GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 29, 2025

Jordan Walch
Spectrum Community Services
Suite 700, 185 E. Main St, Benton Harbor, MI 49022

RE: License #: AS410357191
Investigation #: 2025A0467043
Clyde Park Home

Dear Mrs. Walch:

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) 356-0100.

Sincerely,

Anthony Mullins

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 #:	2025A0467043
Complaint Receipt Date:	06/02/2025
Investigation Initiation Date:	06/03/2025
Report Due Date:	08/01/2025
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Jordan Walch
Licensee Designee:	Jordan Walch
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?
Resident A eloped from the home between 5/29/25 and 6/1/25 and was nearly hit by a vehicle.	Yes

III. METHODOLOGY

06/02/2025	Special Investigation Intake 2025A0467043
06/03/2025	Special Investigation Initiated - On Site
06/04/2025	Contact – telephone call made to AFC staff member Delicia Bonto
06/04/2025	Contact – text messages received from AFC associate director, Sam Johnson.
07/29/2025	Exit conference with licensee designee, Jordan Walch.
07/29/2025	APS Referral not necessary based on findings of investigation.

ALLEGATION: Resident A eloped from the home between 5/29/25 and 6/1/25 and was nearly hit by a vehicle.

INVESTIGATION: On 6/2/25, I received a LARA-BCHS online complaint stating that on or around 6/1/25, Resident A was able to elope from the AFC home and crossed a busy street unsupervised for approximately 10 minutes. As a result of this, Resident A was almost hit by several vehicles. The complaint alleged that staff have allowed residents to elope from the home before, putting them at risk of harm.

On 6/3/25, I made an unannounced onsite investigation at the facility. Upon arrival, I knocked on the door and staff member, Anna Nyiuamugisha answered the door and allowed entry into the home. Ms. Nyiuamugisha was asked about the allegation and stated that she has no knowledge of any of the residents eloping within the last week. However, Ms. Nyiuamugisha added Resident A and Resident B have a history of eloping the home within the last two years. Also present in the home was Sparks Behavioral Monitor, Demetrius Burke. Mr. Burke confirmed that Resident A has a history of eloping. Mr. Burke stated that Resident A likes to go outside to the neighbor's tree, which was reportedly approved by the home manager. Ms. Nyiuamugisha was unable to provide any additional information regarding this reported incident.

While onsite, I reviewed Resident A and Resident B's assessment plan. Resident A's assessment plan indicates that he needs "verbal directions for safety" and "complete assistance in community." It also indicates that Resident A is fast and

likes to run while in community. Resident B's assessment plan states that "staff should stay in arm's length as (Resident A) has no regards to safety."

On 6/4/25, I spoke to home manager, Delicia Bonto via phone. Ms. Bonto denied any knowledge of residents eloping from the home on 5/29/25. Ms. Bonto stated that on the day in question, she was away from the home to take two residents to the grocery store. Regarding a resident eloping from the home, Ms. Bonto stated, "the only person it could have been was (Resident A)." Ms. Bonto confirmed that both Resident A and Resident B have a history of eloping. However, Resident B was at school during the reported incident. Ms. Bonto stated that the only staff member at the home was Urayeneza Theogene as she and Aimabale Ngendahayo were with other residents at the grocery store. Ms. Bonto stated that Mr. Theogene did not inform her of any residents eloping when she returned home.

However, on 6/1/25, Ms. Bonto stated that she received a call from staff member, Idelette Tsobze. Present at the home with Ms. Tsobze was staff member, Aimable Ngendahayo. Ms. Tsobze told Ms. Bonto that Resident B had eloped from the home, but he has since returned. Ms. Tsobze confirmed that Resident B was not harmed and Ms. Bonto instructed her to complete an incident report. Ms. Tsobze told Ms. Bonto that on 6/1/25, she was cleaning the home. While doing so, Resident B was pacing back and forth. Ms. Bonto stated that Ms. Tsobze eventually heard the front door open, which she believed to be Aimable Ngendahayo. After confirming that Mr. Ngendahayo was in the home and not being able to locate Resident B, Ms. Tsobze informed Mr. Ngendahayo of this, and he ran out the door to locate Resident B. Ms. Tsobze informed Ms. Bonto that Resident B was located "really far" down the road, and Mr. Ngendahayo went to get him. Ms. Tsobze stated that she was outside for approximately 10 minutes. During this time, Mr. Ngendahayo was still outside chasing after Resident B. Another 15 minutes had passed and Ms. Tsobze stated that she went outside and noticed that Mr. Ngendahayo and Resident B were with a police officer at this time. The incident last approximately 25-30 minutes in total prior to Resident A being returned to the home. Ms. Tsobze stated that Mr. Ngendahayo told her that Resident B "almost got hit by a car."

Ms. Bonto shared that she spoke to Mr. Ngendahayo via phone. Ms. Bonto stated that Mr. Ngendahayo did not give her any of the details that Ms. Tsobze gave her. Mr. Ngendahayo only stated that he went outside to find Resident B and that he had to redirect him back to the home. Ms. Bonto stated Resident B likely eloped due to issues with his iPad not working. Ms. Bonto stated that both Resident A and Resident B are non-verbal and have limited communication skills. Therefore, they are unable to be interviewed.

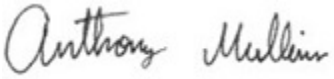
On 6/4/25, I spoke to Spectrum Community Services Associate Director, Sam Johnson via text message. Ms. Johnson confirmed that there is documentation confirming that Resident B eloped on 6/1/25, leading to police involvement. Ms. Johnson sent over a copy of an incident report from 6/1/25, which also confirmed that Resident B had eloped from the home.

On 7/29/25, I conducted an exit conference with licensee designee, Jordan Walch. She was informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receipt of this report. Mrs. Walch also confirmed that there have not been any further incidents of elopement with Resident B since this occurred.

APPLICABLE RULE	
R 400.14306	**Resident care; licensee responsibilities**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident B eloped from the home on 6/1/25 and was nearly hit by a vehicle. This also led to law enforcement getting involved to assist in returning Resident B to the home. Per Resident B's assessment plan, "staff should stay in arm's length as (Resident B) has no regards to safety" while in the community. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

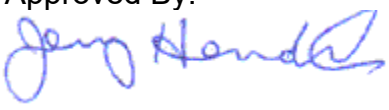
Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.



07/29/2025

Anthony Mullins Date
Licensing Consultant

Approved By:



07/29/2025

Jerry Hendrick Date
Area Manager