



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 5, 2026

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

RE: License #: AS410269176  
Investigation #: 2026A0467016  
Iris

Dear Mrs. Walch:

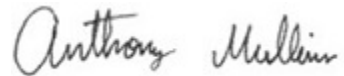
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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. 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,

A handwritten signature in cursive script that reads "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**

<b>License #:</b>	AS410269176
<b>Investigation #:</b>	2026A0467016
<b>Complaint Receipt Date:</b>	03/03/2026
<b>Investigation Initiation Date:</b>	03/03/2026
<b>Report Due Date:</b>	05/02/2026
<b>Licensee Name:</b>	Spectrum Community Services
<b>Licensee Address:</b>	Suite 700, 185 E. Main St Benton Harbor, MI 49022
<b>Licensee Telephone #:</b>	(734) 458-8729
<b>Administrator:</b>	Jordan Walch
<b>Licensee Designee:</b>	Jordan Walch
<b>Name of Facility:</b>	Iris
<b>Facility Address:</b>	3728 Iris Drive, SW Grandville, MI 49418-1884
<b>Facility Telephone #:</b>	(616) 538-4921
<b>Original Issuance Date:</b>	09/30/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/31/2025
<b>Expiration Date:</b>	03/30/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL



## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A was given a medication after her prescription expired.	Yes
Additional Findings	Yes

## III. METHODOLOGY

03/03/2026	Special Investigation Intake 2026A0467016
03/03/2026	APS Referral Not necessary based on findings
03/03/2026	Special Investigation Initiated - On Site
03/03/2026	Exit conference with licensee designee, Jordan Walch
03/04/2026	Contact – document received from Jordan Walch

**ALLEGATION: Resident A was given a medication after her prescription expired.**

**INVESTIGATION:** On 03/03/26, I received a complaint from Kent County Recipient Rights Officer Ashton Bryne alleging that Resident A was administered PRN (as needed) clonidine on 02/27/26 and 02/28/2026 despite the prescription being expired.

On the same day, 03/03/26, I conducted an unannounced onsite investigation at the home. Upon arrival, staff member Jack Bizimana answered the door and allowed entry. Mr. Bizimana confirmed that he worked at the home on 02/27/26 and administered clonidine to Resident A according to the Medication Administration Record (MAR). I reviewed the MAR and confirmed that Resident A received clonidine twice on 02/27/26. Mr. Bizimana reported that he was unaware the clonidine prescription had expired.

Staff member Kenya Hunt was interviewed next. She confirmed that she worked at the home on Saturday, 02/28/26 and administered the PRN clonidine to Resident A. Prior to administering the medication, Ms. Hunt reported that she contacted her supervisor, Jeanine Dickins, who approved her to pass the medication. Ms. Hunt reported that she had no knowledge that Resident A's prescription had expired.

I then introduced myself to Resident A, who agreed to be interviewed. Resident A confirmed her DOB and stated that she has lived in the home for one year. She reported that she receives her medications as prescribed and denied any concerns

regarding care. Resident A spoke highly of all staff and confirmed that her needs are being met. Resident A quickly became distracted and was unable to continue the interview. Resident A was thanked for her time as this interview concluded.

After speaking to Resident A, I interviewed staff member Jeanine Dickins in her office and staff member Heidi Smith by phone. Both Ms. Dickins and Ms. Smith confirmed that Resident A's clonidine prescription became effective on 02/26/25 and expired on 02/26/26. Based on this, the dose administered on 02/27/28 and 02/28/26 occurred two days after the prescription expiration date.

Ms. Dickins and Ms. Smith stated that the pharmacy typically notifies the home when a prescription requires renewal, but they did not receive any notification for this medication. Ms. Dickins and Ms. Smith both confirmed that they would obtain an updated prescription for Resident A as soon as possible.

On 3/3/26, 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.

On 03/04/26, I received an email from Mrs. Walch with an updated prescription for Resident A's Clonidine.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(7) Prescription medication that is no longer required by a resident or expired must be properly disposed of.</b>
<b>ANALYSIS:</b>	Ms. Dickens and Ms. Smith both confirmed that Resident A received clonidine despite the prescription expiring. Resident A's MAR confirmed this as well. Therefore, there is a preponderance of evidence to support this applicable rule. Mrs. Walch provided an updated prescription on 03/04/26 via email.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** While investigating the allegation listed above, I reviewed Resident A's February 2026 MAR. I observed that several medications, including Cetirizine Tab 10MG, Lantus Solos Inj 100, Novolin 70/30 Flexpen, Novolog Inj flex

pen, and Olanzapine, Cap 40MG, did not have staff initials recorded for passing the medication.

I also noticed that on 02/27/26, Resident A's MAR showed "2X," indicating that the medication was passed twice by two different people. However, no staff initials were recorded as required. I explained to Ms. Dickins and Ms. Smith that these documentation issues are considered a licensing rule violation.

On 3/3/26, I conducted an exit conference with licensee designee, Jordan Walch. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<p><b>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</b></p> <ul style="list-style-type: none"> <li><b>(a) Be trained in the proper handling and administration of medication.</b></li> <li><b>(b) Complete an individual medication log that contains all of the following:</b> <ul style="list-style-type: none"> <li><b>(i) Medication name.</b></li> <li><b>(ii) Dosage.</b></li> <li><b>(iii) Label instructions for use.</b></li> <li><b>(iv) Time to be administered.</b></li> <li><b>(v) Initials of the individual who administered the medication at the time given.</b></li> </ul> </li> </ul>
<b>ANALYSIS:</b>	Staff members failed to initial Resident A's MAR after passing medications several times in February 2025. Therefore, there is a preponderance of evidence to support this applicable rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** While investigating the allegations listed above, I requested to review Resident A's assessment plan. The assessment plan was last signed in

January 2025 by Resident A as she is her own guardian. However, the assessment plan is nearly 2 months expired and needs to be updated.

On 03/03/26, I conducted an exit conference with licensee designee, Jordan Walch. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

On 03/04/26, I received a copy of Resident A's updated assessment plan from licensee designee, Jordan Walch via email.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>
	<b>(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.</b>
<b>ANALYSIS:</b>	Resident A's assessment plan was outdated during my onsite investigation. Therefore, there is a preponderance of evidence to support this applicable rule. Mrs. Walch provided a copy of Resident A's updated assessment plan on 03/04/26 via email.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Anthony Mullins*

03/05/2026

Anthony Mullins  
Licensing Consultant

Date

Approved By:

*Jerry Hendrix*

03/05/2026

Jerry Hendrick  
Area Manager

Date