GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 27, 2021

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

RE: License #: AS340359953
Investigation #: 2022A0350008
Westlake VII

Dear Ms. Frazier:

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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS340359953
Investigation #:	2022A0350008
Complaint Receipt Date:	12/08/2021
Investigation Initiation Date:	12/10/2021
Report Due Date:	01/07/2022
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890, 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 643-0795
Administrator:	Katherine Frazier
Licensee Designee:	Katherine Frazier
Name of Facility:	Westlake VII
Facility Address:	11652 Grand River Avenue Lowell, MI 49331
Facility Telephone #:	(616) 897-2551
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?
Resident A did not have his required 1:1 staffing for approximately 3 hours on 12/07/2021.	Yes

III. METHODOLOGY

12/08/2021	Special Investigation Intake 2022A0350008
12/10/2021	Special Investigation Initiated - Telephone I spoke with Brandon White, Manager
12/10/2021	Contact - Telephone call made I spoke with Kathleen Lancaster, DCW
12/10/2021	Contact - Telephone call made I spoke with Robin Cox, Assistant Manager
12/14/2021	Contact - Telephone call made I spoke with Alex Duram, DCW
12/16/2021	Contact - Telephone call made I spoke with Robin Cox
12/16/2021	Contact - Telephone call made I spoke with Alex Duram
12/16/2021	Contact - Telephone call made I spoke with Bradon White
12/17/2021	Contact - Telephone call made I spoke with Heather Burnell, Program Manager
12/21/2021	Contact – Telephone call made I spoke with Heather Burnell
12/21/2021	Contact – Document received I received an email with an attachment from Laken Colby, Clinical Supervisor for Hope Network
12/22/2021	Exit conference – Held with Alexandra Kruger, Licensee Designee

ALLEGATION: Resident A did not have his required 1:1 staffing for approximately 3 hours on 12/07/2021.

INVESTIGATION: This special investigation was made on 12/08/2021, and included the following information:

'On 12/8/21, Detroit Wayne Integrated Health Network – Office of Recipient Rights (DWIHN-ORR) received a phone complaint…alleging that "(Resident A) who is a 1:1 member did not have 1:1 staffing for approximately 3 hours. This was due to Brandon White the program manager pulling her staff and sending them to another cottage.

With regard to the incident, complainant stated there were to (two) staff at the cottage, herself and Alex Duram, and six (6) residents. Alex was the 1:1 staff for member, (Resident A). Program Manager, Brandon White pulled Alex to another cottage leaving complainant alone with six residents, one of which is member, (Resident A), who requires 1:1 staffing. Complainant stated she was unaware that Alex had been pulled, and in his absence, she kept member (Resident A) in her line of sight. Complainant stated member (Resident A) was without a 1:1 staff between 3pm and 5pm and 7pm and 8pm [sic].'

On 12/10/2021, I called and spoke with Brandon White, Manager. Mr. White informed me that he did not tell Alex Duram, Direct Care Worker (DCW), to go to another cottage. Mr. White stated that someone else may have told Mr. Duram to go to another cottage, but it wasn't him.

On 12/10/2021, I called and spoke with Kathleen Lancaster, DCW, who worked 2nd shift during this alleged incident. Ms. Lancaster told me that Robin Cox, Assistant Manager, was the one who told Mr. Duram to go to Cottage 8 at about 3 p.m., which left Ms. Lancaster at Cottage 7 as the only DCW at cottage 7 where Resident A, who requires 1:1 staffing, resides. Ms. Lancaster explained that the front doors to both Cottage 6 and Cottage 7 were left open so that if she needed assistance she could shout across to the other cottage. Ms. Lancaster said that Resident A needs to be "kept occupied" and within the line of sight and added that she did not have any problems or issues with Resident A during her entire shift.

On 12/10/2021, I called and spoke with Robin Cox, Assistant Manager. Ms. Cox informed me that on 12/7 Mr. White told her to send Mr. Duram to Cottage 2 to take a resident on an outing. Ms. Cox said she told Mr. White that that would leave Ms. Lancaster alone to supervise a few residents, one requiring 1:1 staffing, but he told her to send Mr. Duram anyway. Ms. Cox reported that Mr. Duram was on the outing "for at least one hour." Ms. Cox stated that later that day, Mr. Duram took another resident from Cottage 7 on an outing, again leaving Ms. Lancaster to care for several residents, including Resident A, by herself. Ms. Cox was not sure how long Mr. Duram was gone this second time.

On 12/14/2021, I called and spoke with Alex Duram, DCW, who stated that when he worked 2nd shift on 12/07/2021, he was sent to Cottage 8 for what was supposed to be just a couple of minutes; however, he ended up having to take one of Cottage 8's residents on an outing. The outing lasted for about two hours, from 3 and 5 p.m. Mr. Mr. Duram informed me that after the outing he went back to Cottage 7, where he was assigned to work from 3 to 11 p.m., but then was told by Ms. Lancaster that she spoke with the On-Call Manager, Brandon White, who told her to tell Mr. Duram to go work at Cottage 8 again, this time from about 7 to 8 p.m., which he did. Mr. Duram was aware that Ms. Lancaster had to work alone at Cottage 7 from about 3 to 5 p.m., and then again from about 7 to 8 p.m., even though one of the residents at Cottage 7 required 1:1 staffing, and there were about 4 or 5 other residents at Cottage 7.

On 12/16/2021, I made a follow-up phone call to Ms. Cox. Ms. Cox said that she was not aware that Ms. Lancaster was working at Cottage 7 by herself until she made her rounds sometime during that shift. Ms. Cox said that there was no other available staff member to cover for Mr. Duram at Cottage 7, so she "kept going over there (to Cottage 7)" to see how things were going. No noteworthy incidents had occurred that evening regarding Resident A. I requested that Ms. Cox send me documentation pertaining to Resident A's supervision requirements, and she said she would.

On 12/16/2021, I made a follow-up phone call to Mr. Duram, who stated that both times he left Cottage 7 to take a resident on an outing, he was "just doing what he was told." He told me that he knew his leaving Cottage 7 left just Ms. Lancaster to work by herself, but he assumed one of the managers would have sent someone to Cottage 7 to cover for him.

On 12/16/2021, I made a follow-up phone call to Mr. White, who said that when he instructed Ms. Cox to send Mr. Duram to another cottage, he advised her to have another staff member from the adjacent cottage cover for Mr. Duram until he returned. Mr. White said that he would never have it so there was only one staff member at a cottage where there was a resident who required 1:1 supervision, and that he did not find out this happened until the following morning when his supervisor, Heather Burnell, spoke with him about it.

On 12/16/2021, I called and spoke with Heather Burnell, who said that she came on the campus at about 9 or 10 p.m. on 12/7 and learned that Cottage 7 had been short one staff member from about 7 to 8 p.m. She was not aware that this cottage was also short one staff member from about 3 to 5 p.m. as well. My telling her was the first she heard of this. Ms. Burnell stated that she spoke with Mr. White the following morning (12/8) and he said that he told Ms. Cox to have Faith go to Cottage 7 to cover for Mr. Duram, but Faith was not told this. Ms. Burnell informed me that due to one of the staff members not being able to drive and there being a need to transport a resident on an outing, some shuffling of staff took place. She said that someone from Cottage 2 was supposed to go to Cottage 7 and someone from Cottage 8 was

supposed to go to Cottage 2 so that the resident needing transportation could be taken by a staff member who could do so. Ms. Burnell told me that Ms. Lancaster should have called the on-call manager, Mr. White, and informed him of the staffing mishap that left Cottage 7 one staff member short.

On 12/21/2021, I called Ms. Burnell and informed her that I had still not received Resident A's Treatment Plan, although I had requested it three times. Ms. Burnell said that she would make sure I received it this same day.

On 12/21/2021, I received an email from Laken Colby, Clinical Supervisor for Hope Network, the company that owns and operates the West Lake AFC homes. Resident A's Treatment Plan was attached to the email. I observed that the plan showed that Resident A was assessed on 03/17/2021 and it was determined that he required 1:1 staffing.

On 12/22/2021, I called and held an exit conference with Alexandra Kruger, Licensee Designee. I informed Ms. Kruger that I was citing a violation of this rule. Ms. Kruger accepted this finding, thanked me, and had no further comment.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, an d protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 12/07/2021, during 3rd shift (3 p.m. to 11 p.m.), Brandon White, Manager, told Robin Cox, Assistant Manager, to have Alex Duram, DCW, sent to another cottage to take a resident on an outing. This left Cottage 7, the cottage Mr. Duram was supposed to work at from 3 p.m. to 11 p.m., with only one staff member, Kathleen Lancaster, to care for 4 residents, including Resident A, who requires 1:1 staffing. Later, during this same shift, Mr. Duram was told to take another resident on an outing, again leaving Ms. Lancaster at Cottage 7 to care for 4 residents, including Resident A. There were several staffing changes between many cottages during this shift, and the lack of clear communication between DCWs and managers, and between the managers themselves, led to Resident A not receiving the 1:1 staffing as required by his treatment/care plan.

	Resident A's most current Treatment Plan states that he requires 1:1 staffing. Resident A did not receive the required 1:1 staffing during this shift for approximately 3 hours. As a result, the above cited rule was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

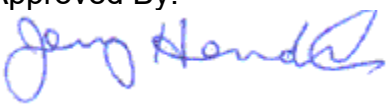
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

December 22, 2021

Ian Tschirhart — Date
Licensing Consultant

Approved By:



December 27, 2021

Jerry Hendrick — Date
Area Manager