GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 24, 2025

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

RE: License #: AS410357191
Investigation #: 2025A0467026
Clyde Park Home

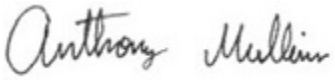
Dear Ms. Payne

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 356-0183.

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 #:	AS410357191
Investigation #:	2025A0467026
Complaint Receipt Date:	02/26/2025
Investigation Initiation Date:	02/26/2025
Report Due Date:	04/27/2025
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:	Clyde Park Home
Facility Address:	8510 Clyde Park Ave. SW Byron Center, MI 49315
Facility Telephone #:	(616) 277-1955
Original Issuance Date:	04/02/2014
License Status:	REGULAR
Effective Date:	02/08/2025
Expiration Date:	02/07/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents were left unsupervised at the home for a short period of time on Sunday, 2/23/25.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/26/2025	Special Investigation Intake 2025A0467026
02/26/2025	Special Investigation Initiated - Letter via email with Recipient Rights Officer, Michael Kuik
02/26/2025	Inspection Completed On-site
02/26/2025	APS Referral Not required due to allegations.
02/26/2025	Contact - Telephone call made Samantha Johnson
03/06/2025	Exit conference with Jordan Walch.

ALLEGATION: Residents were left unsupervised at the home for a short period of time on Sunday, 2/23/25.

INVESTIGATION: On 2/26/25, I received a complaint from Recipient Rights Officer, Michael Kuik. The complaint alleged that staff member, Urayeneza Theogene ended his shift on Sunday, 2/23/25 at 12:00 am and left the residents in the home unsupervised. At 12:07am, staff member John Kamau arrived at the home to start his shift when he noticed that residents were left alone. The complaint stated that Mr. Theogene did not contact the program manager or the incoming staff prior to leaving.

On 2/26/25, I made an unannounced onsite investigation at the facility. Upon arrival, staff member Anna Nuiramugisha answered the door and allowed entry into the home. Staff introduced me to Resident A and he agreed to be interviewed regarding the allegation. Resident A was unable to recall how long he has lived in the home. Resident A stated that things are “good” at the home and he likes living there. Resident A denied any knowledge of staff leaving him or other residents unsupervised in the home. Resident A reported feeling safe in the home and denied any questions.

It should be noted that the other residents were not interviewed as Ms. Nuiramugisha shared that they are unable to be interviewed due to their cognitive

ability. Ms. Nuiramugisha and staff member, Maie Legerre were asked about residents being left unsupervised in the home. Both staff members stated that they have no knowledge of this happening on other staff members' shifts. However, residents have never been left alone on their shift. Both staff members shared that management will likely be able to provide additional information.

On 2/26/25, I spoke to staff member, Samantha Johnson via phone. Ms. Johnson confirmed that staff member, Mr. Theogene admitted to ending his shift at 12:00am on 2/23/25 and leaving the residents unsupervised. Ms. Johnson stated that Mr. Theogene couldn't provide a good explanation as to why he left early. Ms. Johnson confirmed that staff member, Mr. Kamau arrived at the home at 12:07am, which is when he discovered residents were left alone. Mr. Kamau contacted management to inform them of this incident.

On 3/6/25, I conducted an exit conference with Jordan Walch, director, on behalf of licensee designee, Delissa Payne. Ms. Walch confirmed knowledge of the incident and aware that a corrective action is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Staff member, Mr. Theogene left residents unsupervised after ending his shift prior to the next shift staff arriving. Ms. Johnson and Mrs. Walch both confirmed this. Per Ms. Johnson, Mr. Theogene and Mr. Kamau also confirmed this. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegation listed above, staff member Samantha Johnson informed me that Mr. Theogene has only being employed by the agency for 2 weeks. As a result of his recent employment, Mr. Theogene has not completed all required trainings. Therefore, Mr. Theogene should not be providing care to residents alone. Ms. Johnson stated that the staff member that called in never informed management that he asked Mr. Theogene to cover his shift. Ms. Johnson confirmed that if standard protocol was followed by staff, Mr. Theogene would not have provided care to residents without someone else present.

On 3/6/25, I conducted an exit conference with Jordan Walch, director, on behalf of designee, Delissa Payne. Ms. Walch confirmed knowledge of the incident and is aware that a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Ms. Johnson confirmed that Mr. Theogene was providing individual care to residents without completing all required trainings. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

Anthony Mullins 03/24/2025

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Anthony Mullins, Licensing Consultant Date

Approved By:

Jerry Hendrick 03/24/2025

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Jerry Hendrick, Area Manager Date