GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 22, 2023

Alexandra Kruger
Hope Network Behavioral Health Services
11652 Grand River
Lowell, MI 49331

RE: License #: AS340359953
Investigation #: 2023A0464021
Westlake VII

Dear Mrs. 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS340359953
Investigation #:	2023A0464021
Complaint Receipt Date:	02/16/2023
Investigation Initiation Date:	02/16/2023
Report Due Date:	04/17/2023
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	11652 Grand River Avenue Lowell, MI 49331
Licensee Telephone #:	(616) 430-7952
Administrator:	Heather Burnell
Licensee Designee:	Alexandra Kruger
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:	01/07/2023
Expiration Date:	01/06/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 02/15/2023, staff Janessa Barna hit Resident A multiple times.	Yes

III. METHODOLOGY

02/16/2023	Special Investigation Intake 2023A0464021
02/16/2023	Special Investigation Initiated - Telephone Alexandra Kruger, Licensee Designee
02/16/2023	Contact - Document Sent Ed Wilson, ORR
02/16/2023	APS Referral Centralized Intake, DHHS
02/21/2023	Inspection Completed-Onsite Alexandra Kruger (Licensee Designee), Brandi Moore (Program Manager), Joseph Faturoti (Staff), Mary Twigg-Rae (Staff), Residents A and B
02/21/2023	Exit Conference Alexandra Kruger, Licensee Designee

ALLEGATION: On 02/15/2023, staff Janessa Barna hit Resident A multiple times.

INVESTIGATION: On 02/16/2023, I received an email and an incident report (IR) that stated on 02/15/2023 in the evening, Resident A was provoking staff, Janessa Barna. Ms. Barna then hit Resident A multiple times. The Ionia County Sheriff's Department responded, and Ms. Barna was arrested.

On 02/16/2023, I exchanged emails with licensee designee, Alexandra Kruger. Mrs. Kruger stated Ms. Barna was immediately suspended and her employment will be terminated.

On 02/16/2023, I contacted Kent County Network 180's Office of Recipient Rights (ORR) Director, Ed Wilson to provide complaint information.

On 02/16/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete and Adult Protective Services (APS) referral, per policy.

On 02/21/2023, I completed an onsite inspection at the facility. I met with Mrs. Kruger and program manager, Brandi Moore. Both stated Ms. Barna was arrested. Ms. Barna was asked to turn in her employee badge and facility keys prior to leaving the facility on 02/15/2023.

I then interviewed staff Mary Twigg-Rea. She stated she was working with Ms. Barna on 02/15/2023. Ms. Twigg-Rea reported staff, Kathy Lancaster was also working; however, at the time of the incident, Ms. Lancaster was with another resident on an outing. Ms. Twigg-Rae stated it was around dinner time and she was in the kitchen preparing dinner. Ms. Barna was sitting at the kitchen table and Resident A was sitting on the living room couch. Resident A was calling Ms. Barna names from the couch. Ms. Barna asked him why he was acting like that and why he didn't like her. Ms. Twigg-Rea stated she went downstairs to grab supplies and heard Ms. Barna and Resident A start yelling at each other. Ms. Twigg-Rea ran upstairs. At this point Ms. Barna was standing in front of Resident A, while he was sitting on the couch. Ms. Twigg-Rea stated she tried to put her arm between the two of them and told Ms. Barna to step away, but she refused to do so. Resident A then stated to Ms. Barna, "what you need a side kick to do your dirty work". At this point Ms. Barna had her cell phone in her hand, lunged over Ms. Twigg-Rae's arm and began hitting Resident A on the head with her phone. Ms. Twigg-Rae stated she tried to pull Ms. Barna away, but she continued to throw punches at him. Resident B reportedly got involved and held Resident A's hands so that he would not go after Ms. Barna. Ms. Twigg-Rea was able to move Ms. Barna towards the entrance of the facility. Ms. Barna then stopped, threw her keys, and told Ms. Twigg-Rae, "I am sorry. I am done".

Ms. Twigg-Rae advised Ms. Barna to go into the next cottage. At this point staff, Joseph Faturoti came over. He sat on the couch, calming Resident A down. Ms. Twigg-Rae called the facility manager, who contacted the police. The Ionia County Sheriff's Department responded, took witness statements, and arrested Ms. Barna on an assault charge. Ms. Twigg-Rae stated she has worked with Ms. Barna before, and she has never done anything like this.

I then interviewed Mr. Faturoti. He denied witnessing the incident between Ms. Barna and Resident A. He stated he was working in the cottage next door when he heard Ms. Twigg-Rae ask for help. Mr. Faturoti ran into the cottage and saw Resident B with Resident A. Mr. Faturoti stated he sat with Resident A to calm him down and Ms. Barna was already in a different cottage when he arrived.

I then interviewed Resident B. Resident B stated Resident A yells at everyone and calls everyone names. Resident B stated Resident A was calling Ms. Barna, "a fucking lesbian, fucking bitch and mind your own fucking business". Resident B

stated he saw Ms. Barna “loose it” and start punching Resident A. Resident B stated Ms. Twigg-Rea was trying to pull Ms. Barna away. Resident B stated he went over and blocked Resident A from going after Ms. Barna. He held Resident A’s hands so that Resident A could not punch Ms. Barna. Resident B stated the police came to the facility and arrested Ms. Barna. Resident B stated this is the first time he ever saw Ms. Barna treat a resident this way. He denied witnessing any other staff hit residents.

I then interviewed Resident A, privately. Resident A stated on 02/15/2023 around dinner time, he was sitting on the couch playing his Nintendo Switch. Resident A stated Ms. Barna was sitting at the kitchen table, “doing her stupid coloring books”. Resident A stated, “I told Ms. Barna I don’t respect you, because you don’t respect me and my friends. You are a slut and a cunt”. Resident A stated Ms. Barna then started punching him all over with her cell phone. She punched him in the head, the chest and on his “private”. Resident A stated Ms. Twigg-Rea was pulling Ms. Barna away. He stated Mr. Faturoti came into their cottage and sat with him. Resident A stated the police came and he had to tell them what happened. Ms. Barna was then arrested. Resident A stated he had a lump on his head, but it is gone now. He denied having any other injuries. Resident A stated Ms. Barna has not done this previously.

On 02/21/2023, I completed an exit conference with Ms. Kruger. She was informed of the investigation findings and recommendations. Ms. Kruger demonstrated understanding of the rule violation. Ms. Kruger stated Ms. Barna’s employment with Hope Network has been terminated.

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 02/16/2023, a complaint was opened, alleging physical abuse towards Resident A. Facility staff Mary Twigg-Rea, Resident A and Resident B all reported staff, Janessa Barna physically assaulted Resident A on 02/15/2023. The Ionia County Sheriff’s Department responded to the complaint and Ms. Barna was arrested on assault charges.

	Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Barna mistreated Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

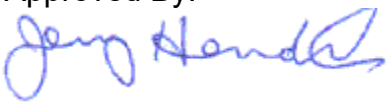
IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore, I recommend that the licensing status remain unchanged.

02/22/2023

Megan Aukerman Date
Licensing Consultant

Approved By:



02/22/2023

Jerry Hendrick Date
Area Manager