GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 16, 2023

Crystal Herzhaft-France
Hope Network Behavioral Health Services
PO Box 890
3075 Orchard Vista Drive
Grand Rapids, MI 49518-0890

RE: License #: AL410015935
Investigation #: 2023A0467055
Rivervalley 1

Dear Ms. Herzhaft-France:

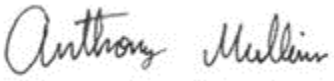
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 #:** | AL410015935 |
| | |
| **Investigation #:** | 2023A0467055 |
| | |
| **Complaint Receipt Date:** | 08/17/2023 |
| | |
| **Investigation Initiation Date:** | 08/17/2023 |
| | |
| **Report Due Date:** | 10/16/2023 |
| | |
| **Licensee Name:** | Hope Network Behavioral Health Services |
| | |
| **Licensee Address:** | PO Box 890, 3075 Orchard Vista Drive<br>Grand Rapids, MI 49518-0890 |
| | |
| **Licensee Telephone #:** | (616) 430-7952 |
| | |
| **Administrator:** | Crystal Herzhaft-France |
| | |
| **Licensee Designee:** | Crystal Herzhaft-France |
| | |
| **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:** | 04/25/2023 |
| | |
| **Expiration Date:** | 04/24/2025 |
| | |
| **Capacity:** | 16 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Residents are being verbally abused by staff. | No |
| Staff are not appropriately addressing residents' hygiene. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/17/2023 | Special Investigation Intake<br>2023A0467055 |
| 08/17/2023 | Special Investigation Initiated - Telephone |
| 09/19/2023 | Inspection Completed On-site |
| 10/10/2023 | Inspection Completed On-site |
| 10/16/2023 | APS Referral – sent via email. |
| 10/16/2023 | Exit conference with licensee designee,<br>Crystal Herzhaft-France. |

**ALLEGATION: Residents are being verbally abused by staff.**

**INVESTIGATION:** On 8/17/23, I received a BCAL online complaint stating that "an abundance of verbal abuse is going on" within the facility. On 8/30/23, I was able to connect with the complaint via phone. The complainant observed these concerns between May and June 2023. The complainant stated that Resident A, Resident B, Resident C, Resident D, and Resident E were all verbally abused by different staff members, including Jessie Adrianson, Tanya Favreau, Yanitcy Moreira, and agency staff members.

On 9/19/23, I made an unannounced onsite investigation at the facility. Upon arrival, AFC staff member, Tanya Favreau assisted residents to the main lobby to be interviewed privately. Introductions were made with Resident A, and he agreed to discuss case allegations. Resident A stated that he has lived at the facility for approximately 11 months, and he is ready to move back to Kalamazoo Michigan, where he is originally from. Resident A stated that his time at River Valley I has been "alright." Resident A stated that all staff members within the facility have been respectful towards him throughout his stay. Resident A did not have any additional information to add.

While onsite, I was unable to interview Resident B, Resident C, and Resident D. Resident B was reportedly admitted to Pine Rest psychiatric hospital for the past two weeks. Resident C was away at a doctor's appointment, and Resident D was

positive for Covid and in quarantine. I was able to interview AFC staff/program manager, Yanitcy Moreira. Ms. Moreira denied yelling at Resident C as alleged by the complainant. Ms. Moreira stated that she has told Resident C to stop screaming and yelling because she was upsetting other residents. However, she would never yell at Resident C or other residents for any reason. Ms. Moreira denied knowledge of Hope Network staff or agency staff members yelling at any of the residents either. It should be noted that several residents in the facility either had covid or were in quarantine from Covid. Due to this, in addition to some residents not being available, a second onsite visit will need to occur later.

On 10/10/23, I made a second unannounced onsite investigation at the facility. Upon arrival, AFC staff member, Ms. Moreira assisted in gathering residents to allow me to interview them individually. Resident B made her way to the lobby of the facility and introductions were made. She was interviewed privately in a room just off the main lobby. Resident B stated that she has lived at the facility for one year. Despite this, she prefers to live in Ionia Michigan. Resident B stated that she has a case manager and guardian, and she was encouraged to relay her concerns to them. Resident B was asked about staff at the facility. Resident B stated that “staff are okay. I write them poetry and that’s how I buy my time here.” Resident B stated that staff are “nice and treat me well.” In fact, Resident B stated that AFC staff member, Paige Gillespie is her favorite staff member. Resident B denied staff calling her any degrading or derogatory terms. Resident B then added that she feels staff thinks she’s “dumb,” despite her stating that all staff are nice and respectful to her. Resident B could not elaborate on her statement. Resident B was thanked for her time.

Introductions were made with Resident C, and she agreed to discuss case allegations. Resident C stated that she has been at the facility for 17 months and things are going well for her. Resident C stated that when she first arrived at the facility, she had a hard time warming up to staff members “but I like them now.” Resident C stated that she did not like Ms. Favreau initially because she was the staff member that stopped her from running away from the facility, although she knows it was a good thing since she shouldn’t have been roaming the streets. Resident C stated that Ms. Favreau has never yelled, screamed, or called her any derogatory or degrading names. Resident C stated that Ms. Favreau “brings a stern mom voice” but denied any concerns with this. Regarding other staff members, Resident C stated “there are some bad seeds, but they weed them out. All of them.” Resident C stated that management is working on weeding out the last “bad seed” and denied any concern regarding how staff are treating her. Resident C was thanked for her time.

Introductions were made with Resident D, and she agreed to discuss case allegations. Resident D was unable to recall how long she has lived at the facility but stated things are going well for her. Resident D stated that all staff within the AFC are nice and respectful to her. She denied anyone yelling, screaming, or calling her degrading names or making rude statements to her. It was also alleged that

Resident D had a fall between May and June and was not evaluated by staff, resulting in a bruise on her face. Resident D denied having any falls in May or June or marks or bruises. Resident D was observed to be free of any marks or bruises during this onsite visit.

Introductions were made with Resident E, and she agreed to discuss case allegations. Resident E stated that she has been at the facility for a couple years. Resident E was asked about her interactions with staff, including agency staff members. Resident E stated that staff are nice and treat her well. Resident E immediately followed her previous statement with, “they (staff) don’t seem to be good to me.” Resident E was asked to elaborate. Resident E stated that “they (staff) were going to have me in the hallway to speak to you and I didn’t want to be in the hallway.” Resident E was asked if she wished to end the interview and she stated no. Resident E was fixated on her recent nightmares and did not have any additional information to add. Therefore, this interview was concluded.

Introductions were made with Resident F, and she agreed to discuss case allegations. Resident F stated that she has been at the facility for 14 years. I attempted to ask Resident F questions about how staff treat her and talk to her. However, Resident F was fixated on talking about her husband and how she has not spoken to him in a long time. Resident F was tearful throughout our brief conversation, and she did not disclose any concerns relating to verbal abuse. Resident F was thanked for her time as this interview concluded.

Introductions were made with AFC staff member, Jessie Adrianson. Ms. Adrianson was asked about being verbally abusive to residents, including Resident A. Ms. Adrianson denied verbally abusing Resident A or any other resident in the facility. Ms. Adrianson stated, “it’s actually opposite,” referring to Resident A being verbally abusive towards her. Ms. Adrianson stated that Resident A is a diabetic, so she often has to provide education to him on things related to his diet. Ms. Adrianson’s communication with Resident A reportedly led to him calling her degrading names such as “stupid bitch.” Ms. Adrianson stated that her working relationship with Resident A has gotten better over time, but she knows that if he doesn’t get what he wants, he can be rude to staff. Ms. Adrianson was thanked for her time as this interview concluded.

On 10/16/23, I conducted an exit conference with licensee designee, Ms. Herzhaft-France. She was informed of the investigative findings and denied having any questions.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15305** | **Resident protection.** |
| | **(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be** |

| | |
|---|---|
| | **attended to at all times in accordance with the provisions of the act.** |
| **ANALYSIS:** | Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F were all interviewed. None of the six residents disclosed any form of verbal abuse by staff.<br><br>Staff members were interviewed as well, all of which denied verbally abusing any of the residents. Therefore, there is not a preponderance of evidence to support the allegation. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION: Staff are not appropriately addressing residents' hygiene.**

**INVESTIGATION:** On 8/17/23, I received a BCAL online complaint listing vague concerns regarding the facility. On 8/30/23, I was able to connect with the complainant via phone. The complainant stated that Resident B, Resident G, Resident H, Resident I, Resident J, and Resident K's hygiene needs were not being addressed by staff. The complainant stated that residents are being left in soiled diapers and diapers are being left in trash cans inside their rooms, causing a strong urine odor. The complainant also alleged that residents are not being bathed consistently.

On 9/19/23, I made an unannounced onsite investigation at the facility. Upon arrival, AFC staff member Tanya Favreau stated that Resident B was away at Pine Rest. Therefore, she was unable to be interviewed. Ms. Favreau then introduced me to Resident G, and she agreed to discuss case allegations. Resident G stated that she has lived at the facility for one year. Resident G was asked about her hygiene at the facility. Resident G stated that she showers twice a week on Tuesdays and Fridays. Resident G stated that staff always assist her in washing her body when needed. Resident G also stated that at times, she's able to bathe herself without the assistance of staff. Resident G denied any concern with how often she bathes and staff helping her. It should be noted that Resident G's room had a strong urine odor, and a soiled diaper was observed in her bedroom trash can.

While onsite, introductions were made with Resident H, and she agreed to discuss case allegations. Resident H stated that she has been at the facility for five years. Resident H stated that "staff are nice, but they ignore me too much." Resident H stated that it takes staff a "couple of hours" to change her, leaving her in a soaked diaper for an extended period of time. I attempted to ask Resident H additional questions, but it was difficult to understand her at times. I would often ask Resident H to repeat herself and it was still difficult to understand her. Resident H was thanked for her time. It should be noted I observed a soiled diaper in her trash can, which created a strong urine odor in the room.

I attempted to speak to Resident I and Resident J regarding the allegations. Resident I made eye contact, but she never responded to any of my questions. Resident J is reportedly on hospice and when I asked her questions, she stated, "how can you be alive?" There was no additional communication with Resident J. Resident I and J share a room and the room had a strong urine smell. I observed multiple diapers in the bedroom trash cans, which likely are the cause of the urine smell. There was also soiled linens on the floor, causing the odor. Other residents were not interviewed due to having covid or being unavailable on the day of my onsite visit. Prior to leaving the facility, AFC staff member, Paige Gillespi removed all soiled diapers from the resident's room.

While onsite, I spoke to AFC staff member, Yanitcy Moreira regarding the allegation. Ms. Moreira confirmed that she has communicated with staff about not leaving diapers in residents' bedroom. Ms. Moreira stated that residents' bedrooms are supposed to be cleaned at least 1-2 times per week. Ms. Moreira stated that she

feels the strong odor could have seeped into the walls. Ms. Moreira denied any knowledge of Resident H being left in a soiled diaper for an extended period of time. She also denied any knowledge of residents not being bathed, except for residents that refuse to be cleaned and changed at times. Ms. Moreira stated that staff can't force residents to bathe or change.

On 10/10/23, I made a second unannounced onsite visit at the facility and staff allowed entry. Upon arrival, introductions were made with Resident B who was away at Pine Rest Psychiatric hospital during my previous onsite visit. Resident B did not list any concerns for her hygiene. Instead, she was fixated on moving to Ionia Michigan. It should be noted that Resident B's bedroom trash can also had soiled diapers in it during my previous onsite investigation.

Introductions were made with Resident F, and she agreed to discuss case allegations. Resident F stated that she is showered three times a week and "I just got one recently." Despite receiving showers often at the facility, Resident F stated that she hates it because she receives a "murder shower." Resident F explained a murder shower as staff being too rough. She was unable to name or identity the staff member she was referring to. However, she shared that her last shower was "nice" and denied any concerns.

Introductions were made with Resident K while onsite and she agreed to discuss case allegations. Resident K stated that she has been at the facility for four years and she would like to move into an apartment with one of her peers. Resident K did not answer any of my questions related to hygiene needs as she was fixated on moving out of the City of Grand Rapids. Resident K spoke highly of AFC staff member Paige Gillespi and how she treats her. Resident K's room was observed during my previous onsite visit, and I observed a soiled diaper in the trash can, causing a strong urine odor.

Introductions were made with Resident E onsite, and she agreed to discuss case allegations. Resident E was asked about her hygiene care at the facility. Resident E stated that she doesn't get showers often and her last one was "weeks ago." Resident E stated that when she does shower, she needs assistance from staff. It should be noted that I also observed a soiled diaper in Resident E's bedroom trash can while onsite on 9/19/23, causing a strong odor smell. This is consistent with the lack of cleanliness in other residents' bedrooms.

During this onsite visit, I spoke with the executive director, Crystal Herzhaft-France regarding the allegation. Ms. Herzhaft-France stated that she noticed the urine smell in the facility the week prior to me coming onsite and this should have been addressed. Ms. Herzhaft-France stated that staff are aware that diapers are not to be left in residents' trash cans and additional conversations will be had with management and staff. Ms. Herzhaft-France denied any knowledge of staff leaving Resident H in soiled diapers for an extended period of time as she has never observed this or received any complaints regarding this. Ms. Herzhaft-France did

state that Resident H is encouraged to utilize some skills to do herself, but she does refuse at times. Regarding cleanliness for residents, Ms. Herzhaft-France stated that residents can request a shower at any time, in addition to their regularly scheduled showers. Ms. Herzhaft-France stated that she does morning huddle with managers daily to ensure that this is occurring. Ms. Herzhaft-France stated that this was implemented when she started two years ago because she was concerned that residents weren't being bathed. However, this is no longer an issue except for residents that refuse care, which she is looking to see if those residents need a higher level of care.

On 10/16/23, I conducted an exit conference with licensee designee, Crystal Herzhaft-France. 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 400.15314** | **Resident hygiene.** |
| | **(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.** |
| **ANALYSIS:** | Soiled diapers and/or linens were observed in the following residents' bedrooms: Resident B, Resident E, Resident G, Resident H, Resident I, Resident J, and Resident K.<br><br>Resident H stated that staff ignore her and leave her sitting in soiled diapers for an extended period of time. Resident E stated that she doesn't get showers often and she could not recall the last time she's received a shower.<br><br>Staff member Paige Gillespi removed soiled diapers from several residents' bedrooms while I was onsite on 9/19/23. Based on the information provided, 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.

Anthony Mullins

10/16/2023

Anthony Mullins Date
Licensing Consultant

Approved By:

10/16/2023

Jerry Hendrick Date
Area Manager