



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 4, 2025

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

RE: License #: AS410269176  
Investigation #: 2026A0467006  
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>	2026A0467006
<b>Complaint Receipt Date:</b>	11/24/2025
<b>Investigation Initiation Date:</b>	11/24/2025
<b>Report Due Date:</b>	01/23/2026
<b>LicenseeName:</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>
On 11/13/25, staff member Jeanine Dickens failed to follow Resident A’s behavior support plan while attempting to de-escalate her.	Yes

**III. METHODOLOGY**

11/24/2025	Special Investigation Intake 2026A0467006
11/24/2025	Special Investigation Initiated - Letter Via email with Recipient Rights Officer, Michael Kuik
11/24/2025	Contact – document received Resident A’s Behavior Support Plan (BSP) from Michael Kuik via email.
11/24/2025	Inspection Completed On-site
11/24/2025	APS Referral Not necessary based on findings of complaint.
12/04/2025	Exit conference with licensee designee, Jordan Walch.

**ALLEGATION: On 11/13/25, staff member Jeanine Dickens failed to follow Resident A’s behavior support plan while attempting to de-escalate her.**

**INVESTIGATION:** On 11/24/25, I received a complaint from Kent County Recipient Rights Officer, Michael Kuik. The complaint alleged that on 11/13/25, staff member Jeanine Dickens grabbed Resident A’s arm and pulled her out of a vehicle after returning home from an outing. It was also alleged that Ms. Dickens failed to follow Resident A’s behavior support plan (BSP) when attempting to de-escalate her.

On 11/24/25, I spoke to Mr. Kuik via email and agreed to conduct a joint investigation at the facility today at 11:30 am.

On 11/24/25, Mr. Kuik and I conducted an onsite investigation at the facility. Upon arrival, staff member, Heidi Smith answered the door and allowed entry into the home. Entry was made into the basement and introductions were made with Resident A. At the request of Resident A, behavior support specialist Amanda Moore from Network 180 was present. Resident A recalled a recent incident with staff member Jeanine Dickens when they returned home from an outing. Resident A stated that Ms. Dickens grabbed her right arm just below her elbow to pull her out of the vehicle. Resident A stated that she eventually got out of the vehicle and admitted that she became physical with Ms. Dickens by pushing her in retaliation. Resident A

denied Ms. Dickens pushing or hitting her back. Resident A shared that she attempted to get back into the vehicle but this was unsuccessful due to Ms. Dickens keeping the door shut. Resident A stated that there were no witnesses to this incident. Resident A recalled police being involved but she is unsure why they were at the home and added that they only spoke to Ms. Dickens and Ms. Smith.

Prior to this incident, Resident A denied being grabbed or hit by Ms. Dickens. However, Resident A accused Ms. Dickens of being “loud” with her and using her “mom voice” as recent as last week when she was frustrated with her. It should be noted that no physical marks or bruises were observed on Resident A’s arm during this investigation. Despite the reported incident, Resident A spoke highly of her relationship with Ms. Dickens. Prior to concluding this interview, behavior support specialist, Ms. Moore added that no part of Resident A’s behavior support plan includes any hands-on de-escalation as physical aggression is infrequent for her.

Mr. Kuik and I made our way to the upstairs staff office and interviewed staff member Jeanine Dickens. On the day in question at approximately 9:30pm - 10:00pm, Ms. Dickens stated that everyone had just returned to the home from the Shed Aquarium in Chicago after being away all day. When they arrived at the home, Resident A reportedly did not want to get out of the vehicle after being asked several times. Resident A closed the car door in an attempt to stay in, which led to Ms. Dickens opening it. Ms. Dickens stated that due to it being late at night and Ms. Smith needing her vehicle to go home, she called the police for assistance. Prior to the police arriving at the home, Ms. Dickens stated that Resident A “bum rushed” her while exiting the vehicle. Ms. Dickens stated that due to the vehicle being Ms. Smith’s personal vehicle, she stood in front of the door to prevent Resident A from entering it again.

Ms. Dickens was adamant that at no point during this incident with Resident A did she grab her arm or assault her in any manner. Ms. Dickens confirmed that there were no witnesses to the incident between her and Resident A as Ms. Smith and other residents were already inside the home. Ms. Dickens denied yelling or screaming at Resident A during the incident or any other time. She was, however, firm with Resident A but it never led to yelling or raising her voice. Despite this incident, Ms. Dickens stated that she and Resident A have a “great” relationship and the two have been on good terms since the incident occurred. Recipient Rights Officer, Michael Kuik stated that per Resident A’s behavior support plan (BSP), staff are to intervene once and give Resident A space as opposed to asking her to calm down multiple times. Ms. Dickens again confirmed that she did ask Resident A to exit the vehicle multiple times without walking away to give her space per her BSP. Ms. Dickens shared that Resident A could have been in the car for hours if she didn’t intervene.

I interviewed staff member Heidi Smith regarding the allegation. Ms. Smith stated that it was approximately 9:30pm on 11/13/25 when everyone returned home from an all-day outing in Chicago. Ms. Smith stated that prior to exiting the vehicle, the

residents were asking about sodas. Resident A became upset that she was unable to get a soda, so she began crying and escalating. Ms. Smith stated that she was able to get the other residents out of the vehicle and settled into the home for the night while Resident A remained in the vehicle with Ms. Dickens outside of it. When Ms. Smith returned to the vehicle, she observed Resident A “crumbled up” in the back seat with the door open while Ms. Dickens was talking to her. Ms. Smith stated that she went back inside again to attend to a different resident. While inside, Ms. Smith heard a scream. Ms. Smith came back outside and noticed Resident A out of the vehicle. Ms. Dickens yelled for Ms. Smith to lock the car door, to which she did. The intent behind this was to prevent Resident A from entering the vehicle again as it was Ms. Smith’s personal vehicle as opposed to a company vehicle. Ms. Smith denied witnessing or having any knowledge of Ms. Dickens grabbing Resident A’s arm to pull her out of the vehicle. Ms. Smith observed Resident A yelling and rolling on the ground outside of the vehicle. Ms. Smith stated that police arrived at the home and informed her that they were unable to assist due to Resident A already being out of the vehicle. Ms. Smith denied observing Ms. Dickens yelling or screaming at Resident A. She did, however, confirm that Ms. Dickens was firm when asking her to calm down and stop escalating.

On 11/24/25, I reviewed Resident A’s behavior support plan, which indicates that when she is escalating, staff are to “provide one clear verbal prompt for (Resident A) and provide minimal attention to the behavior that is occurring.” It also states that “If (Resident A) does not follow through after being provided a verbal prompt, step away from (Resident A) and tell her that you will be available when she is ready.” This did not occur during the incident between Ms. Dickens and Resident A.

On 12/04/25, 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 receiving this report.

<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>
	<b>(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.</b>
<b>ANALYSIS:</b>	Resident A alleged that Ms. Dickens attempted to pull her out of the vehicle by grabbing her arm. Ms. Dickens denied the allegation, and no witnesses or physical evidence was available to substantiate the claim.  However, during the investigation, Ms. Dickens acknowledged

	<p>that she repeatedly asked Resident A to exit the vehicle, rather than following the specific approach outlined in Resident A's behavior support plan, which emphasizes the importance of the resident expressing their readiness.</p> <p>Based on the disclosure from Ms. Dickens and deviating from the behavior support plan, there is a preponderance of evidence to support this applicable rule.</p>
<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*

12/04/2025

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Anthony Mullins Date  
Licensing Consultant

Approved By:

*Jerry Hendrick*

12/04/2025

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Jerry Hendrick Date  
Area Manager