GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 15, 2022

Stephanie Leone
Hope Network Behavioral Health Services
PO Box 890
3075 Orchard Vista Drive
Grand Rapids, MI 49518-0890

RE: License #: AS410067880
Investigation #: 2022A0467043
Breton Valley

Dear Mrs. Leone:

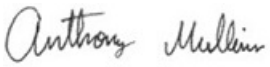
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

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 #:	AS410067880
Investigation #:	2022A0467043
Complaint Receipt Date:	06/13/2022
Investigation Initiation Date:	06/13/2022
Report Due Date:	08/12/2022
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(161) 643-0795
Administrator:	Stephanie Leone
Licensee Designee:	Stephanie Leone
Name of Facility:	Breton Valley
Facility Address:	2451 Breton Road, SE Grand Rapids, MI 49546-5627
Facility Telephone #:	(616) 949-3813
Original Issuance Date:	09/28/1995
License Status:	REGULAR
Effective Date:	03/28/2022
Expiration Date:	03/27/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 6/12/22, residents were left unattended for approximately 40 minutes due to staff member Aliyah Jordan leaving the facility prior to relief staff arriving.	Yes
Resident A, D, and E did not receive their morning medication on 6/12/22.	Yes

III. METHODOLOGY

06/13/2022	Special Investigation Intake 2022A0467043
06/13/2022	Special Investigation Initiated - Telephone
06/15/2022	Exit conference completed with licensee designee, Stephanie Leone

ALLEGATION: On 6/12/22, residents were left unattended for approximately 40 minutes due to staff member Aliyah Jordan leaving the facility prior to relief staff arriving.

INVESTIGATION: On 6/13/22, I spoke to Lula Jackson, Program Manager of the facility. Ms. Jackson informed me that on the morning of 6/12/22, staff member Aliyah Jordan walked off her shift, leaving residents unattended for approximately 40 minutes. Ms. Jackson stated that a staff member was pulled from a different program to attend to residents at this facility until she was able to arrive. Ms. Jackson stated that there were no incidents of any kind during the time there were no staff in the facility. Ms. Jackson stated that Breton Valley typically has two staff members on 3rd and first shift. However, this was an unforeseen incident as there was initially staff scheduled to cover.

Ms. Jackson stated that Ms. Jordan left the facility at approximately 9:01 am and a staff member replaced her approximately 40 minutes later. During the time that the residents were alone in the facility, Ms. Jackson stated that the Director of Residential Treatment, Stephanie Leone was on the phone with a resident, providing support and making sure everyone in the home was safe and reassured them that staff were coming. Ms. Jackson stated that Grand Rapids Police Department (GRPD) also did a welfare check after she arrived at the facility.

On 6/14/22, I reviewed the incident reports related to this incident, which stated that staff member Aliyah Jordan is suspended pending an investigation. On the same day, I spoke to Ms. Jackson via phone. She stated that Stephanie Leone spoke to Resident A via phone while no staff were present on the morning of 6/12/22. I

informed Ms. Jackson that I read the incident reports associated with this incident and noticed that Ms. Jordan was suspended. Ms. Jackson stated that yesterday, HR placed a call to terminate Ms. Jordan. A message was left requesting a call back. Ms. Jackson stated that Ms. Jordan is not scheduled to work again until 6/26/22. Ms. Jackson believes that Ms. Jordan's termination will be final by then. I explained to Ms. Jackson that I will be completing an onsite inspection within the next day or two to speak with residents.

On 6/14/22, I made an announced onsite investigation to the facility. Upon arrival, I spoke to Resident A, B, and C. Resident A stated that he went to church this past Sunday (6/12/22) morning. Prior to doing so, he and other residents were left alone in the facility. As a result of being left alone in the facility, Resident A stated that Resident B called the police. Resident A stated that this was the only time that he and other residents were left alone in the home. Resident A stated that he feels safe in the home and with the exception of this incident, he feels that his daily needs are met.

After speaking to Resident A, I spoke to Resident B. Resident B stated that he has been at the facility for approximately one-and-a-half years and he "loves it here." Resident B confirmed that he and the other residents were left alone at the facility on Sunday (6/12/22) morning. Resident B was unable to recall the name of the staff member that was working. However, he stated that the staff member gave him his medication and "took off and didn't say anything." Resident B waited 15 minutes to see if the staff member would return. The staff member never returned to the facility, which caused Resident B to be scared. Resident B called GRPD to notify them that the home did not have staff present. Resident B stated approximately 15 to 20 minutes later, a staff member from the Alpine Grove facility arrived at the home. Although Resident B called the police, he stated that he did not see them at the home. Resident B stated that this is the only time that he and other residents have been left alone in the home. Resident B stated that prior to the staff member leaving, she did not make breakfast for the residents. Resident B stated that he did eat when Program Manager, Lula Jackson arrived at the home. With the exception of this incident, Resident B stated that he feels safe in the home and all of his daily needs are met.

After speaking to Resident B, I spoke to Resident C. Resident C stated that he has been at the home for more than a year. Resident C recalled being at the home this past Sunday and confirmed that he and other residents were left alone. Resident C stated that Resident B called the police as a result of this. Resident C stated that to his knowledge, this is the only time that he and other residents have been left alone in the home. Resident C stated that he feels safe in the home and feels that his daily needs are being met. Resident C also stated that he went to Catholic mass on Sunday and didn't have anything to eat until dinner time. Resident C then clarified that staff at the facility offered him food. However, he opted to not eat the food and preferred to wait until dinner time.

On 6/15/22, I conducted an exit conference with licensee designee, Stephanie Leone. She was informed of the investigative findings and agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Resident A, B, and C all confirmed that they were left at the home without staff being present. All three residents stated that this is the only time that this has happened. With the exception of this incident, Resident A, B, and C all stated that their needs are being met daily. Program Manager, Lula Jackson confirmed that staff member Aliyah Jordan ended her shift at 9:01 am on Sunday and it took approximately 40 minutes to get another staff there. Ms. Jackson stated that Human Resource (HR) has placed a call to terminate Ms. Jordan and anticipates this will be finalized prior to her next scheduled shift. There is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A, D, and E did not receive their morning medication on 6/12/22.

INVESTIGATION: On 6/14/22, I made an announced onsite investigation to the facility. Upon arrival, I spoke to Resident A. Resident A confirmed that he did not receive his morning medication on 6/12/22 due to no staff being present. I reviewed Resident A's MAR and it confirmed that he did not receive the following medications: Docusate Cap 250MG, Fluoxetine Cap 20MG, Fluoxetine Cap 40MG, Pantoprazole 40MG, Reguloid Pow Orange, Senna 8.8MG/5ML-SYRP, and Vitamin D3 – 2000unit-tabs. Resident B confirmed that he did receive his medication prior to staff leaving the home. I also reviewed Resident B, C, D, E's MAR. Resident B and C's MAR indicated that they received all of their medication, with the exception of their daily temperature reading and oxygen saturation checks. Resident D's MAR indicated that he missed the following medications: Benzoyl Per Liq 10% Wash, Benztropine Tab 1MG, Doxycycl Hyc Tab 100MG, Omeprazole Cap 20MG, Polyeth Gly Pow 3350 (Miralax), Primidone Tab 50MG, Vitamin D2 Cap 2000Unit, and Daily

temp reading and oxygen saturation. Resident E's MAR indicated that he missed the following medications: Clozapine Tab 100MG, Lorazepam Tab 1MG, Polyeth Gly Pow 3350 (Miralax), Propranolol Tab 10MG, Sertraline Tab 100MG, Tamsulosin Cap 0.4MG, Vitamin B-12 Tab 1000MCG, Vitamin D3 2000U Tabs, and daily covid monitoring.

On 6/15/22, I conducted an exit conference with licensee designee, Stephanie Leone. She was informed of the investigative findings and agreed to complete a corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 6/14/22, Resident A confirmed that he missed his morning medication on 6/12/22. I reviewed Resident A, B, C, D, and E's MARs, which indicated that they all missed a scheduled medication, daily temperature reading and oxygen saturation check, and/or daily covid monitoring check. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Anthony Mullins 06/15/2022

Anthony Mullins Date
Licensing Consultant

Approved By:

06/15/2022

Jerry Hendrick Date
Area Manager