GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 12, 2023

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

RE: License #: AS340089072
Investigation #: 2024A0464004
Westlake IV

Dear Ms. Leone:

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 #:	AS340089072
Investigation #:	2024A0464004
Complaint Receipt Date:	10/12/2023
Investigation Initiation Date:	10/12/2023
Report Due Date:	12/11/2023
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890, 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 430-7952
Administrator:	Heather Burnell
Licensee Designee:	Stephanie Leone
Name of Facility:	Westlake IV
Facility Address:	11652 Grand River Lowell, MI 49331
Facility Telephone #:	(616) 897-5900
Original Issuance Date:	11/09/1999
License Status:	REGULAR
Effective Date:	09/28/2023
Expiration Date:	09/27/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's Clonazepam 2mg was missing.	Yes

III. METHODOLOGY

10/12/2023	Special Investigation Intake 2024A0464004
10/12/2023	Special Investigation Initiated - Telephone Stephanie Leone, Licensee Designee
10/12/2023	APS Referral Centralized Intake, DHHS
10/20/2023	Inspection Completed On-site Brandi Moore (Program Manager), Chris Thelen (Staff), Lydia Wynalda (Staff), Ryleigh Kelly (Staff) and Shae Moore (Staff)
10/20/2023	Contact-Document received Resident A's MAR
12/12/2023	Exit Conference Stephanie Leone, Licensee Designee

ALLEGATION: Resident A's Clonazepam 2mg was missing.

INVESTIGATION: On 10/12/2023, I received an online BCAL complaint which alleged that on 09/16/2023, while staff were completing the shift change narcotic count, they noticed the count was off for Resident A's Clonazepam 2mg. Resident A was missing two pills.

On 10/12/2023, I spoke to licensee designee, Stephanie Leone. She was aware of the new complaint.

On 10/12/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral.

On 10/20/2023, I completed an unannounced, onsite inspection at the facility and interviewed program manager, Brandi Moore. Ms. Moore stated she recently learned of the missing medications and conducted an internal investigation. Ms. Moore stated the two pills have not been located and at this point and they do not

have any information regarding where the pills may have gone. She confirmed no other controlled substances were missing.

I then interviewed facility staff, Chris Thelen. He stated he has administered Resident A's Clonazepam 2mg; however, he does not typically complete the controlled substance count during shift change. Mr. Thelen denied being aware of any missing medications.

I then interviewed staff, Lydia Wynalda and Ryleigh Kelly, individually. Both stated they are trained in medication administration and were working on 10/15/2023, as well as 10/16/2023. Both stated they complete controlled substance counts at every shift change. Both confirmed Resident A's Clonazepam 2 mg counts were on prior to 10/15/2023. Ms. Wynalda and Ms. Kelly stated that when counts were completed on 10/16/2023, Resident A had two Clonazepam 2mg tablets missing. Both denied taking the pills or witnessing someone else take the medications.

I then interviewed staff, Shae Moore. Mr. Moore stated he worked second shift on 10/15/2023. Mr. Moore stated he completed the controlled substance count with Ms. Wynalda. At that time, the count matched the number of pills regarding Resident A's Clonazepam 2mg.

On 10/20/2023, I then reviewed the controlled substance log and medication. The log reflected Resident A was missing Clonazepam 2mg. The two pills were also missing from the medication room.

On 12/12/2023, I completed an exit conference with licensee designee, Stephanie Leone. She was informed of the investigation findings and recommendations. She stated a corrective action plan would be submitted.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On 10/12/2023, a complaint was received, alleging Resident A was missing two Clonazepam 2mg. On 10/20/2023, an onsite inspection was completed at the facility. Staff, Brandi Moore, Lydia Wynalda and Ryleigh Kelly all reported there were two missing pills of Resident A's Clonazepam 2mg. All three staff denied having information regarding where the missing pills went.

	The controlled substance log and medications were reviewed. Both reflected Resident A was missing two Clonazepam 2mg. Based on the investigative findings, there is sufficient evidence to support a rule violation that Resident A had two missing Clonazepam 2mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/12/2023

Megan Aukerman Date
Licensing Consultant

Approved By:

12/12/2023

Jerry Hendrick Date
Area Manager