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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 9, 2022

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

RE: License #: AL410015935
Investigation #: 2022A0340038
Rivervalley 1

Dear Ms. Frazier:

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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410015935
Investigation #:	2022A0340038
Complaint Receipt Date:	07/08/2022
Investigation Initiation Date:	07/08/2022
Report Due Date:	09/06/2022
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:	Rivervalley 1
Facility Address:	1450 Leonard Street, NE, Grand Rapids, MI 49505
Facility Telephone #:	(616) 774-8789
Original Issuance Date:	10/26/1994
License Status:	REGULAR
Effective Date:	04/25/2021
Expiration Date:	04/24/2023
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Residents were left without staff supervision.	Yes

III. METHODOLOGY

07/08/2022	Special Investigation Intake 2022A0340038
07/08/2022	APS Referral
07/08/2022	Special Investigation Initiated - Telephone Stephanie Leone-Designee
07/29/2022	Contact - Telephone call made staff Sarah Moisma; number disconnected
07/29/2022	Contact - Telephone call made staff Nancy Callahan; left message
07/29/2022	Contact - Telephone call made Staff Marissa Nichols
07/29/2022	Contact - Telephone call made Lynn Tenbrock; obtained contact information for Supervisor Herzhaft-France.
07/29/2022	Contact - Telephone call made Supervisor Crystal Herzhaft-France; message left requesting another number for Ms. Moisma.
07/29/2022	Contact - Telephone call made Supervisor Jamie Darling, obtained alternative contact information for Ms. Moisma.
07/29/2022	Contact – Telephone call made Staff Nancy Callahan
07/29/2022	Contact - Telephone call made staff Sarah Moisma
08/04/2022	Inspection Completed On-site
08/08/2022	Inspection Completed-BCAL Sub. Compliance

08/09/2022	Exit Conference Designee Stephanie Leone

ALLEGATION: Residents were left without staff supervision.

INVESTIGATION: On July 8, 2022, I received a complaint from BCAL Online Complaints. It stated that River Valley staff Sarah Moisma arrived for her scheduled work shift at 11:30 pm on July 1, 2022. When she rang the bell to be let in Resident A opened the door for her and she discovered that there were no other staff at the home. Marissa Nichols and Nancy Callahan had left the home around 11:00 pm without ensuring that other staff were in the home.

On July 8, 2022, I contacted Designee Stephanie Leone. She informed me that the involved staff are contracted through an agency, referred to as "agency staff". They will not be returning to River Valley after this incident occurred. Ms. Leone provided me with the contact information for the staff members.

On July 29, 2022, I interviewed staff Marissa Nichols. I informed Ms. Nichols of the complaint allegation. She stated that she is "agency staff" and cannot be mandated to stay beyond her shift, adding that "If the incoming staff is late, that's not my problem". Ms. Nichols stated that she assumed someone else was there, but denied looking around to verify. I pointed out to Ms. Nichols that the common area of the home is a wide open space and therefore she would have been able to see if anyone else was working. I also suggested that she could have gone to the adjoining home and asked if there was anyone there that could work until the next shift arrived. Ms. Nichols responded again with the statement that agency staff cannot be mandated to remain after their shift.

On July 29, 2022, I interviewed staff Nancy Callahan. I informed her of the allegation made. She stated that there were four staff working on her shift from 3-11 pm. At 11:00 pm everyone but her had left. Ms. Callahan stated that the next shift person was late so she remained behind. After 15 minutes however, Ms. Callahan left, stating that agency staff cannot be mandated to stay and it seemed that the 3rd shift person was not going to show. I asked if she called anyone to inform them that 3rd shift hadn't arrived. She said she did not. I asked if she spoke to anyone in the adjoining home. She said she did not. Ms. Callahan stated that she thought maybe there was a med tech working, but denied that she checked to verify.

On July 29, 2022, I spoke with Lynn Tenbrock regarding the staff schedule. She informed me that two staff were done with their shift at 11:00 pm. However, Ms. Nichols and Ms. Callahan were scheduled to work until 11:30 pm when Ms. Moisma was to begin her 3rd shift. Agency staff were trained in orientation and provided with manager phone numbers to call if the next shift was running late. When Ms. Moisma arrived she called Supervisor Jamie Darling and informed her of the incident.

On July 29, 2022, I interviewed staff Sarah Moisma. I informed Ms. Moisma of the allegation. She recalled that when she arrived for her scheduled 3rd shift at 11:30 pm she rang the bell to be let in and no one responded. Eventually, Resident A came to the door and let her inside. She asked Resident A where Ms. Nichols and Ms. Callahan were, and Resident A informed her that they had left at 11:00 pm. Ms. Moisma called Supervisor Darling and then asked the staff in the adjoining home if anyone had contacted them before leaving, which they said no. Ms. Darling then arrived and worked with Ms. Moisma on 3rd shift.

I asked Ms. Moisma about training in what to do if someone is late or doesn't show. She stated that the supervisor phone numbers are hanging up in the home. Staff were told to call them and it is "obvious" that the numbers are there.

On August 4, 2022, I conducted an unannounced on-site inspection. I interviewed Resident A. I told her of the allegation and that I was there to make sure it did not happen again. Resident A had told me that she was having problems sleeping so she had gone out to the common area where she likes to sit in the recliners. There were four staff present when she went out. At 11:00 pm Resident A stated that she saw all four of the staff looking around the home and then they all left at the same time. Resident A stated that she had heard that Ms. Callahan was telling people that she "waited" but that was not true.

APPLICABLE RULE	
R 400.15206	**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 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	An allegation was made that staff left their shift, which left residents without supervision. Staff Callahan and Nichols admitted to leaving at the end of their shift and not waiting for the next shift staff to arrive. Staff Moisma stated when she arrived for her shift no staff was present.
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 9, 2022, I conducted an exit conference with Designee Stephanie Leone. We discussed the findings and subsequent rule violation. She agreed to send a Corrective Action Plan and had no further questions.

IV. RECOMMENDATION

Upon receiving an acceptable Corrective Action Plan, I recommend no change to the current license status.

August 9, 2022

Rebecca Piccard — Date
Licensing Consultant

Approved By:

August 9, 2022

Jerry Hendrick — Date
Area Manager