GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 31, 2022

Alexandra Kruger
Hope Network Behavioral Health Services
11654 Grand River Ave
Lowell, MI 49331

RE: License #: AS340359953
Investigation #: 2023A0464003
Westlake VII

Dear Ms. Kruger:

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) 356-0183.

Sincerely,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS340359953
Investigation #:	2023A0464003
Complaint Receipt Date:	10/12/2022
Investigation Initiation Date:	10/12/2022
Report Due Date:	12/11/2022
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	11654 Grand River Ave Lowell, MI 49331
Licensee Telephone #:	(616) 430-7952
Administrator:	Alexandra Kruger
Licensee Designee:	Heather Burnell
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?
On 10/03/2022 two staff were overheard yelling and swearing at residents.	Yes

III. METHODOLOGY

10/12/2022	Special Investigation Intake 2023A0464003
10/12/2022	APS Referral
10/12/2022	Special Investigation Initiated - Telephone Brandi Moore, Administrator
10/12/2022	Contact - Document Sent Michelle Richardson, ORR
10/22/2022	Inspection Completed-Onsite Alexandra Kruger (Licensee Designee), Residents A & B
10/31/2022	Exit Conference Alexandra Kruger, Licensee Designee

ALLEGATION: On 10/03/2022, two staff were overheard yelling and swearing at residents.

INVESTIGATION: On 10/12/2022, I received an incident report (IR) which stated on 10/03/2022, a resident did not hang up the phone after leaving someone a voice message. The voice message recorded two staff yelling and swearing at the residents. A special investigation and Recipient Rights referral were initiated based on information provided in the IR.

On 10/12/2022, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral.

On 10/12/2022, I exchanged emails with facility administrator, Brandi Moore. Mrs. Moore stated the staff accused are Robin Cox and Shiri Darnell. Mrs. Moore stated both staff have been suspended, pending the outcome of the investigation.

On 10/22/2022, I completed an onsite inspection at the facility. I met with licensee designee, Alexandra Kruger. She stated the nurse Resident A left a message for sent the voice message to Mrs. Kruger as she was concerned about the way staff was overheard talking to the residents. Mrs. Kruger identified the staff in the voice message as Robin Cox and Shiri Darnell. Both were working the day the message

was left. Mrs. Kruger then played the voice message. In the voice message, two separate staff are heard yelling at the residents. One is heard telling a resident to, “shut up”. The other staff person is heard telling a resident, “I don’t give a shit. You better cut this shit out. Knock it off”.

I then interviewed Ms. Cox, privately. Ms. Cox confirmed she was working in the afternoon of 10/03/2022. Ms. Cox stated she heard the recording where she was allegedly yelling at the residents. Ms. Cox stated she was unable to make out that it was her voice. Ms. Cox stated she does not remember yelling or swearing at the residents. Ms. Cox stated she gets along well with all the residents in the facility.

I then interviewed Ms. Darnell, privately. Ms. Darnell confirmed she was working the afternoon of 10/03/2022. Ms. Darnell stated she was aware there was a recording where she allegedly yelled at the residents but has not heard the recording. Ms. Darnell denied she ever yelled or swore at the residents. She denied having any issues with any of the residents on 10/03/2022, which would have caused her to yell. Ms. Darnell stated she has worked in the facility for over four years and has good rapport with each resident.

I then interviewed Residents A and B, individually. Both residents stated staff have yelled and swore at them. Resident B had a difficult time recalling the staff who he heard yell and swear. Resident A stated on 10/03/2022, Resident B was picking on Resident A, therefore Ms. Cox told Resident B to “cut this shit out, I don’t give a shit”. Resident A stated he also heard Ms. Darnell tell another resident to “shut up”.

On 10/31/2022, I completed an exit conference with Mrs. Kruger. She was informed of the investigation findings and recommendations. Mrs. Kruger was advised she would be sent a copy of the investigation report once it is signed.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 10/12/2022, a complaint was received alleging two facility staff were heard yelling and swearing at residents. Staff Robin Cox and Shiri Darnell both denied they swore or yelled at the residents.

	Residents A and B both stated staff yelled and swore at them. A recording was played and two staff were overheard telling residents to “cut this shit out, I don’t give a shit” and “shut up”. Based on the investigative findings, there is sufficient evidence to support the allegations that staff treated Resident A and B poorly.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.

10/31/2022

Megan Aukerman Date
Licensing Consultant

Approved By:

10/31/2022

Jerry Hendrick Date
Area Manager