GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 3, 2025

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

RE: License #: AS340358904
Investigation #: 2025A0464013
Westlake II

Dear Mr. Pelletier:

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 #:	AS340358904
Investigation #:	2025A0464013
Complaint Receipt Date:	12/05/2024
Investigation Initiation Date:	12/05/2024
Report Due Date:	02/03/2025
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:	Andre Pelletier
Licensee Designee:	Andre Pelletier
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:	01/07/2025
Expiration Date:	01/06/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Robin Cox grabbed Resident A by the arms and shook her.	Yes

III. METHODOLOGY

12/05/2024	Special Investigation Intake 2025A0464013
12/05/2024	Special Investigation Initiated - Telephone Michelle Richardson, ORR
12/05/2024	APS Referral
12/06/2024	Contact - Telephone call made Jeannie Haff, ORR
12/13/2024	Inspection Completed On-Site Brandi Moore (Program Manager), Robin Cox (Staff) and Resident A
12/31/2024	Contact-Document received Jeannie Haff, ORR
01/08/2025	Inspection Completed On-site Brandi Moore (Program Manager), Andre Pelletier (Licensee Designee) and Resident A
01/08/2025	Contact-Document received Resident A's IPOS
02/03/2025	Exit Conference Andre Pelletier, Licensee Designee

ALLEGATION: Staff Robin Cox grabbed Resident A by the arms and shook her.

INVESTIGATION: On 12/05/2024, I received a complaint which alleged that on 12/01/2024, staff Robin Cox was arguing with Resident A. Resident A became agitated and started rocking back and forth, holding her head. Ms. Cox then grabbed Resident A by each arm and started shaking her.

On 12/05/2024, I sent the complaint to Network 180, Office of Recipient Rights (ORR), to coordinate the investigation.

On 12/05/2024, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 12/06/2024, I spoke to ORR worker, Jeannie Haff to coordinate the investigation. Ms. Haff reported she spoke to Resident A. Resident A disclosed Ms. Cox grabbed Resident A by both arms and shook her. Resident A appeared to minimize the event as well as Ms. Cox's behavior towards her. Resident A informed Ms. Haff she realized Ms. Cox was just trying to prevent Resident A from hurting herself.

On 12/13/2024, I completed an onsite inspection at the facility and interviewed program manager, Brandi Moore. Mrs. Moore stated Ms. Cox is currently suspended until the investigation is complete. Mrs. Moore stated Ms. Cox was previously substantiated "a long time ago" for the way she spoke to a resident. Mrs. Moore denied witnessing the incident that occurred on 12/01/2024.

I then interviewed Ms. Cox privately. Ms. Cox reported on 12/01/2024, Resident A became very agitated. She began throwing things and punching herself in the head. Ms. Cox stated she proceeded to "gently touch" Resident A's arms to get her to stop hurting herself. Ms. Cox denied anything further occurred. She denied causing any harm to Resident A or shaking her. Ms. Cox explained Resident A has a history of self-harming behaviors.

I then attempted to interview Resident A; however, Resident A refused to speak with me.

On 12/31/2024, I received an email from Ms. Haff. She stated she was able to interview staff Amanda Herbstreith, who witnessed the alleged incident. Ms. Herbstreith reported she was assisting Resident A with getting dressed in her room and Resident A was venting about staff Robin Cox. Ms. Cox "swung" the door open and "stormed" into the room yelling at Resident A, instigating an argument with her. Ms. Herbstreith reported to Ms. Haff that Resident A was becoming visibly distressed by the tone of Ms. Cox's voice. Resident A started rocking back and forth and making statements of "I'm stupid" "I'm a fucking retard". Ms. Herbstreith stated that although Resident A was visibly distressed, she had no signs of self-injurious intentions or actions. Ms. Cox at one point yelled out "I know, I'm the big bad person!" Ms. Cox then walked up to Resident A, grabbed both of her wrists and started shaking her. Resident A started yelling at Ms. Cox to stop. Ms. Herbstreith reported she herself was kind of in a state of shock at what she was witnessing. She stated that she was shocked because Ms. Cox was her Assistant Shift Manager that day. Once she gained composure, Ms. Herbstreith reported she "nudged" Ms. Cox while she was still standing in front of Resident A yelling and told Ms. Cox to go for a walk. Ms. Cox ignored Ms. Herbstreith suggestion however, she did finally leave the room. Ms. Herbstreith reported that she was able to de-escalate Resident A and she calmed down soon after Ms. Cox left her room. Ms. Herbstreith stated that she

reported the incident to the Program Manager, filed a recipient rights complaint and contacted APS as well.

On 01/08/2025, I completed an onsite inspection at the facility. I attempted to interview Resident A; however, she refused to meet with me.

I then met with licensee designee, Andre Pelletier. He stated Ms. Cox has returned to work; however, she is now working in a different facility on campus.

On 01/08/2025, I received and reviewed a copy of Resident A's Individual Plan of Service (IPOS). The IPOS documented Resident A has a long history of physical and verbal aggression, as well as self-injurious behaviors. Interventions were identified for direct care staff to use when Resident A becomes escalated to ensure her health and safety. At no point did the interventions include physical management.

On 02/03/2025, I completed an exit conference with Mr. Pelletier. He was informed of the investigation findings and recommendations. Mr. Pelletier stated a corrective action plan would be completed.

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 12/05/2024, a complaint was received alleging staff, Robin Cox grabbed Resident A by the arms and shook her. Ms. Cox reported that on 12/01/2024, Resident A became agitated and was going to hurt herself. Ms. Cox stated she gently grabbed Resident A's arms to prevent her from hurting herself. Resident A was interviewed by Network 180's Office of Recipient Rights. Resident A disclosed that on 12/01/2024, Ms. Cox grabbed her by the arms and shook her. Resident A stated Ms. Cox was trying to calm her down.

	Staff, Amanda Herbstreith reported she witnessed the incident that occurred on 12/01/2024. Ms. Herbstreith reported Ms. Cox came into the room yelling at Resident A. She then proceeded to grab Resident A by the arms and shook her. Resident A's Individual Plan of Service reflected Resident A has a history of self-injurious behaviors; however, at no point did the plan document use of physical interventions. Based on the investigative findings, there is a preponderance of evidence that Ms. Cox mistreated Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Megan Aukerman, MSW 02/03/2025

Megan Aukerman Date
Licensing Consultant

Approved By:

02/03/2025

Jerry Hendrick Date
Area Manager