



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

March 8, 2023

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

RE: License #: AS410412315  
Investigation #: 2023A0340020  
Pivot Crisis

Dear Ms. Wilson:

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**

<b>License #:</b>	AS410412315
<b>Investigation #:</b>	2023A0340020
<b>Complaint Receipt Date:</b>	03/07/2023
<b>Investigation Initiation Date:</b>	03/07/2023
<b>Report Due Date:</b>	05/06/2023
<b>Licensee Name:</b>	Hope Network Behavioral Health Services
<b>Licensee Address:</b>	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
<b>Licensee Telephone #:</b>	(616) 430-7952
<b>Administrator:</b>	Tony Tudon
<b>Licensee Designee:</b>	Leslie Wilson
<b>Name of Facility:</b>	Pivot Crisis
<b>Facility Address:</b>	470 Baltimore Dr. NE Grand Rapids, MI 49503
<b>Facility Telephone #:</b>	(616) 454-4777
<b>Original Issuance Date:</b>	05/04/2022
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/04/2022
<b>Expiration Date:</b>	11/03/2024
<b>Capacity:</b>	6
<b>Program Type:</b>	MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Incident Reports were sent a month after the incidents occurred.	Yes
Incident Reports did not include the names of people involved.	Yes

**III. METHODOLOGY**

03/07/2023	Special Investigation Intake 2023A0340020
03/07/2023	Special Investigation Initiated - Telephone Home Manager Anne Michaels
03/07/2023	Contact - Telephone call made Lynn Tenbrock
03/07/2023	Inspection Completed-BCAL Sub. Compliance
03/08/2023	Exit Conference Compliance Manager Lynn Tenbrock
03/08/2023	Corrective Action Plan requested and due by March 23, 2023

**ALLEGATION:** Incident Reports were sent a month after the incident occurred.

**INVESTIGATION:** On Monday March 6, 2023, I received an email from Pivot Home manager Anne Michaels. It included a 15-page attachment with 12 Incident Reports (IR's). Three were from February 3rd, two from February 4<sup>th</sup>, and one for each of the following dates; February 6<sup>th</sup>, February 8<sup>th</sup>, February 10<sup>th</sup>, February 19<sup>th</sup>, February 22<sup>nd</sup>, February 26<sup>th</sup> and February 28<sup>th</sup>. These IR's were received after many conversations with Hope Network Administrators regarding the timeliness of the IR's being sent.

On March 6, 2023, I had a conversation with Ms. Michaels regarding the IR's. She acknowledged that the IR's were late but stated that she was busy because she had two homes to supervise. Ms. Michaels supervises both Pivot homes.

<b>APPLICABLE RULE</b>	
<b>R 400.14311</b>	<b>Investigation and reporting of incidents, accidents, illnesses, absences, and death.</b>

	<b>(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.</b>
<b>ANALYSIS:</b>	Incident Reports were sent to Licensing well over 24 hours of the incident occurring.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:** Incident Reports did not include the names of people involved.

**INVESTIGATION:** On March 6, 2023, I received thirteen IR's and on March 7<sup>th</sup> I received three additional IR's from home manager Anne Michaels. Fourteen of these IR's had coded names of either staff or residents and did not include the actual names of those involved.

On March 7, 2023, I contacted Ms. Michaels. This issue has been addressed numerous times in the past and I have been in recent contact with compliance manager Lynn Tenbrock regarding this issue. Ms. Tenbrock had previously informed me that an email reminder was sent to home managers at Hope Network to ensure staff do not code names on an IR. I asked Ms. Michaels about this email and she told me that she may have read it but she has been busy.

<b>APPLICABLE RULE</b>	
<b>R 400.14311</b>	<b>Investigation and reporting of incidents, accidents, illnesses, absences, and death.</b>
	<b>(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: (a) The name of the person who was involved in the accident or incident.</b>
<b>ANALYSIS:</b>	Fourteen IR's were sent to me and did not include the names of either the staff or residents who were involved in the incident.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On March 8, 2023, I conducted an exit conference with Lynn Tenbrock. We discussed our ongoing attempts to remedy these ongoing issues. I advised her that a citation is being made for which she understood and agreed to send a Corrective Action Plan.

**IV. RECOMMENDATION**

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



March 8, 2023

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Rebecca Piccard  
Licensing Consultant

Date

Approved By:



March 8, 2023

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Jerry Hendrick  
Area Manager

Date