GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 7, 2025

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

RE: License #: AL410015787
Investigation #: 2025A0467024
Rivervalley 2

Dear Ms. Herzhaft-France:

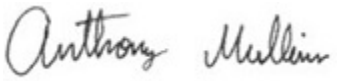
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL410015787
Investigation #:	2025A0467024
Complaint Receipt Date:	02/14/2025
Investigation Initiation Date:	02/18/2025
Report Due Date:	04/15/2025
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 430-7952
Administrator:	Crystal Herzhaft-France
Licensee Designee:	Crystal Herzhaft-France
Name of Facility:	Rivervalley 2
Facility Address:	1450 Leonard Street, NE Grand Rapids, MI 49505-5515
Facility Telephone #:	(616) 774-8789
Original Issuance Date:	04/04/1994
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?
Staff did not contact hospice or 911 immediately after finding Resident A deceased in his room.	Yes
Resident A's hygiene needs were not being attended to properly.	No

III. METHODOLOGY

02/14/2025	Special Investigation Intake 2025A0467024
02/18/2025	APS Referral Complaint received from Kent County APS
02/18/2025	Special Investigation Initiated - On Site
03/06/2025	Contact – Telephone call made to Licensee Designee, Crystal Herzhaft-France.
03/31/2025	Contact – telephone call made to AFC staff member, Jonathan Muhirwa
03/31/2025	Contact – telephone call made to AFC staff member, Daniqua Hartfield
03/31/2025	Contact – Telephone call made to AFC staff member, Mariah Ferguson
04/01/2025	Contact – telephone call made to licensee designee, Crystal Herzhaft-France
04/01/2025	Contact – Document received from Tanya Favreau
04/02/2025	Contact – telephone call made to AFC staff member, Daniqua Hartfield
04/02/2025	Contact – telephone call made to AFC staff member, Tanya Favreau
04/07/2025	Exit conference with licensee designee, Crystal Herzhaft-France.

ALLEGATION: Staff did not contact hospice or 911 immediately after finding Resident A deceased in his room.

INVESTIGATION: On 2/14/25, I received a LARA-BCHS online complaint stating that Resident A was found deceased and AFC staff member, Jonathan Muhirwa was

asleep on shift during this time. There is a concern that proper protocols were not followed after finding Resident A deceased.

On 2/18/25, I made an unannounced onsite investigation at the facility. Upon arrival, I spoke to staff member, Tanya Favreau regarding the allegation. Ms. Favreau confirmed that Resident A recently passed away and staff member Jonathan Muhirwa was working on the day in question, along with other staff. Ms. Favreau stated that another staff member took a picture of Mr. Muhirwa sleeping on shift and showed her. Ms. Favreau was informed that Mr. Muhirwa reportedly sleeps from 2:00am or 3:00am to 6:00am during his shifts. However, this is the first time that this has been brought to her attention. Ms. Favreau stated that she has not yet followed up with Mr. Muhirwa regarding this incident as HR is reportedly working to address this.

Ms. Favreau confirmed that on the shift in question was the night of 2/12/25 into the morning of 2/13/25. Ms. Favreau stated that she received a call at approximately 6:00am from staff member Daniqua Hartfield indicating that she passed Resident A's 6am medications (morphine/Ativan) through a syringe. After doing so, Ms. Hartfield stated that Resident A appeared as if he wasn't responsive. At this point, staff members Andrea Wise and Mariah Ferguson came to check on Resident A to confirm his status, and Ms. Hartfield contacted Ms. Favreau. Ms. Favreau stated that Resident A had a Do Not Resuscitate (DNR) in place per Faith Hospice. Ms. Favreau provided me with contact information for the nurse at Faith Hospice to confirm this. Ms. Favreau stated she called hospice immediately after staff informed her that Resident A was no longer breathing. Ms. Favreau was able to connect with them and they agreed to send someone to the facility. Ms. Favreau made her way to the facility immediately after being notified of this incident. Ms. Favreau stated that she arrived at the facility by 6:30am and checked on Resident A and confirmed that he did not have any vital signs and his body was warm. Ms. Favreau stated that shortly after her arrival, Faith Hospice arrived at the facility and pronounced Resident A deceased at 7:23 am and did postmortem care.

While onsite, I spoke to staff member, Andrea Wise as she was working on the day in question. Ms. Wise shared that she was working at RiverValley side 1 when her colleague, Ms. Hartfield asked her to come to Resident A's bedroom to verify that he was no longer breathing just after 6:00am. Ms. Wise stated that she walked up to Resident A and immediately noticed that he wasn't breathing. Ms. Wise stated that she called Ms. Favreau to inform her of this and then she checked Resident A's vitals. After confirming that Resident A was deceased, Ms. Wise stated that she assisted his roommate out of the room. Ms. Wise stated that Ms. Favreau arrived at the facility first and Hospice arrived sometime after her. Ms. Wise was unsure if Resident A had a DNR. It should be noted that Ms. Wise did not contact hospice or 911 after she confirmed Resident A's condition. When asked about staff sleeping on the job, Ms. Wise denied any knowledge of this.

On 3/6/25, I spoke to licensee designee, Crystal Herzhaft-France via phone. I informed Ms. Herzhaft-France that staff member, Tanya Favreau informed me that staff member Jonathan Muhirwa was sleeping on the day in question and another staff member had a picture of this. Ms. Herzhaft-France stated that she had to discipline Ms. Favreau regarding this matter because she didn't immediately inform her of Mr. Muhirwa sleeping while on shift. Ms. Herzhaft-France confirmed that Resident A was on hospice and his death was anticipated. Ms. Herzhaft-France stated that she does not believe Resident A's death had anything to do with Mr. Muhirwa sleeping as she has not seen any correlation. However, she acknowledged that Mr. Muhirwa should not be sleeping on shift. Ms. Herzhaft-France stated that Mr. Muhirwa admitted that he was tired and sleeping during his scheduled shift. It should be noted that other staff were working in the facility at this time. Ms. Herzhaft-France stated that Mr. Muhirwa received discipline for sleeping on his shift, which included a one-day suspension on 2/21/25.

On 3/31/25, I spoke to staff member, Jonathan Muhirwa via phone regarding the allegation. Mr. Muhirwa confirmed that he worked with Resident A at the facility on the day he passed away. It should be noted that there were other staff members working during this time as well. Mr. Muhirwa stated that on the day in question, he was writing a report. While doing so, he "dosed off" briefly. After waking up, staff informed him that Resident A had passed away. Mr. Muhirwa confirmed that he and staff members Mariah Ferguson and Mary (last name unknown) went to confirm this and care for the other resident in the room with Resident A. Mr. Muhirwa stated that this was the first and only time that he had dosed off while working. Prior to dozing off, Mr. Muhirwa stated that he checked on Resident A at 4:00am and did not note any concerns regarding his health. Mr. Muhirwa was supposed to check on Resident A again around 6:00am, but Resident A passed away prior to this occurring.

On 3/31/25, I spoke to staff member, Daniqua Hartfield via phone regarding the allegation. Ms. Hartfield stated that on the day in question, she was working as the medication tech at RiverValley side one. However, staff member Mary (last name unknown) left side two around 5:00am, so Ms. Hartfield was tasked with passing Resident A's medications at 6:00am. Ms. Hartfield confirmed that she passed Resident A's 6:00am medications. After doing so, she noticed that he appeared to be unresponsive. Ms. Hartfield stated that she asked staff member Andrea Wise to confirm the medication pass and she attempted to confirm that Resident A wasn't breathing. Ms. Hartfield stated that Ms. Wise was unable to confirm Resident A wasn't breathing, so she called staff member Mariah Ferguson to assist, and Ms. Ferguson reportedly confirmed that Resident A wasn't breathing. After doing so, Ms. Hartfield stated that she called the manager on-call, which was Tanya Favreau and informed her of this. Ms. Hartfield stated that Mariah Ferguson was working on side two with Jonathan Muhirwa. Staff member Mary (last name unknown) was also working side two, but she left around 5am, which left Ms. Ferguson and Mr. Muhirwa to care for residents.

Ms. Hartfield stated that the manager, Ms. Favreau arrived at the home and went into Resident A's room. Ms. Hartfield stated that Ms. Favreau called Hospice and told her and other staff to stay calm because "we were freaking out because it was kind of scary walking in on someone that had been deceased, and I passed a med to them." Ms. Hartfield was unable to confirm if Ms. Favreau checked Resident A's vitals when she went into his room because she reported back to side one at this time. Ms. Hartfield was asked if she saw any staff members sleeping on side two while there. Ms. Hatfield stated that it was a quick glance, but she saw Mr. Muhirwa's "head leaned over" while sitting in his chair. However, Ms. Hartfield stated that she was unable to confirm if Mr. Muhirwa was asleep.

On 3/31/25, I left a voicemail for staff member, Mariah Ferguson requesting a call back. On the same day, I received a text message at 11:50am from Ms. Ferguson stating, "who is this?" I responded to Ms. Ferguson by providing her with my name and job title. I also informed Ms. Ferguson that I received her phone number from Tanya Favreau and that I need to speak with her regarding an incident that took place at River Valley last month.

On 3/31/25, I spoke to Kaila Degroot via phone. Ms. Degroot is a Registered Nurse (RN) case manager at Faith Hospice and she was responsible for overseeing Resident A's care while on hospice. Ms. Degroot worked with Resident A during normal business hours and denied witnessing any staff members sleeping on shift. Ms. Degroot shared that their team did have nurses visiting the home after hours when needed, and she never received a report of staff members sleeping during their scheduled shifts. Ms. Degroot also confirmed that Resident A did have a Do Not Resuscitate (DNR) order on file. Ms. Degroot shared that there was a question about discharging Resident A from hospice since there was a period of time that he was improving. However, it never happened because Resident A ended up declining. Ms. Degroot was thanked for her time as this interview concluded.

On 4/2/25, I spoke to AFC staff member, Daniqua Hartfield to provide clarification on the incident with Resident A. I asked Ms. Hartfield to clarify how she passed the medications to Resident A and how he responded. Ms. Hartfield stated that she gave Resident A 5mg of liquid morphine through a syringe. Ms. Hartfield stated that she passed the medications based on how the previous medication tech told her to. Ms. Hartfield stated that Resident A has a history of hitting and swinging his hands at staff when his medications are being passed. Ms. Hartfield stated that due to being pregnant, the previous med tech told her to be careful. Ms. Hartfield stated that she was expecting Resident A to swing on her during the medication pass. Therefore, she put the medication in the syringe, called Resident A's name and informed him that his medication was ready. However, Resident A never responded. Ms. Hartfield assumed Resident A didn't respond due to sleeping and proceeded to put the liquid morphine in his mouth.

Prior to giving Resident A the morphine, Ms. Hartfield did not notice any indication that Resident A was deceased. After passing the medication, Ms. Hartfield stated

that Resident A still didn't move, which is when she became concerned and called in two staff members to verify that he was no longer breathing. I asked Ms. Hartfield if she or the other two staff members checked Resident A's vitals. Ms. Hartfield stated that Andrea Wise checked Resident A's pulse and O2 and Mariah Ferguson checked Resident A's breathing and pulse on his neck and wrist. Ms. Hartfield again confirmed that she called the on-call manager, Tanya Favreau as opposed to hospice or 911 when she discovered Resident A deceased. Ms. Hartfield stated, "I don't know hospice protocol." As a result, she called Ms. Favreau and told her that she didn't know what to do while trying to keep herself calm. Ms. Hartfield stated that Ms. Favreau confirmed that Resident A's body was still warm when she arrived at the facility. Based on the information provided by Ms. Hartfield, Resident A should not have received his 6:00am medication as it was likely he was already deceased.

On 4/2/25, I spoke to Ms. Favreau via phone and asked her to share what the hospice protocol is within the facility if a resident is found in cardiac arrest or not showing signs of life. Ms. Favreau stated anytime a resident is on hospice they typically have a DNR in place, which was the case for Resident A. Ms. Favreau stated that staff have been told that if a resident is on hospice and found unresponsive, they are to hold their hands and keep them comfortable until they pass away. Ms. Favreau confirmed that staff are required to call hospice to inform them of the incident, and hospice will typically send someone to assess the resident. Ms. Favreau was not at the facility when Resident A was found deceased and she confirmed that staff called her directly, and she ultimately made the call to hospice. I informed Ms. Favreau that it is concerning the staff did not follow standard protocol as staff should have called hospice or 911 if they were unable to get ahold of hospice, prior to calling her as the on-call manager. Despite Ms. Hartfield not calling hospice first, Ms. Favreau stated that staff are aware of this process.

Ms. Favreau stated that she spoke to staff member Ms. Hartfield when she arrived at the facility on the morning of Resident A's death. Ms. Favreau stated that Ms. Hartfield told her that Resident A took his last breath in front of her right after she put the medication in his mouth "and it freaked her out." I told Ms. Favreau that during my conversation with Ms. Hartfield, she did not disclose this information. In fact, Ms. Hartfield stated that she only noticed Resident A wasn't breathing when he did not move after putting the liquid morphine on his mouth.

Based on my conversation with Ms. Hartfield, I explained to Ms. Favreau that Ms. Hartfield never confirmed that Resident A was alive prior to putting the medication in his mouth, which is concerning. I informed Ms. Favreau that apparently Ms. Hartfield has provided two different explanations as to what occurred, making it difficult to confirm exactly what the truth is. Ms. Favreau stated that she believes Ms. Hartfield and other staff members got on the "band wagon" and decided to make it seem as if Resident A was deceased for hours. However, when hospice arrived at the facility, Resident A was still mobile and did not have any rigor mortis setting in, which allowed hospice to reposition him. Based on this, Ms. Favreau believes that Resident A passed away after the medication was given to him by Ms. Hartfield.

I informed Ms. Favreau that I reached out to Mariah Ferguson on 3/31/25 to discuss this and she responded via text stating “who is this?” Ms. Favreau stated that Ms. Ferguson works 3rd shift and she would have her call me on the morning off 4/3/25 prior to ending her shift. As of the conclusion of this investigation, Ms. Ferguson has not returned my call.

On 04/07/25, I conducted an exit conference with licensee designee, Crystal Herzhaft-France. She was informed of the investigative findings and aware that all staff will need to be educated on the importance of never passing a medication, regardless of hospice status, to a resident while they are sleeping. Ms. Herzhaft-France agreed to complete a corrective action plan within 15 days of receipt of this report and plans to follow-up with staff on this issue, including Mariah Ferguson who never returned a call to be interviewed.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident’s physician condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Staff members Ms. Hartfield, Ms. Ferguson, and Ms. Wise all observed Resident A deceased. However, none of the staff followed appropriate protocol and called hospice or 911. Instead, staff called the on-call manager, Tanya Favreau, who then called hospice to provide an update on Resident A’s status. Due to calls being delayed to the medical professionals (hospice and 911) after Resident A was found deceased, and Resident A potentially receiving medication while deceased, there is a preponderance of evidence to support this applicable rule violation. There is also a discrepancy regarding when Resident A actually passed away as Ms. Hartfield provided different explanations to me and the program manager. In addition, staff member Mr. Muhirwa was asleep during this incident. However, Mr. Muhirwa being asleep does not appear to have been a contributing factor or to have had any impact on Resident A’s passing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A’s hygiene needs were not being attended to properly.

INVESTIGATION: On 2/14/25, I received a LARA-BCHS online complaint stating

that residents' hygiene needs were not being attended to properly.

On 2/18.25, I spoke to staff member, Andrea Wise onsite and she denied any knowledge of Resident A or other residents hygiene needs not being met. Ms. Wise has worked for Hope Network since May 2023 and has not observed this concern.

On 3/31/25, I spoke to staff member, Jonathan Muhirwa regarding the allegation. Mr. Muhirwa denied any concerns regarding Resident A's hygiene needs. He also denied concern regarding other residents and confirmed that all resident's hygiene needs are being met.

On 3/31/25, I spoke to staff member Daniqua Hartfield regarding the allegation. Ms. Hartfield denied any concern regarding Resident A or other's hygiene needs not being attended to.

On 3/31/25, I spoke to Kaila Degroot via phone. Ms. Degroot is a Registered Nurse (RN) case manager at Faith Hospice and she was responsible for overseeing Resident A's care. I asked Ms. Degroot if she had any concerns regarding Resident A's personal hygiene needs while providing care for him at the facility. Ms. Degroot stated that it seemed as if 3rd shift staff members didn't change Resident A overnight. Ms. Degroot stated that when she came in during the mornings to provide care for Resident A, "he would be soaked." Ms. Degroot also stated that she knows that Resident A refused care a lot of times. Ms. Degroot stated that during the times she observed Resident A soaked, "he wasn't with it enough" to report if he had refused to be changed or if staff failed to do so. However, Ms. Degroot stated that Resident A always let her change him. Ms. Degroot was thanked for her time as this interview concluded.

On 4/1/25, I spoke to licensee designee, Crystal Herzhaft-France. I informed her that the hospice nurse overseeing care for Resident A informed me that there were times that she came in to care for Resident A in the mornings and he was soaked. Ms. Herzhaft-France confirmed that staff keep logs for personal hygiene needs for residents, and she agreed to have the program manager, Tanya Favreau send me logs for the last 14-21 days of care Resident A received prior to passing away.

On 4/1/25, Ms. Herzhaft-France sent me an email stating that Ms. Favreau will send me 3rd shift documentation from 1/25/25 through 2/13/25, which equates to 20 days of care. Ms. Herzhaft-France stated that the documentation that will come from Ms. Favreau will also include documentation from other shifts that confirmed that Resident A was still responding to staff until Faith Hospice increased his medication doses to every 2 hours, 3 days prior to his death.

On 4/1/25, I received an email from Ms. Favreau that included 3rd shift documentation from 1/26/25 through 2/13/25, which was the day that Resident A passed away. The email also included documentation from 1st and 2nd shift throughout the month of February. The shift documentation indicated that staff

completed hourly checks on Resident A, including bed baths, linen changes, and changing his briefs and clothes when needed. Documentation also confirmed that Resident A refused hygiene care on several occasions, and he was able to verbalize his refusal up until 2 days prior to passing away.

On 04/07/25, I conducted an exit conference with licensee designee, Crystal 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:	Four staff members denied any concerns regarding the care that Resident A received at the facility. Hospice nurse Ms. Degroot expressed concern that Resident A's brief was soaked in the mornings that she provided care for him when he was unable verbally refuse care due to his declining condition. Program manager, Tanya Favreau provided me with documentation from 1/26/25 through 2/13/25 that indicated staff were addressing all Resident A care needs during 3rd shift. Resident A also refused care often and was able to communicate clearly through 2/11/25, which was 2 days prior to his death. Based on the information provided, there is not a preponderance of evidence to support this applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

Anthony Mullins 04/07/2025

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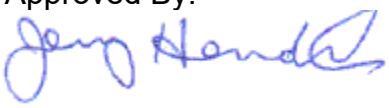
Anthony Mullins Date
Licensing Consultant

Approved By:



04/07/2025

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Jerry Hendrick Date
Area Manager