GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 14, 2023

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

RE: License #: AS340358904
Investigation #: 2024A0464007
Westlake II

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
THIS REPORT CONTAINS SEXUAL ABUSE CONTENT

I. IDENTIFYING INFORMATION

License #:	AS340358904
Investigation #:	2024A0464007
Complaint Receipt Date:	10/17/2023
Investigation Initiation Date:	10/17/2023
Report Due Date:	12/16/2023
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 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:	01/07/2023
Expiration Date:	01/06/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 10/14/2023, staff Cynthia Vandenhout touched Resident A's private area.	Yes
Resident B reported staff, Cynthia Vandenhout touched her breast.	No

III. METHODOLOGY

10/17/2023	Special Investigation Intake 2024A0464007
10/17/2023	Special Investigation Initiated - Telephone Brandi Moore, Program Manager
10/20/2023	Inspection Completed On-site Brandi Moore (Program Manager), Resident A, and Resident B
12/07/2023	Contact-Document received Vicki Pohl, Ionia County APS
12/12/2023	Contact-Document received Police Report, Ionia County Sherriff's Department
12/13/2023	Exit Conference Stephanie Leone, License Designee

ALLEGATION: On 10/14/2023, staff Cynthia Vandenhout touched Resident A's private area.

INVESTIGATION: On 10/17/2023, I received a complaint, alleging staff, Cynthia Vandenhout informed other staff that she had touched Resident A's private area to feel if she was wet and needed to be changed. Resident A later confirmed Ms. Vandenhout touched her vaginal area and stated it made her feel uncomfortable. Resident A did not want to be left alone with Ms. Vandenhout.

On 10/17/2023, I spoke to program manager, Brandi Moore. Mrs. Moore stated Ms. Vandenhout's employment has been terminated since the incident. Ms. Moore stated the staff who heard Ms. Vandenhout state she touched Resident A's vaginal area, immediately reported it to Adult Protective Services (APS) and the Ionia County Sheriff's Department.

On 10/20/2023, I completed an onsite inspection at the facility. I interviewed Mrs. Moore. Mrs. Moore stated that on 10/14/2023, during shift change, Ms. Vandenhout was talking with staff, Amanada Herbstreith, and Jody Holmes. Ms. Vandenhout informed Ms. Herbstreith and Ms. Holmes that Resident A was going to report to

them that Ms. Vandenhout touched Resident A inappropriately. Ms. Vandenhout stated she went to Resident A to give her a prompt to use the bathroom. Ms. Vandenhout then demonstrated to Ms. Herbstreith and Ms. Holmes how she ran her hand down Resident A's pelvic bone and on her vaginal area to see if she had urinated herself. Resident A later confirmed this with Ms. Herbstreith and Ms. Holmes, telling them both she did not feel comfortable being left alone with Ms. Vandenhout. Both Ms. Herbstreith and Ms. Holmes informed Ms. Vandenhout that her actions were highly inappropriate. The incident was immediately reported to the manager, APS, and law enforcement. Mrs. Moore stated an officer from the Ionia County Sheriff's Department immediately responded and interviewed everyone. Ms. Vandenhout's employment was terminated. Mrs. Moore reported Ms. Herbstreith and Ms. Holmes were not working today.

I then attempted to interview Residents A and B. Both residents had returned home from school and chose to take a nap. Both Resident A and Resident B were observed to be asleep in their bedrooms. I informed Mrs. Moore that I would make another attempt at a later time.

On 12/07/2023, I exchanged emails with Ionia County APS worker, Vicki Pohl to coordinate the investigation.

On 12/12/2023, I received and reviewed Ionia County Sheriff's Department police report # SH23-06479. The police report reflected that Officer Richard Charon responded to the call on 10/14/2023 at 12:41 pm. Upon arrival, Officer Charon interviewed Ms. Herbstreith, who's statement was consistent with the interview above.

Officer Charon then interviewed Resident A, utilizing the Forensic Interviewing Protocol. Resident A informed Officer Charon that Ms. Vandenhout came into her bedroom in the middle of the night and asked her if she was wet. Resident A told her she wasn't wet, but Ms. Vandenhout proceeded to touch her "private spot". Resident A was not sure if this was done intentionally or not, but it did make her feel uncomfortable. Resident A stated she wears adult diapers as she struggles with accidents. Resident A confirmed this was the first time anything like that had happened to her.

The police report reflects Officer Charon went to the home of Ms. Vandenhout on 10/15/2023. Ms. Vandenhout confirmed she was working on 10/14/2023. She stated she was instructed to go prompt Resident A to use the bathroom. Ms. Vandenhout stated she tried to wake Resident A up to use the bathroom; however, she did not want to get up. Ms. Vandenhout stated she then brushed her hand on Resident A's inner thigh to check if she was wet. Resident A was not wet, so Ms. Vandenhout then left the room. Ms. Vandenhout stated she previously worked in a nursing home, where most of the residents wore adult briefs. She stated this is how they would check to see if a resident was wet and needed to be changed. The report reflected a

warrant request was submitted to the prosecutor's office for Ms. Vandenhout to be charged with criminal sexual conduct 4th degree.

On 12/13/2023, I completed an exit conference with licensee designee, Stephanie Leone. She was informed of the investigation findings and recommendations. Ms. Leone stated a corrective action plan would be submitted.

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 10/17/2023, a complaint was received alleging staff, Cynthia Vandenhout touched Resident A's vaginal area. Program manager, Brandi Moore stated Ms. Vandenhout admitted to staff, Amanada Herbstreith, and Jody Holmes that she touched Resident A's private area. Ionia County Sheriff's Department police report reflected Resident A was interviewed and reported Ms. Vandenhout touched Resident A's vaginal area and it made her feel uncomfortable. Ms. Vandenhout admitted to Officer Richard Charon to touching Resident A's vaginal area. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Vandenhout touched Resident A inappropriately.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B reported staff, Cynthia Vandenhout touched her breast.

INVESTIGATION: On 10/17/2023, a complaint was received stating that when Resident B learned Ms. Vandenhout inappropriately touched Resident A, Resident B stated Ms. Vandenhout came into her bedroom and touched her breasts.

On 10/20/2023, an onsite inspection was completed at the facility. I interviewed Mrs. Moore. Mrs. Moore stated Resident B has a significant history of fabricating allegations against others. She has made statements in the past about staff and residents touching her inappropriately, which were investigated and found to be untrue. On 10/14/2023, Resident B would constantly interrupt staff and heard Ms. Herbstreith talking about the incident that occurred between Ms. Vandenhout and Resident A. Mrs. Moore believes based on what Resident B heard, Resident B then fabricated allegations against Ms. Vandenhout.

I then attempted to interview Resident A and B. Both residents had returned home from school and chose to take a nap. Both Resident A and Resident B were observed to be asleep in their bedrooms. Mrs. Moore was informed another attempt would be made at a later time.

On 12/12/2023, I received and reviewed Ionia County Sheriff's Department police report # SH23-06479. The police report reflected that Officer Richard Charon responded to the call on 10/14/2023 at 12:41 pm. Upon arrival, Officer Charon interviewed Ms. Herbstreith. Ms. Herbstreith informed Officer Charon that Resident B was walking around listening to Ms. Herbstreith about the incident. Ms. Herbstreith then stated Resident B told her Ms. Vandenhout touched her breasts. Ms. Herbstreith told Officer Charon that it was not out of the ordinary for Resident B to fabricate such statements as part of her attention seeking behaviors.

Officer Charon then interviewed Resident B, privately. Resident B stated around 3:00 am on 10/14/2023, she was in her bedroom listening to music. Ms. Vandenhout then came in her bedroom and touched both of her breasts. Resident B told Ms. Vandenhout that she was uncomfortable and then Ms. Vandenhout left.

On 10/15/2023, Officer Charon interviewed Ms. Vandenhout at her residence. Ms. Vandenhout reported since she has only worked at the facility for a short period of time, she did not know Resident B well and has not had any interactions with her. Ms. Vandenhout adamantly denied the allegation and stated she has never set foot in Resident B's bedroom.

On 12/13/2023, I received and reviewed Resident B's Behavior Support Plan. The plan reflects Resident B will use maladaptive behaviors to attain attention. The plan also states Resident B has history of becoming physically aggressive and suicidal ideation.

On 12/13/2023, I completed an exit conference with Ms. Leone. She was informed of the investigation findings and recommendations.

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 10/17/2023, a complaint was received alleging staff, Cynthia Vandenhout touched Resident B's breasts. Program manager, Brandi Moore reported Resident B has history of fabricating allegations against staff and other residents. Mrs. Moore stated Resident B heard staff talking about sexual abuse allegations against staff Cynthia Vandenhout. The Ionia County Sheriff's Department police report was reviewed. Staff, Amanda Herbstreith was interviewed and reported Resident B overheard staff talking about the incident that occurred with Resident A. Resident B then reported Ms. Vandenhout touched her breasts. Officer Richard Charon interviewed Resident B and Resident B disclosed Ms. Vandenhout touched her breasts but was unable to provide details regarding the incident. Ms. Vandenhout was interviewed and denied the allegation. Resident B's Hope Network Behavior Plan was reviewed and reflected Resident B has history of expressing maladaptive behaviors for attention. She also has history of physical aggression and suicidal ideation. Based on the investigative findings, there is insufficient evidence to support a rule violation that Ms. Vandenhout touched Resident B's breasts.
CONCLUSION:	VIOLATION NOT ESTABLISHED

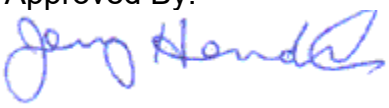
IV. RECOMMENDATION

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

12/14/2023

Megan Aukerman Date
Licensing Consultant

Approved By:



12/14/2023

Jerry Hendrick Date
Area Manager