



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 12, 2026

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

RE: License #: AL410015787  
Investigation #: 2026A0469001  
Rivervalley 2

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Natasha Grew".

Natasha Grew, 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**

<b>License #:</b>	AL410015787
<b>Investigation #:</b>	2026A0469001
<b>Complaint Receipt Date:</b>	01/26/2026
<b>Investigation Initiation Date:</b>	01/27/2026
<b>Report Due Date:</b>	02/25/2026
<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>	Crystal Herzhaft-France
<b>Licensee Designee:</b>	Crystal Herzhaft-France
<b>Name of Facility:</b>	Rivervalley 2
<b>Facility Address:</b>	1450 Leonard Street, NE Grand Rapids, MI 49505-5515
<b>Facility Telephone #:</b>	(616) 774-8789
<b>Original Issuance Date:</b>	04/04/1994
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/25/2025
<b>Expiration Date:</b>	04/24/2027
<b>Capacity:</b>	16
<b>Program Type:</b>	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED



## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A received incorrect medications on 01/21/2026.	Yes

## III. METHODOLOGY

01/26/2026	Special Investigation Intake 2026A0469001
01/26/2026	APS Referral – Complaint received from Kent County APS
01/27/2026	Special Investigation Initiated - Letter To Recipient Rights per licensing consultant Arlene Smith
03/10/2026	Inspection Completed On-site
03/10/2026	Contact - Telephone call made Phone call with Mandy Hamp
03/12/2026	Exit conference – Telephone call made with licensee designee, Crystal Herzhaft-France

### **ALLEGATION: Resident A received incorrect medications on 01/21/2026.**

**INVESTIGATION:** On 01/26/2026, LARA received a complaint from Kent County Adult Protective Services (APS). The complaint alleged that on 01/21/2026, Resident A was administered incorrect medications, including Aspirin 81 mg, Gabapentin 400 mg, Lacosamide 200 mg, Risperidone 3 mg, Omeprazole 40 mg, Trintellix 10 mg, Vitamin D, and Tylenol 500 mg. Resident A is reportedly receiving hospice services, and the hospice nurse was notified of the medication error. According to the hospice nurse, Resident A did not experience any adverse side effects and remained in stable condition following the incident. APS screened out the complaint and did not assign it for investigation.

It should be noted that this complaint was initially assigned to Licensing Consultant Arlene Smith on 01/26/2026. However, it was reassigned to me on 03/09/2026.

On 03/10/2026, I completed an onsite inspection at the facility and interviewed licensee designee Crystal Herzhaft-France, program manager Tanya Favreau, and staff member Anna Habimana.

Ms. Herzhaft-France confirmed that a medication error occurred on 01/21/2026 when Resident A was administered incorrect medications by staff member Anna Habimana. Ms. Herzhaft-France reported that she was notified of the incident after it

occurred and that Ms. Habimana contacted the on-call hospice nurse for follow-up instructions, which were followed. An incident report (IR) was completed for this medication error. Ms. Herzhaft-France stated that “serious disciplinary action” was taken with Ms. Habimana and that Ms. Habimana will be terminated if a similar incident occurs in the future. Ms. Herzhaft-France also stated that a Recipients Rights complaint was investigated and substantiated.

Ms. Herzhaft-France confirmed that Ms. Habimana was properly trained to pass medications prior to this incident occurring. She also confirmed that Ms. Habimana has been retrained in medication management, which included more observations of her administering medications.

Ms. Favreau confirmed that she was working on 01/21/2026 when Ms. Habimana administered the incorrect medications to Resident A. Immediately after the medication error, Ms. Habimana informed Ms. Favreau of the incident. Ms. Favreau stated that she instructed Ms. Habimana to contact the on-call hospice nurse for instructions and to complete an IR. According to Ms. Favreau, the hospice nurse instructed Ms. Habimana to withhold Resident A’s next dose of medications and to monitor him for any adverse side effects. Ms. Favreau confirmed that Resident A did not experience any adverse side effects as a result of the medication error.

Although Resident A received another resident’s medications, Ms. Favreau confirmed that no other residents were affected and that all other residents received their medications as prescribed. Ms. Favreau confirmed that this has been the only incident when Ms. Habimana has made a medication error. Ms. Favreau confirmed that Ms. Habimana was properly trained to pass medications prior to this incident. She also confirmed that Ms. Habimana has been retrained on medication management.

Ms. Habimana confirmed she administered the incorrect medications to Resident A on 01/21/2026. Ms. Habimana explained that she “prepped” medications to take to another resident. While in the process of transporting the medication to a different resident, she somehow went into Resident A’s room and administered the wrong medications to him. Ms. Habimana stated that she realized the mistake immediately and told her supervisor, Ms. Favreau, who directed her to contact the hospice nurse for follow-up instructions. Ms. Habimana stated that she contacted Corewell Health’s on-call hospice team and spoke with nurse Mandy Hamp. Ms. Haimana was told to withhold the next dose of Resident A’s medications and monitor him for any adverse side effects. Ms. Habimana confirmed she was properly trained in medication management prior to this incident. Ms. Habimana denied any similar incidents occurring prior to the medication error on 01/21/2026. Ms. Habimana stated she received “serious discipline” for this incident, which included her being retrained on medication management.

While on-site, Ms. Herzhaft-France and Ms. Favreau provided me with copies of training verification for Ms. Habimana and the IR related to medication error. Ms.

Habimana’s initial medication training occurred on 05/29/2024 and the retraining occurred on 02/23/2026. The IR from 01/21/2026 was written by Ms. Habimana. The IR confirms the explanations provided above by Ms. Herzhaft-France, Ms. Favreau, and Ms. Habimana.

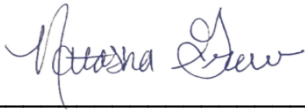
On 03/10/2026, I interviewed Ms. Hamp via telephone. Ms. Hamp confirmed she was contacted by Ms. Habimana immediately after Resident A received the incorrect medications on 01/21/2026. Ms. Hamp confirmed the incorrect medications given to Resident A included Aspirin 81 mg, Gabapentin 400 mg, Lacosamide 200 mg, Risperidone 3 mg, Omeprazole 40 mg, Trintellix 10 mg, Vitamin D, and Tylenol 500 mg. This is the first time this has occurred. Ms. Hamp confirmed that Resident A experienced no adverse side effects as a result of this incident. Ms. Hamp stated that Resident A was prescribed some of the same medications he was mistakenly given but in different doses. Ms. Hamp instructed Ms. Habimana to withhold Resident A’s next dose of medications and monitor him for any adverse side effects.

On 03/12/2026, I conducted an exit conference with licensee designee, Crystal Herzhaft-France. I informed her of the investigative findings and she agreed to complete a corrective action plan (CAP) within 15 days of receipt of this report.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.</b>
<b>ANALYSIS:</b>	Ms. Herzhaft-France, Ms. Favreau, Ms. Habimana and hospice nurse Mandy Hamp all confirmed that on 01/21/2026, Resident A was administered incorrect medications. Therefore, there is sufficient evidence to support this rule violation.  It should be noted that staff member Ms. Habimana immediately contacted the hospice nurse after the medication error and followed all instructions, as given. Resident A did not have any adverse side effects after receiving the wrong medications. Licensee designee Ms. Herzhaft-France disciplined Ms. Habimana, which included her being retrained in medication management and additional observations administering medications.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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



03/12/2026

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Natasha Grew  
Licensing Consultant

Date

Approved By:



03/12/2026

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Jerry Hendrick  
Area Manager

Date