GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 17, 2026

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

RE: License #: AS410357191
Investigation #: 2026A0464043
Clyde Park 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. 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,
Megan Leavitt, LMSW
Megan Leavitt, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410357191
Investigation #:	2026A0464043
Complaint Receipt Date:	06/14/2026
Investigation Initiation Date:	06/16/2026
Report Due Date:	08/13/2026
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:	Clyde Park Home
Facility Address:	8510 Clyde Park Ave. SW Byron Center, MI 49315
Facility Telephone #:	(616) 277-1955
Original Issuance Date:	04/02/2014
License Status:	REGULAR
Effective Date:	02/08/2025
Expiration Date:	02/07/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 06/12/2026, Resident A was admitted to the hospital for severe sepsis and fecal impaction. It is believed facility staff were not recording when Resident A had a bowel movement. It is unclear how long Resident A went without having a bowel movement.	Yes

III. METHODOLOGY

06/14/2026	Special Investigation Intake 2026A0464043
06/14/2026	APS Referral
06/16/2026	Special Investigation Initiated - Telephone Jeannie Haff, ORR
06/23/2026	Inspection Completed On-site Jeannie Haff, ORR Cedric Marshall, Spectrum Community Services
06/23/2026	Contact-Document received Facility Records
08/11/2026	Contact-Document received Jeannie Haff, ORR
08/17/2026	Exit Conference Jordan Walch, Licensee Designee

ALLEGATION: On 06/12/2026, Resident A was admitted to the hospital for severe sepsis and fecal impaction. It is believed facility staff were not recording when Resident A had a bowel movement. It is unclear how long Resident A went without having a bowel movement.

INVESTIGATION: On 06/14/2026, I received a complaint which alleged 39-year-old Resident A was admitted into the hospital on 06/12/2026 with severe sepsis and fecal impaction. Resident A required sedation and decompaction. Hospital case management followed up with facility staff, who confirmed they have not been recording when Resident A has a bowel movement.

On 06/14/2026, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 06/16/2026, I spoke with Network 180's Office of Recipient Rights (ORR) worker, Jeannie Haff, to coordinate the investigation.

On 06/23/2026, Ms. Haff and I completed an unannounced, onsite inspection at the facility. We met with Spectrum Community's Heath's Rights worker, Cedric Marshall. Mr. Marshall reported Resident A is completely nonverbal; therefore, he will not be able to be interviewed. He reported that Resident A is still in the hospital. The facility manager is at the hospital with Resident A. Mr. Marshall stated Resident A has a bowel movement (BM) protocol staff are supposed to follow. While Resident A is in the bathroom, staff are supposed to be in the bathroom with Resident A. Resident A has a long history of constipation.

On 06/23/2026, I received an email from Ms. Haff. She reported Resident A is still in the ICU. He was administered Fentanyl for agitation, has his arms tied down, tubes draining his lungs from pneumonia. They do not have an anticipated date for discharge.

On 06/23/2026, I received and reviewed a copy of Resident A's Bowel Health Log from April 1, 2026, to June 23, 2026. The log reflects Resident A had a large BM on 06/08/2026. The only other BM listed was from 04/01/2026.

On 06/23/2026, I received and reviewed Resident A's Individual Plan of Service (IPOS) which was signed and completed on 04/08/2026. The IPOS reflects Resident A struggles with bowel movements and staff are to follow a strict BM protocol for Resident A. The IPOS reflects staff are to sit in the bathroom with Resident A to ensure he has a BM as well as check his brief every two hours to see if it has been soiled. Staff are to document when Resident A has a BM.

On 08/11/2026, I received an email from Ms. Haff. She stated she had spoken with Mr. Marshall who reported Resident A was discharged from the hospital on 06/29/2026 and returned to the facility.

On 08/17/2026, I completed an exit conference with license designee, Jordan Walch. She was informed of the investigation findings and recommendations. A corrective action plan will be submitted.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	On 06/14/2026, a complaint was received alleging facility staff were failing to follow Resident A's bowel movement protocol. Resident A was hospitalized for sepsis and severe fecal

	impaction at the time of the inspection. Resident A is also nonverbal; therefore, an interview was not conducted. Spectrum Community Services Rights worker, Cedric Marshall reported staff are to follow Resident A's bowel movement protocol and document each time Resident A has a BM. Resident A's Individual Plan of Service (IPOS) reflected Resident A struggles with bowel movements. Facility staff are to follow Resident A's BM protocol and document any BM's made by Resident A. Resident A's Bowel Movement Log was reviewed from April 1, 2026 through June 2026. The log reflected staff only documented two bowel movements within the three month period. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff were not following Resident A's BM protocol.
CONCLUSION:	**VIOLATION ESTABLISHED**

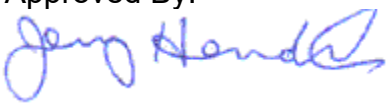
IV. RECOMMENDATION

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

Megan Leavitt, LMSW 08/17/2026

Megan Leavitt Date
Licensing Consultant

Approved By:



08/17/2026

Jerry Hendrick Date
Area Manager