GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 30, 2021

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

RE: License #: AS340358904
Investigation #: 2021A0355027
Westlake II

Dear Ms. Johnson:

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) 356-0100.

Sincerely,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS340358904
Investigation #:	2021A0355027
Complaint Receipt Date:	03/16/2021
Investigation Initiation Date:	03/16/2021
Report Due Date:	05/15/2021
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890, 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 726-1998
Administrator:	Heather Burnell
Licensee Designee:	Amanda Johnson
Name of Facility:	Westlake II
Facility Address:	11652 Grand River Avenue, Lowell, MI 49331
Facility Telephone #:	(616) 897-5900
Original Issuance Date:	07/07/2014
License Status:	REGULAR
Effective Date:	01/07/2021
Expiration Date:	01/06/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff yelled at Resident A on 03/16/2021.	Yes

III. METHODOLOGY

03/16/2021	Special Investigation Intake 2021A0355027
03/16/2021	APS Referral
03/16/2021	Special Investigation Initiated - Telephone Administrator
03/22/2021	Inspection Completed On-site Interviewed staff
03/29/2021	Contact - Telephone call made Interviewed staff
03/29/2021	Exit Conference Licensee designee by telephone

ALLEGATION: Staff yelled at Resident A on 03/16/2021.

INVESTIGATION: On 03/16/2021, I received a complaint filed on behalf of Resident A in which it is alleged that on 03/16/2021, staff Robin Cox yelled at Resident A, telling him to sit correctly at the dining room table. When Resident A did not sit completely correctly at the table, Ms. Cox again yelled at Resident A telling him, “sit right at the table or sit on the floor.”

On 03/22/2021, I completed an on-site investigation and interviewed staff Robin Cox and Megan Thelan, who was working with Ms. Cox. The program manager, Brandi Moore, sat in on the interviews. I did not attempt to interview Resident A as in the years I have tried to interview him for investigations and/or renewal inspections, Resident A has never responded to me or acknowledged my presence.

Ms. Thelan stated that on the date in question, Resident A was sitting at the dining table with his legs sticking out to the side while he worked on a puzzle book. Ms. Thelan stated that Resident A’s legs sticking out did not present a safety hazard as there were no other residents in the vicinity. Ms. Thelan stated that Ms. Cox proceeded to yell at Resident A to, “sit right”. Ms. Thelan stated that Resident A moved his legs over but they were still sticking out a little bit. Ms. Thelan stated that

Ms. Cox yelled again at Resident A to, “sit at the table right or you can sit on the floor.” Ms. Thelan stated that Resident A was not hurting anyone by the way he was sitting and being mild mannered, was not being a disturbance that morning.

Ms. Cox stated she did not recall what she said to Resident A and denied yelling at him. Ms. Cox stated that she does prompt Resident A to sit fully at the table as he will sit, “half on and half off” of the seat. Ms. Cox described what she meant as one butt cheek on and one off the seat. Ms. Cox acknowledged that Resident A’s manner of sitting did not hurt anyone or present a safety issue.

On 03/29/2021, I interviewed by telephone staff Shiree Darnell. Ms. Darnell was working with Ms. Cox and Ms. Thelan on 03/16/2021. Ms. Darnell stated that she recalled the interaction between Ms. Cox and Resident A. Ms. Darnell stated that she could not remember the exact words Ms. Cox used but stated that Ms. Cox was yelling at Resident A about the way Resident A was sitting at the table. Ms. Darnell stated that Ms. Cox was unnecessarily “harsh” in her tone with Resident A.

On 03/29/2021, I conducted by telephone an exit conference with the licensee designee, Amanda Johnson. Ms. Johnson accepted the findings of my investigation.

APPLICABLE RULE	
R 400.14305	**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:	Staff Megan Thelan heard and observed staff Robin Cox yelling at Resident A to “sit right” at the table and “sit right at the table or sit on the floor.” Staff Shiree Darnell stated that she heard and observed Ms. Cox yelling at Resident A about the way he was sitting at the table and Ms. Darnell stated Ms. Cox used a “harsh” tone. Staff Robin Cox stated that she did not recall what she said to Resident A and denied that she yelled at Resident A. Ms. Cox did recall prompting Resident A because of the manner in which Resident A was sitting at the table. I find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

03/29/2021

Grant Sutton — Date
Licensing Consultant

Approved By:

03/29/2021

Jerry Hendrick — Date
Area Manager