



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2026

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

RE: License #: AS700402368
Investigation #: 2026A0340058
River View Transitions Living Center

Dear Mrs. Pena:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 356-0100.

Sincerely,

A handwritten signature in blue ink that reads "Rebecca Piccard".

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

License #:	AS700402368
Investigation #:	2026A0340058
Complaint Receipt Date:	08/31/2026
Investigation Initiation Date:	08/31/2026
Report Due Date:	10/30/2026
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 301-8000
Administrator:	Chane Hicks
Licensee Designee:	Dave Paul
Name of Facility:	River View Transitions Living Center
Facility Address:	340 Coburn Street Grand Haven, MI 49417
Facility Telephone #:	(616) 607-2152
Original Issuance Date:	01/01/2020
License Status:	REGULAR
Effective Date:	07/01/2026
Expiration Date:	06/30/2028
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was found deceased unexpectedly in his room.	No
Additional Finding	Yes

III. METHODOLOGY

08/31/2026	Special Investigation Intake 2026A0340058
08/31/2026	APS Referral Not accepted for investigation
08/31/2026	Special Investigation Initiated - Telephone GHPS Det. Rasch
08/31/2026	Contact - Document Sent Licensee Dave Paul
09/01/2026	Contact - Face to Face Det Rasch-GHPS
09/01/2026	Inspection Completed On-site
09/28/2026	Exit Conference Dave Paul

ALLEGATION: Resident A was found deceased unexpectedly in his room.

INVESTIGATION: On August 29, 2026, Licensee Designee Dave Paul informed me that Resident A from the River View Transitional Living Center had passed away unexpectedly. He was 50 years old. Mr. Paul provided the Incident Report written by staff Abigail Biniecki. He also provided Resident A's Assessment Plan and Health Care Appraisal. These documents were reviewed and included the following information.

Resident A's Health Care Appraisal was completed by RN Timothy Buchholz on 7/30/26. It states he had a diagnosis of Paranoid Schizophrenia, Antisocial personality disorder, mild intellectual disability, and Tachycardia.

The Assessment Plan for Resident A was signed by Dave Paul on 8/27/25. The Assessment Plan did not indicate whether Resident A could be in the community independently at the time of his passing. It does state Resident A does not use drugs or alcohol.

The Incident Report (IR) was completed by staff Abigail Biniecki on 8/29/26. It states that at approximately 7:29 AM Ms. Biniecki went to Resident A's bedroom to pass his medication, however, Resident A did not respond. After a second attempt to pass the medication, Ms. Biniecki touched Resident A and he was stiff to the touch. Ms. Biniecki pulled the blanket back and observed him to be still and unresponsive. Ms. Biniecki called for assistance from her co-worker Jamie Evans to call 911 and help move Resident A from his bed to the floor to begin CPR until paramedics arrived. Paramedics continued CPR for approximately 5 minutes until he was determined to be deceased.

Grand Haven Public Safety Det. Rasch arrived to the home and relayed that both her and the Medical Examiner did not find anything suspicious. Resident A's body was removed from the home for an autopsy. Notifications were made to Licensing, Recipient Rights, Resident A's guardian. Det. Rasch stated he will inform Resident A's mother.

On August 31, 2026, I called Det. Rasch and asked him to meet regarding the incident.

On September 1, 2026, I met with Det. Rasch at the Grand Haven Dept of Public Safety. He confirmed he received a call on 8/29/26 and arrived on scene that morning. He did not find anything suspicious or concerning regarding the unexpected death of Resident A. There is an autopsy that was conducted with no findings, however, the results of the toxicology screen will take approximately two months.

On September 1, 2026, I conducted an unannounced home inspection and met with home manager Toveda Moffett. She stated Resident A behaved as usual the day prior to his death. She reviewed the shift notes and there was nothing out of the ordinary. She stated it was a "shock" for everyone when they found out he had passed. I asked Ms. Moffett if there were any concerns regarding the cause of death and she stated no, Resident A had no "drug issues" and he was "eye's on" in the community due to his vulnerability.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Ms. Biniecki found Resident A deceased in the morning when she attempted to pass his medication. Det. Rasch stated there was nothing suspicious or concerning regarding Resident A's passing. He stated the Medical Examiner did not find anything unusual in his autopsy but the toxicology report will take a while for results. Ms. Moffett stated there was nothing unusual regarding Resident A's behavior the day prior to his passing. There is not a preponderance of evidence to support a rule violation related to Resident A passing away unexpectedly.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS

INVESTIGATION: While conducting the above investigation I discovered Resident A's Assessment Plan was not completed to provide the answer to the first section item "Moves Independently in the Community".

Ms. Moffett stated Resident A was "eye's on" in the community due to his vulnerability, however, there is no documentation to support this need.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident A's Assessment Plan did not have all questions answered, specifically, whether or not Resident A could be in the community unsupervised or not.
CONCLUSION:	VIOLATION ESTABLISHED

On September 28, 2026, I conducted an exit conference with Designee Dave Paul. I

discussed with him the allegation pertaining to Resident A and the subsequent findings regarding the incomplete Assessment Plan. He understood the violation as explained 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.

 September 28, 2026

Rebecca Piccard
Licensing Consultant

Date

Approved By:

 September 29, 2026

Jerry Hendrick
Area Manager

Date