial the blister pack as well as the MARs as a secondary verification that the medication was administered. He stated he believed the concern was that the staff are instructed to initial the blister pack and include the start date if it is start of a new pack. He stated for example if a resident receives medication from the hospital, sometimes they don't receive a month's worth of medication, so when the actual script is filled the staff initial the blister back and include the start date of the medication. He stated the residents receive their medication as prescribed. As far as Resident A missing program, Mr. Faulk confirmed Resident A missed a substantial amount of program due to a misdiagnosis of scabies. He stated Resident A was examined at urgent care and was treated to address it. He stated during Resident A's follow-up appointment the doctor stated it didn't appear to be scabies and referred him to a dermatologist. Mr. Faulk stated because the skin rash was not cleared, he couldn't return to program. He stated he notified program of what was going on. Mr. Faulk stated Resident A was examined by the dermatologist and received a clearance to return to program. I explained that it was reported that due to insufficient staffing he missed several days, which Mr. Faulk confirmed. He stated it is not a regular occurrence that staff call off and Resident A miss program, but it has happened. I made him aware that Resident A has a right to attend program. I also explained that Ms. McBride stated that Ms. Graham is available to transport if there is an issue with staffing, which he confirmed. He stated Ms. McBride made him aware that Ms. Graham is available in case there is a staff shortage. I requested medical documentation to confirm Resident A was seen at urgent care and the dermatologist. He stated he is currently on vacation for a week and suggested I contact Daniella Graham.

On 08/18/2026, I contacted quality coordinator, Daniella Graham and requested medical documentation to confirm Resident A was seen at urgent care and the dermatologist, which she agreed to provide.

On 09/01/2026, I made follow-up contact with Ms. Graham regarding the requested documents. She explained that she gathered the documents and will send the copies today.

On 09/01/2026, I received consultation forms for Resident A. Consultation form dated 06/08/2026; the location/facility/agency visited area was not completed. The diagnosis: scabies, seborrheic dermatitis; medication was prescribed and a referral to Advanced Dermatology Cosmetic Surgery. Consultation form dated 06/29/2026; the location/facility/agency visited area, Internal Medicine Associates. The diagnosis: a form of dermatitis; medication was prescribed. Consultation form dated 07/06/2026; the location/facility/agency visited area was not completed. Findings:

scabies resolved. I also received a return-to-work form for Resident A dated 07/06/2026.

On 09/11/2026, I made face-to-face contact with direct care staff, Ross Henderson and Resident C. Mr. Henderson denied having knowledge of the allegation. He stated Resident B is currently hospitalized.

I attempted to interview Resident C regarding the allegation; he has a slight speech impediment. Resident C denied hearing staff, Chris tell Resident A take his “white motherfucking ass back in his room.” Resident C stated he receives his medication regularly.

On 09/24/2026, I contacted former direct care staff, Chris Lacy, and interviewed him regarding the allegation, which he denied. He stated he would often tell Resident A to go back to bed because he would get up late at night and there were times, he would disturb his roommate. However, he stated he has never used any form of derogatory language towards Resident A or any of the residents. He stated he believes someone coached him into saying that. He stated he has never had an issue with Resident A, and he doesn’t believe he reported that on his own.

On 09/28/2026, I contacted Guardians A1 and A2 regarding the allegation. Guardians A1 and A2 confirmed there were some issues with Resident A missing program, but it was addressed with Mr. Faulk, a representative from Community Living Services (CLS) and Ms. Graham during a meeting; he stated the issue was resolved. He stated there was an issue with Resident A being misdiagnosed with scabies. Guardians A1 stated he believed it was a combination of Mr. Faulk dropping the ball and not making sure there were staff available and staff were also calling off. Guardians A1 and A2 stated Resident A has been experiencing some issues at the home with his roommate, Resident B and staff Chris. However, he stated the issues have been addressed, and Resident A will be relocating. As it pertains to his roommate, he stated his roommate has extreme behaviors and can become violent. Guardians A1 and A2, stated staff Chris was using derogatory language towards Resident A and called him, “a white hunky” and told him to go to bed. Guardian A1 stated there is no reason for the staff to talk to any of the residents like that. Guardian A1 stated Mr. Faulk and Chris are no longer at that home. Guardians A1 and A2 stated Resident A is relocating and it’s for the best. Guardians A2 stated she likes Spectrum services and they have diligently worked with Resident A to make sure his needs are addressed and that he is safe.

On 09/29/2026, I made follow-up contact with Ms. Burgess. She stated she did not substantiate on the alleged medication neglect or verbal abuse. She stated it appears as though the home had two separate blister packs with the same medication and the medication was given. As it pertains to the alleged verbal abuse, she stated there was not enough evidence to substantiate. She stated it was Resident A’s word against Chris and there were no witnesses. Ms. Burgess stated she did substantiate due to Resident A missing a substantial amount of program due

to staff calling or just failure to provide Resident A with transportation to and from program.

On 10/01/2026, I conducted an exit conference with Ms. McBride regarding the findings. I explained that there is insufficient evidence to support the allegation of verbal abuse by the staff and medical neglect. As it pertains to missing program, Resident A did miss a substantial amount of program and failure to provide Resident A with transportation to and from program. I also explained that Resident A, Guardian A1 and A2 explained that there were also issues with him attending program regularly. Ms. McBride stated steps have been implemented to ensure Resident A is able to attend program. I made Ms. McBride aware that due to the violations identified in the report, a written corrective action plan (CAP) is required; she agreed to submit the CAP.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	During this investigation, I interviewed licensee designee, Donna McBride; home manager, Lawrence Faulk; quality coordinator, Daniella Graham; direct care staff, Micheal Tetteh and former staff, Chris Lacy; ORR, Tiffany Burgess; Guardian A1 and A2; and Resident C regarding the allegation. All of which denied the allegation. Residents A, stated staff Chris told him to “take his white motherfucking ass back in his room.” Former staff, Chris, stated he often told Resident A to go back to bed because he would get up late at night and disturb his roommate. Chris denied using any form of derogatory language towards Resident A or any of the residents. Based on the information obtained during this investigation, there is insufficient evidence to support the allegation. The allegation is denied.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	During this investigation, I interviewed licensee designee, Donna McBride; home manager, Lawrence Faulk; quality coordinator, Daniella Graham; direct care staff, Micheal Tetteh; ORR, Tiffany Burgess; Guardian A1 and A2; Residents A and C regarding the allegation. All of which denied the allegation. Resident A stated he receives his medication daily around the same time; he denied having any concerns regarding his medications. I reviewed Resident A's medication administration records (MARs) and didn't observe any discrepancies. Based on the information obtained during this investigation, there is insufficient evidence to support the allegation. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following: **(b) The services to be provided and the fee for those services.**

ANALYSIS:	During this investigation, I interviewed licensee designee, Donna McBride; home manager, Lawrence Faulk; quality coordinator, Daniella Graham; direct care staff, and Micheal Tetteh; ORR, Tiffany Burgess; Guardian A1 and A2; and Resident A regarding the allegation. All of which denied the allegation. Lawrence Faulk stated in addition he stated Resident A missing program due to a medical issue; there were also instances when transportation was not provided which resulted in Resident A missing program. Tiffany Burgess also stated she spoke with a representative from Resident A's program that confirmed Resident A had a substantial number of unexcused absences. Resident A confirmed he has missed program multiple times. I completed an unannounced onsite on 8/11/2026, and Resident A did not attend program. Based on the information obtained during this investigation, transportation was not provided as outlined in Resident A's resident care agreement. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.



10/06/2026

Denasha Walker — Date
Licensing Consultant

Approved By:



10/06/2026

Ardra Hunter — Date
Area Manager