GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 29, 2026

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

RE: License #: AS410356636
Investigation #: 2026A0467042
Terrace Park Home

Dear Mrs. Walch:

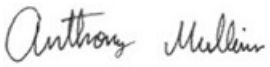
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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,



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 #:	AS410356636
Investigation #:	2026A0467042
Complaint Receipt Date:	07/07/2026
Investigation Initiation Date:	07/07/2026
Report Due Date:	09/05/2026
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:	Terrace Park Home
Facility Address:	5901 Terrace Park Dr. NE Rockford, MI 49341
Facility Telephone #:	(616) 884-5788
Original Issuance Date:	03/12/2014
License Status:	REGULAR
Effective Date:	10/24/2025
Expiration Date:	10/23/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 07/02/26, staff member Solange Murakatete failed to provide Resident A with his anti-seizure nasal spray medication during an active seizure.	Yes
Resident A was injured after falling in the middle of a seizure and staff failed to check on him throughout the night and did not seek medical care.	Yes

III. METHODOLOGY

07/07/2026	Special Investigation Intake 2026A0467042
07/07/2026	Special Investigation Initiated - Letter Complaint received from Kent County Recipient Rights Officer, Ashton Byrne
07/07/2026	Inspection Completed On-site
07/07/2026	Contact – document sent to associate director Sam Johnson
07/07/2026	Contact - Document Received Received employee statements from staff involved with the incident from associate director, Sam Johnson
07/29/2026	Contact – telephone call made to Sam Johnson, associate director.
07/29/2026	Exit conference with licensee designee, Jordan Walch
07/29/2026	APS Referral

ALLEGATION: On 07/02/26, staff member Solange Murakatete failed to provide Resident A with his anti-seizure nasal spray medication during an active seizure.

INVESTIGATION: On 07/07/26, I received a complaint from Kent County Recipient Rights Officer Ashton Byrne. The complaint alleged that on 07/02/26, staff member Solange Murakatete failed to administer Resident A's prescribed anti-seizure nasal spray during an active seizure. The incident reportedly occurred while Resident A was receiving assistance in the bathroom. Ms. Murakatete stated she attempted to obtain the medication but was unable to locate it.

On 07/07/26, I conducted an unannounced onsite investigation at the home. Upon arrival, staff member Danielle Dolph answered the door and allowed entry into the home. Ms. Dolph confirmed she worked first shift on 07/02/26 and had no concerns regarding Resident A that day. She reported that Ms. Murakatete worked a double shift beginning at 4:00pm on 07/02/26 and ending at 8:00am on 07/03/26. According to Ms. Dolph, when she returned to work on the morning of 07/06/26, Ms. Murakatete informed her that Resident A experienced a seizure around 5:00pm on 07/02/26, during which he fell. Ms. Dolph asked whether the anti-seizure nasal spray had been administered, and Ms. Murakatete stated it had not. Ms. Dolph reported that Ms. Murakatete failed to document the incident and left at the end of her shift. As a result, Ms. Dolph contacted staff member Janet Olson and requested that she return to the home to complete the required documentation, as Ms. Olson had been working with Ms. Murakatete and was involved with the incident. Ms. Dolph reported that Ms. Olson explained she had been assisting Resident A outside of the bathtub when she briefly turned to grab an item, and Resident A fell. According to Ms. Olson, she was able to catch him and “guide him to the ground” as safely as possible. Ms. Olson stated that she then called out to Ms. Murakatete to get Resident A’s anti-seizure nasal spray because he was having a seizure. However, Ms. Murakatete told her she could not locate the medication. As a result, Resident A did not receive his prescribed nasal spray.

Ms. Dolph added that a similar situation involving Resident A and Ms. Murakatete happened in the past, although she was unable to recall a specific date. She stated that her colleague, Vienelle Gay could likely provide additional information about the prior incident. Ms. Dolph stated that she has personally trained Ms. Murakatete on the medication process several times, including notifying her where the medication is stored and how to administer it.

Ms. Dolph provided me with a copy of the seizure protocol, which contains eight steps. Step 6 directs staff to administer “Nayzilam, 1 spray (5mg) into one nostril at the beginning of a seizure with bilateral motor semiology. A second spray may be administered in the other nostril after 10 minutes if needed, using the second nasal spray unit. Do not exceed two sprays in a 24-hour period.” During the onsite investigation, Resident A’s July MAR indicated that Nayzilam (5mg) was not administered on 07/02/26, despite clear instructions on the seizure protocol.

Prior to concluding my onsite investigation, I observed Resident A resting comfortably in bed. He was not interviewed due to his limited cognitive ability.

On 07/07/26, I sent associate director Sam Johnson a text message requesting full names and contact information for staff members directly involved in this investigation. Mrs. Johnson provided names and statements from all involved staff members, including Solange Murakatete, Janet Olson, and Vienelle Gay. Ms. Dolph also provided a statement, but she was already interviewed at the home. The statements from all other staff members are summarized below:

Ms. Olson reported that on 07/02/26, she had just finished giving Resident A a shower. When she turned around to grab his clothes from the counter, she noticed that his eyes were closed and his head was tilted back. Ms. Olson assisted Resident A to the floor, where he experienced a seizure lasting approximately one and a half minutes. Resident A was positioned on the floor by the bathroom door, making it difficult for Ms. Olson to exit. She called out to her colleague, Ms. Murakatete, asking her to bring Resident A's anti-seizure nasal spray. Ms. Olson reported that Ms. Murakatete told her she did not know where the nasal spray was located. Ms. Olson then contacted her supervisor, Heather Reamon for further direction.

In Ms. Murakatete's statement, she reported that she was passing medications for other residents while Ms. Olson was assisting Resident A with a shower when he experienced a seizure. She acknowledged that Ms. Olson asked her to administer Resident A's anti-seizure nasal spray, but was "unfamiliar" with where the medication was stored. Ms. Olson then asked her to remain with Resident A while she went to locate the medication. According to Ms. Murakatete, by the time Ms. Olson returned with the nasal spray, the seizure had already ended. Ms. Murakatete stated that Resident A recovered and was able to get up from the floor independently and then went to bed. Ms. Murakatete added that Resident A was "monitored closely for the remainder of the shift."

In staff member Vienelle Gray's statement, she reported that she worked the morning following Resident A's seizure on 07/03/26. Upon arriving, Ms. Murakatete informed her that Resident A "had a seizure the evening before, and that he was not administered his Nayzilam 5mg." Ms. Gay stated that Resident A's seizure protocol is posted throughout the home, including in the medication room where Ms. Murakatete was standing and in the bathroom where the seizure occurred. The seizure protocol requires staff to administer the nasal spray at the onset of a seizure.

Ms. Gay asked Ms. Murakatete why the medication had not been administered, and Ms. Murakatete reportedly "did not have an answer." Ms. Gay also reviewed all documentation and noted that Ms. Murakatete did not document Resident A's seizure anywhere. She stated that the seizure documentation section had been marked "no," indicating no seizure occurred, which was inaccurate. Ms. Gay further explained that Resident A's nasal spray is stored in a locked box inside the medication closet with other controlled medications, along with a medication count sheet that staff are required to complete daily before the end of their shifts.

Ms. Gay reported that it is Ms. Murakatete's responsibility as his caregiver to know the location of emergency medication. She also indicated that a similar incident occurred in the past in which Ms. Murakatete failed to respond appropriately after Resident A experienced a known seizure. However, Ms. Gay did not provide a specific date for the prior event.

On 07/29/26, 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.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Resident A had a seizure on the evening on 07/02/26 and was not administered his anti-seizure nasal spray because staff member Solange Murakatete did not know where the medication was stored, despite actively passing medications to other residents at the time of the seizure. Based on the information provided, there is a preponderance of evidence to support this applicable licensing rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was injured after falling in the middle of a seizure and staff failed to check on him throughout the night and did not seek medical care.

INVESTIGATION: On 07/07/26, I received a complaint from Kent County Recipient Rights Officer Ashton Byrne. The complaint alleged that following a seizure experienced by Resident A on the evening of 07/02/26, he sustained an ankle injury and staff failed to check on him throughout the night or seek medical care.

On 07/07/26, I conducted an unannounced onsite investigation at the home. Upon arrival, staff member Danielle Dolph answered the door and allowed entry into the home. Ms. Dolph confirmed that Resident A had a seizure on the evening of 07/02/26, which was disclosed to her by her colleague Solange Murakatete when she returned to work on the morning of 07/03/26. Ms. Dolph stated that Ms. Murakatete initially claimed she had “checked” Resident A after the seizure, but then quickly changed her statement and admitted she had not assessed him. Ms. Dolph also reported that Ms. Murakatete told her that Resident A was limping and unable to put weight on his foot/ankle. Despite acknowledging that Resident A was injured, Ms. Murakatete did not seek medical care or address the concern before leaving the home at the end of her shift on 07/03/26. As a result, staff member Vienelle Gay had to take Resident A to urgent care that morning.

Ms. Dolph provided an After Visit Summary (AVS) from Corewell Health Urgent Care in Rockford. The AVS indicated that Resident A was treated for a “sprain of the left ankle, unspecified ligament, initial encounter” and “acute left ankle pain.” The AVS

included instructions for care such as using a brace, applying ice, resting, and elevating the ankle.

On 07/07/26, I reviewed a statement from Ms. Gay, who reported that when Resident A woke on the morning of 07/03/26, he was unable to walk without assistance from her and another staff member and could not bear weight on his foot.

I also reviewed Ms. Murakatete's statement, in which she reported that after Resident A's seizure, he "got up independently and went to bed and was monitored closely for the remainder of the shift." It is important to note that Resident A's seizure and injury occurred at approximately 5:00pm on 07/02/26. Ms. Murakatete worked until 8:00am on 07/03/26 and did not seek medical care, despite telling her colleague she noticed Resident A was limping.

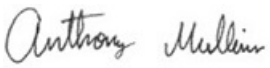
On 07/29/26, I spoke to Sam Johnson, associate director via phone. Ms. Johnson confirmed that the home has a written emergency preparedness plan outlining staff responsibilities in medical situation. Ms. Johnson confirmed that based on this incident, Ms. Murakatete should have taken Resident A to the emergency room or urgent care when she observed that he could not bear weight on his foot/ankle. Ms. Johnson also confirmed that Ms. Murakatete had been trained in this process.

On 07/29/26, 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.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Ms. Murakatete observed Resident A limping but did not seek medical attention for him. Instead, she relayed this information to her colleagues, who subsequently ensured Resident A received care by taking him to urgent care. At urgent care, Resident A was diagnosed with a sprained left ankle resulting from a fall during his seizure. Based on the information, there is a preponderance of evidence to support this applicable licensing rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

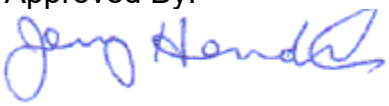
Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.



07/29/2026

Anthony Mullins Date
Licensing Consultant

Approved By:



07/29/2026

Jerry Hendrick Date
Area Manager