



STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

October 6, 2025

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

RE: License #:	AS410360517
Investigation #:	2025A0356052
	Parkview Home

Dear Ms. 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.
- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth Elliott".

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410360517
Investigation #:	2025A0356052
Complaint Receipt Date:	08/19/2025
Investigation Initiation Date:	08/19/2025
Report Due Date:	10/18/2025
Licensee Name:	Spectrum Community Services
Licensee Address:	185 E. Main St Suite 700 Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Jordan Walch
Licensee Designee:	Jordan Walch
Name of Facility:	Parkview Home
Facility Address:	2165 Bayham Dr. SE Kentwood, MI 49508
Facility Telephone #:	(616) 551-3129
Original Issuance Date:	04/28/2014
License Status:	REGULAR
Effective Date:	10/28/2024
Expiration Date:	10/27/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had an unexplained head injury.	No
Resident A did not receive medications as prescribed.	Yes
Additional Finding	Yes

III. METHODOLOGY

08/19/2025	Special Investigation Intake 2025A0356052
08/19/2025	APS Referral Referral came from CI.
08/19/2025	Special Investigation Initiated - Telephone
08/19/2025	Contact - Telephone call made Attempted to reach Admin/LD at the facility number, no answer.
08/19/2025	Contact - Document Sent Anthony Mullins, LARA, Licensing Consultant re: contact person for this SI. He gave me Jordan Walch's info 616-485-5398.
08/21/2025	Contact - Telephone call made Jordan Walch, LD and Admin.
08/21/2025	Inspection Completed On-site
08/21/2025	Contact - Face to Face Olivia Gonzales, program manager, Tammi Franke, program administrator, Sherika Vanharn, community living services case manager, Resident A.
08/26/2025	Contact - Telephone call made Tammi Franke and Olivia Gonzales.
08/28/2025	Contact - Telephone call made Tammi Franke, administrator.
09/02/2025	Contact - Document Received Picked up facility documents at the spectrum community services main office.

09/22/2025	Contact-Telephone call made Relative #1.
09/23/2025	Contact-Document Received Corewell Health hospital report reviewed.
10/06/2025	Exit conference with Jordan Walch, Licensee Designee.

ALLEGATION: Resident A had an unexplained head injury.

INVESTIGATION: On 08/19/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that within the last couple of weeks, Resident A sustained a cut on his head. The complainant reported it is unknown how the cut was sustained. The complainant reported the cut had blood on it and no one informed Resident A's family about the head injury.

On 08/22/2025, I conducted an inspection at the facility and interviewed Tammi Franke, program administrator, Olivia Gonzales, program manager and Sherika Vanharn, Community Living Services case manager. Ms. Franke, and Ms. Gonzales stated Resident A did not have a cut on his head and this information is inaccurate. Ms. Franke stated Adult Protective Services was out in August 2025 because Resident A had scratches on his skin. Ms. Franke explained that Resident A assaulted another resident and sustained scratches on his skin but he never had a cut on his head. Ms. Gonzales and Ms. Franke stated the other resident had a cut and blood on him but Resident A did not.

On 08/22/2025, I attempted to interview Resident A at the facility, but Resident A was unable to provide pertinent information regarding this investigation due to cognitive deficits. I looked at Resident A's head and did not observe a cut or dried blood in any stage of healing.

On 09/02/2025, I reviewed IR's (incident reports) for July and August 2025 involving Resident A. I reviewed an IR dated 07/31/2025, 8:10a.m., employee assigned, Olivia Gonzales, location of incident, kitchen. The IR documented the following information, *'I was on meds, as the other lead was handing out breakfast, I heard lead said, no housemate let's come back this way. As he was trying to get to the table, (Resident A) shouted out nooo nooo, lead got in middle to redirect housemate as (Resident A) got up from table. I sat aside passing meds, locked it back up and began redirecting (Resident A), he began to shove me toward the wall, I then stepped to the side to balance myself. (Resident A) charge toward lead and housemate, as lead was in the middle shielding housemate. (Resident A) made one more big push which caused lead and housemate to fall to the ground. I went towards housemate to get him off the ground as I noticed lots of bleeding but was unsure from where. As I sat housemate in a separate room, I observed a deep gash which was bleeding*

obsessively. Body blocking, verbal re-direction unsuccessful. Resident would not calm even with police intervention and was transferred to St. Mary's Trinity Health for behavioral supportive assistance.'

On 09/02/2025, I reviewed an IR dated 08/05/2025, 10:24a.m. employee assigned, Robert T that stated, *'staff directed (Resident A) to get his shoes then heard a loud boom, staff observed (Resident A) had fell down basement stairs as he was walking down them to grab his shoes. Staff immediately assisted (Resident A) to get off ground, check for head and body injury, he was okay there were not any injuries. He was awake and alert just not responding when spoken to. Due to him not being able to stand and was not his self, becoming weak more than normal, I called program manager and explained what happened. Staff called 911, transported to ER. Staff followed behind in work van. (Resident A) was admitted for medical treatment. (Resident A) currently admitted to Blodgett for blood sugar and UTI treatment, observation after fall.'*

On 09/22/2025, I interviewed Relative #1 via telephone. Relative #1 confirmed that she is Resident A's legal guardian. Relative #1 stated that Resident A sustained a cut on his head over a year ago at the facility. Relative #1 stated the complainant did not have this information correct because Resident A has not had a cut to his head recently. Relative #1 stated Resident A has had a couple of incidents recently but neither incident caused a cut to his head.

On 10/06/2025, I conducted an exit conference with Jordan Walch, Licensee Designee via telephone. Ms. Walch agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	<p>The complainant reported that within the last couple of weeks, Resident A sustained a cut on his head and staff failed to inform Resident A's family about the head injury.</p> <p>Ms. Franke and Ms. Gonzales reported that Resident A did not have a cut on his head, and this information is inaccurate.</p> <p>I looked at Resident A's head and did not observe a cut or injury in any stage of healing.</p> <p>Resident A is not capable of providing pertinent information</p>

	<p>regarding this investigation due to cognitive deficits.</p> <p>I reviewed two IR's that documented incidents involving Resident A but neither IR documented Resident A had sustained a cut to his head.</p> <p>Relative #1 stated that Resident A sustained a cut on his head over a year ago at the facility, but Resident A has not had a cut to his head recently.</p> <p>Based on investigative findings, there is not a preponderance of evidence to show that Resident A sustained an unexplained or unreported cut to his head and therefore, a violation of this applicable rule is not established.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A did not receive medications as prescribed.

INVESTIGATION: On 08/19/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported approximately a week ago Resident A was hospitalized for an unknown urinary issue and prescribed medications after that hospital visit. The complainant reported that no one ever administered the medications to Resident A at the facility.

On 08/22/2025, I conducted an inspection at the facility and interviewed Ms. Franke, Ms. Gonzales, and Ms. Vanharn. Ms. Gonzales and Ms. Franke stated in June 2025, Resident A was diagnosed with a bladder infection and put on antibiotics for 10 days. Relative #1, cancelled the follow-up doctor visit because she was on vacation and the end of July 2025, Relative #1 took Resident A to Urgent Care for a "urinary issue." Ms. Gonzales and Ms. Franke stated Relative #1 dropped Resident A off at the facility after the trip to Urgent Care and gave the discharge paperwork to DCW (Direct Care worker) Promise Dunkudane and then Mr. Dunkudane left work and did not work the rest of the weekend. Ms. Gonzales and Ms. Franke stated Mr. Dunkadane put the discharge paperwork in the medication closet under Resident A's storage area in the med cabinet, no one saw the paperwork or knew Resident A had been given a prescription. Ms. Gonzales stated Resident A had been prescribed an antibiotic while at Urgent Care but she did not know about the prescription until the discharge paperwork was discovered Monday, 08/04/2025. Ms. Gonzales stated Relative #1 did not give anyone information that a prescription had been written but once it was discovered and the medication was delivered on 08/04/2025, the medication was administered right away. Ms. Gonzales stated Resident A got 1 dose of the antibiotic and then he fell and ended up in the hospital on 08/05/2025

until 08/12/2025. Ms. Gonzales stated Relative #1 was upset that Resident A had not gotten the antibiotic all weekend.

Ms. Gonzales stated Resident A was putting his shoes on and tumbled down the stairs at the facility. EMS was called, he went to the hospital where he remained until 08/12/2025. Ms. Gonzales stated while in the hospital, he was diagnosed as having a UTI (urinary tract infection), was on an IV antibiotic and when he came back to the facility, he came home on antibiotics.

Ms. Franke explained that the doctor sends the prescription to the pharmacy, and this facility uses the New Walker pharmacy in Lake Odessa. Ms. Franke stated the New Walker pharmacy is not open on weekends but if Relative #1 informed staff that a medication had been prescribed to Resident A, they could have gotten the prescription from the doctor and staff could have filled the prescription elsewhere and gotten it administered quicker.

On 09/02/2025, I received and reviewed Resident A's MARs for August 2025. The MAR documented an antibiotic, Cephalexin 500mg+, take 1 capsule by mouth twice daily for 5 days, Prescriber Carey O'Donnell, originated 08/04/2025, stop date 08/16/2025. The MAR documented administration times of 8:00a.m. and 8:00p.m. and there was no administration of the medication documented by staff signatures on 08/04/2025 after the medication was delivered to the facility or on 08/05/2025 prior to Resident A's hospitalization. Resident A went to the hospital on 08/05/2025 after EMS was called at or around 10:24a.m. There still are no staff signatures on 08/06/2025 or 08/07/2025 indicating that Resident A was no longer in the facility and was at the hospital.

On 09/22/2025, I interviewed Relative #1 via telephone. Relative #1 stated she took Resident A to Urgent Care on Saturday, 08/02/2025. An oral antibiotic to treat a bladder infection/UTI was prescribed and she gave the discharge information to DCW Promise (Dunkadane). Relative #1 stated she assumed the prescription would get to the facility pharmacy, the medication would be delivered to the facility, and staff would administer it to Resident A. Instead, the medication was never delivered to the facility until Resident A was in the hospital, so he did not get it. Relative #1 stated Resident A was ill and due to his illness, he collapsed and fell off a chair at the facility. Relative #1 stated she was informed by staff that Resident A hit his face, and his nose and face were injured and that is how Resident A ended up in the hospital. Relative #1 stated that had she known the pharmacy was closed over the weekend, she would have picked the prescription up and brought it to the facility so Resident A would have the antibiotic medication.

On 09/23/2025, I reviewed Corewell Health Grand Rapids Blodgett Hospital admission and discharge documents dated 08/05/2025 and 08/12/2025. The hospital documents Relative #1 took Resident A to an *'urgent care and he was diagnosed with UTI and prescribed antibiotics. She states she updated AFC home about this but was told they did not receive/start antibiotics until yesterday. They also*

report they were told that yesterday he was having increased weakness and fell out of the chair at dinner and then developed nausea.'

On 09/29/2025, I interviewed Alexa El Sabeh, at New Walker Pharmacy. Ms. El Sabeh stated the doctor wrote the prescription on Saturday 08/02/2025 at 4:41p.m., when Resident A was seen in Urgent Care. Ms. El Sabeh stated the pharmacy was open until 1:00p.m. on 08/02/2025 and closed on Sunday, 08/03/2025, so the prescription was not received and filled until Monday, 08/04/2025. Ms. El Sabeh stated medication was delivered to the facility on Monday 08/04/2025. Ms. El Sabeh stated they do after-hour prescription fills and deliveries but no one from the facility called to request the medication.

On 10/02/2025, I interviewed Ms. Franke via telephone and the Cephalexin medication arrived at the facility on 08/04/2025 between 2:00p.m. and 5:30p.m. and was accepted by DCW Latasia Mitchell. Ms. Franke thought Resident A got two doses of the medication by the time he went to the hospital on 08/05/2025.

On 10/06/2025, I conducted an exit conference with Jordan Walch, Licensee Designee via telephone. Ms. Walch stated it is unfortunate that Resident A's medications were not administered due to information not being properly passed on. Ms. Walch stated she will review the information in this report with staff and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The complainant reported that no one at the facility administered prescribed antibiotic medications to Resident A at the facility. Based on my investigative findings, there is a preponderance of evidence to show that Resident A was not given the medication Cephalexin after it was prescribed on 08/02/2025 and received at the facility on 08/04/2025 to be administered twice daily for 5 days to treat a UTI. Therefore, a violation of this applicable rule is established.

CONCLUSION:	VIOLATION ESTABLISHED
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ADDITIONAL FINDING:

On 09/29/2025, I interviewed Alexa El Sabeh, at New Walker Pharmacy. While reviewing Resident A's MAR for July and August 2025, Ms. El Sabeh stated the medication '*Nitrofuran Mono/Mac 100MG+, take 1 capsule by mouth 2 times daily for 7 days, Indications: Bladder Infection,*' was prescribed on 06/19/2025 to be administered until 06/26/2025. Ms. El Sabeh stated this medication was a one-time fill and should have been out on 06/19/2025 yet the MAR shows this medication signed as administered by staff at the facility through July 2025 and up until 08/20/2025 when it shows it was discontinued. Ms. El Sabeh stated there was not enough medication to continue to administer this beyond the end date of 06/19/2025 and it should not be on the MAR or signed as administered by staff.

On 10/02/2025, I interviewed Ms. Franke via telephone and reviewed the Nitrofuran Mono/Mac medication on July and August 2025's MAR. Ms. Franke stated she does not know why this medication remains on the MAR or why staff continued to sign that the medication was administered when they did not have the medication.

On 10/06/2025, I conducted an exit conference with Jordan Walch, Licensee Designee via telephone. Ms. Walch stated she understood the information, analysis, and conclusion of this applicable rule and again. She will review the information in this report with staff and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The medication Nitrofuran Mono/Mac 100MG+ was a one-time fill prescribed to Resident A on June 19-26, 2025, for a bladder infection yet the MAR shows this medication was administered by staff through July 2025 and up until 08/20/2025 when it shows it was discontinued.

	<p>Ms. El Sabeh stated there was not enough medication to continue to administer this beyond the end date of 06/19/2025 and it should not be on the MAR or signed as administered by staff.</p> <p>Ms. Franke stated she does not know why this medication remains on the MAR or why staff continued to sign that the medication was administered when they did not have the medication.</p> <p>A violation of this applicable rule is established.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



10/06/2025

Elizabeth Elliott
Licensing Consultant

Date

Approved By:



10/06/2025

Jerry Hendrick
Area Manager

Date