GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 6, 2026

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

RE: License #: AS410360517
Investigation #: 2026A1031011
Parkview Home

Dear Licensee Designee:

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 (616) 356-0100.

Sincerely,

KDuda

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AS410360517
Investigation #:	2026A1031011
Complaint Receipt Date:	10/01/2025
Investigation Initiation Date:	10/30/2025
Report Due Date:	11/30/2025
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Licensee Designee/Administrator:	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?
The facility did not follow Resident A's special diet.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/01/2025	Special Investigation Intake 2026A1031011
10/30/2025	Special Investigation Initiated - Letter Email Exchange with Ashton Byrne
11/07/2025	Inspection Completed On-site
11/07/2025	Contact - Face to Face Interview with Resident A, Promise Dejundana, and Robsert Tuyambaze.
12/23/25	Exit Conference held with Jordan Walch.

ALLEGATION:

The facility did not follow Resident A's special diet.

INVESTIGATION:

On 10/1/2025, a written complaint was received that the facility had not been following Resident A's special diet.

The complaint read: On 9/26/2025, I became aware that Parkview AFC hasn't been following this individual's orders for a mechanical soft diet and nectar-thick liquids during a phone conversation I had with his AFC Manager, Olivia Gonzales. She stated she was unaware of these orders, but that she was only told that he needs his food to be chopped. This diet was ordered in 2024 after [Resident A] had a swallow study completed and he was diagnosed with dysphasia; this information is listed at least twice in his current BPS, and it was recorded on Spectrum Community's annual Healthcare Appraisal, dated 2/3/2025. I also verbally told his AFC Manager during his SPR on 8/29/2025 that these were his orders after confirming this information in his BPS and recommended Olivia follow up with his PCP for orders/more information."

On 10/30/25, I exchanged emails with Network 180 recipient rights officer Ashton Byrne requesting Resident A's health appraisal and swallow study.

A swallow study dated 10/30/24 read “patient is at an increased risk of a dysphagia related aspiration pneumonia secondary to presence of airway compromise, no sensation to airway compromise, and co-morbidities. Risk is decreased with implementation of dysphagia diet and safe swallow strategies. Based on these findings, recommendation of mechanical soft solids/nectar thick liquids by cup. Meds whole in puree. Safe swallow compensatory strategies include sitting fully upright, taking small bites/sips, eating at a slow rate, and alternating solids/liquids with close supervision. Immediately following today's study, SLP provided skilled education to pt caregiver on oropharyngeal anatomy, swallow physiology, noted deficits, and diet/swallowing recommendations. Caregiver provided with dysphagia level 3 handout and thickened liquids resource handout. Caregiver verbalized comprehension.”

The health appraisal dated 2/3/25 read that Resident A has a special diet that is mechanical soft and nectar thick liquids – high protein nutrient dense.

On 11/7/25, I conducted an unannounced visit to the facility and interviewed Resident A and direct care workers Promise Dukundana and Robert Tuyambaze.

Resident A was not able to be interviewed due to being nonverbal.

Mr. Dukundana reported he has been employed at the facility for approximately a year and a half. Mr. Dukundana reported he did not follow Resident A’s special diet as he was not aware of the requirements. Mr. Dukundana reported the facility recently provided thickening liquid and a blender to ensure Resident A’s diet was followed. Mr. Dukundana reported the previous facility manager “Olivia” did not provide him with the information or otherwise he would have implemented the special diet. Mr. Dunundana reported “Olivia” is no longer employed at the facility and he believes it is due to these allegations.

Mr. Tuyambaze reported he has been employed at the facility for a little over a year and a half. Mr. Tuyambaze reported he was not following Resident A’s diet as he was not made aware of it. Mr. Tuyambaze reported he is now following Resident A’s special diet as he is now aware of what is needed.

On 11/7/25, I attempted to contact “Olivia” and the phone number was inactive.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.

ANALYSIS:	Based on interviews and the review of documentation, there was evidence found to support the fact that the facility was not following Resident A's prescribed diet which required mechanically soft foods and nectar thick liquids. The staff admitted to not following the diet as they were not made aware of the requirements by management. Resident A's health dated 2/3/25, clearly states his diet requirements.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Staff in the facility reported they were not trained by the manager or the licensee on Resident A's special diet. They were not informed of the prescribed diet following Resident A's doctors appointments.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) 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 trained and competent in all of the following areas before performing assigned tasks independently: **(i) Nutrition and special diets.**
ANALYSIS:	The staff reported they were not properly trained or informed of Resident A's special diet which resulted in the facility not providing mechanically soft food and nectar thick liquids as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

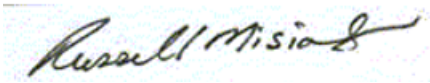
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

11/24/25

Kristy Duda — Date
Licensing Consultant

Approved By:



12/2/25

Russell B. Misiak — Date
Area Manager