GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 13, 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 #: 2025A0467020
Rivervalley 2

Dear Mrs. Herzhaft-France:

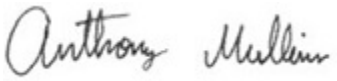
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL410015787
Investigation #:	2025A0467020
Complaint Receipt Date:	01/23/2025
Investigation Initiation Date:	01/23/2025
Report Due Date:	03/24/2025
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 DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his Ativan and Morphine medication as prescribed.	Yes

III. METHODOLOGY

01/23/2025	Special Investigation Intake 2025A0467020
01/23/2025	Special Investigation Initiated - Telephone
01/29/2025	Inspection Completed On-site
01/29/2025	Contact – telephone called made to AFC staff member, Ariel Vaughn
01/30/2025	Exit conference with licensee designee, Crystal Herzhaft-France
02/14/2025	APS Referral

ALLEGATION: Resident A did not receive his Ativan and Morphine medication as prescribed.

INVESTIGATION: On 1/23/25, I spoke to staff member, Lula Jackson. Ms. Jackson informed me that on the night of 1/21 through the morning of 1/22, Resident A did not receive his Ativan and Morphine medication as prescribed. Ms. Jackson stated that staff member Ariel Vaughn was working on the night/morning in question and she instructed her to go to Side-2 to pass Resident A's medication, which she failed to do. Ms. Jackson added that Resident A is on hospice and often times staff will prompt him to take his medications, and he will refuse. Regardless, directives were given to Ms. Vaughn and she did not follow through in providing Resident A with his prescribed medications. Ms. Jackson acknowledged that the other resident that Ms. Vaughn was caring for can be difficult to manage. However, Rivervalley Side-1 and Rivervalley Side 2-has 3 staff members on each side. Ms. Jackson confirmed that Ms. Vaughn was the only trained med tech working at the time due to recently terminating a staff member, which is why she was asked to go to Side-2 to pass Resident A's medication.

On 1/23/25, staff member Lula Jackson sent me an email with a copy of Resident A's Mar for the month of January. After reviewing the Mar, I confirmed that Resident A is scheduled to receive both Ativan and Morphine 6 times per day each. Per the Medication Administration Record (MAR), Resident A did not receive his Ativan for

25 scheduled doses. Based on the number of doses given per day, this would be equivalent to approximately 4 days of medication. The MAR also indicated that Resident A did not receive his Morphine for 20 schedules doses. Based on the number of doses given per day, this is equivalent to approximately 3 days of medication.

On 1/29/25, I made an unannounced onsite investigation at the facility. Upon arrival, introductions were made with Resident A. I attempted to interview Resident A privately, but he insisted on Ms. Favreau being present with him in her office. Resident A was unable to state how long he has been a resident at the home. However, he did share that things are “good” at home and he always receives his medications as prescribed. Resident A denied any issues or concerns related to his medications. It should be noted that Resident A was easily distracted and unable to answer additional questions.

After speaking to Resident A, I spoke to Ms. Favreau regarding the allegation. Ms. Favreau stated that approximately 2 months ago, Resident A became sick and ended up being placed on hospice due to cancer and refusing treatment. As of recent, Resident A began gaining weight and became more active, which has led to hospice planning to discharge him. Ms. Favreau stated that Resident A’s medications are currently scheduled, but this will be changed to PRN due to discharging from hospice. Ms. Favreau also stated that if Resident A is sleeping comfortably, staff will not have to wake him to pass medications. However, on the night/morning in question (1/22-1/23), Ms. Favreau stated that Resident A was awake and wanted his medication. Ms. Favreau stated that staff member Tracey Beck called on-call manager, Lula Jackson on the night in question and informed her that Resident A wanted his meds. This reportedly led to Ms. Jackson calling staff member Ariel Vaughn and instructing her to pass the medications, which she failed to do and Ms. Favreau is unsure why.

On 1/29/25, I spoke to staff member, Ariel Vaughn via phone and she agreed to discuss case allegation. On the day in question, Ms. Vaughn confirmed receiving a call from Ms. Jackson instructing her to go to Rivervalley Side-2 to pass Resident A’s medication since she was the only trained medication tech working. Ms. Vaughn stated that on this night, she was busy and it was only her and one her staff member working. Due to this, Ms. Vaughn stated that it was “a lot” for her to go to the other side of the facility to pass medications. Ms. Vaughn stated that another resident that she was caring for on this night was also “a lot to handle” in addition to cleaning and charting. Ms. Vaughn stated that she informed Ms. Jackson that it was a lot for her to do after being asked to pass medications on Side-2, but Ms. Jackson told her that there was nothing she could do since she was the only person trained to pass medications. Ms. Vaughn again shared that she was overwhelmed. Ms. Vaughn apologized for not passing Resident A’s medications on the night/morning in question.

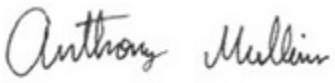
On 1/29/25, I spoke to licensee designee, Crystal Herzhaft-France via phone. Mrs. Herzhaft-France shared that Resident A missed several doses of his Ativan and Morphine as opposed to one day like the complaint alleged. Mrs. Herzhaft-France stated that the hospice nurse informed the team that they did not need to wake Resident A up in the middle of the night to give him his medications if it appeared as if he was sleeping comfortably and not in pain. Mrs. Herzhaft-France stated that med passes appear to be missed more because staff were not documenting when Resident A was asleep and comfortable as they were instructed to do per the hospice nurse. Mrs. Herzhaft-France also confirmed that on the night of 1/21 through the morning of 1/22, Ms. Vaughn was instructed to pass Resident A's medication and failed to do so.

On 1/30/25, I conducted an exit conference with licensee designee, Crystal Herzhaft-France. She was informed of the investigative findings and aware that a corrective action plan is needed because of this citation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Ariel Vaughn acknowledged she did not pass Resident A's medication on the night of 1/21 into the morning of 1/22 due to being overwhelmed. Ms. Jackson and Mrs. Herzhaft-France also confirmed this. I reviewed Resident A's MAR which also indicated that the medication was not passed on the day in question, in addition to several other days. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



02/13/2025

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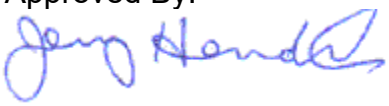
Anthony Mullins Date
Licensing Consultant

Approved By:



02/13/2025

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Jerry Hendrick Date
Area Manager