



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 28, 2025

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

RE: License #: AS340358904
Investigation #: 2025A0583026
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,

A handwritten signature in cursive script, appearing to read "Toya Zylstra".

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS340358904
Investigation #:	2025A0583026
Complaint Receipt Date:	02/26/2025
Investigation Initiation Date:	02/27/2025
Report Due Date:	03/28/2025
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 Thomas Nuir verbally mistreated Resident A.	Yes

III. METHODOLOGY

02/26/2025	Special Investigation Intake 2025A0583026
02/27/2025	Special Investigation Initiated - On Site
02/27/2025	APS Referral
02/28/2025	Exit Conference Licensee Designee Andre Pelletier

ALLEGATION: Staff Thomas Nuir verbally mistreated Resident A.

INVESTIGATION: On 02/26/2025 the above complaint allegation was received from LARA-BCHS-Complaints. The complaint stated that staff Chloe Rush observed staff Thomas Nuir verbally mistreat Resident A. Ms. Rush stated that Resident A had requested assistance from Mr. Nuir and Mr. Nuir yelled, "give me a damn minute".

On 02/27/2025 I emailed the complaint allegation to Adult Protective Services Centralized Intake.

On 02/27/2025 I completed an inspection at the facility and interviewed Resident A and staff Thomas Nuir. Resident A had a difficult time staying on task and focusing. Resident A stated that she could not recall the incident in which Mr. Nuir allegedly verbally mistreated her. Resident A stated that Mr. Nuir can be "grumpy" but that she feels he is kind and helpful. She appeared appropriately dressed and groomed.

Staff Thomas Nuir stated that on the morning of 02/22/2025, Resident A was in her bed and yelled for assistance getting up. Mr. Nuir stated that he told Resident A he needed a moment to put on gloves to assist Resident A because she often urinates in her bed. Mr. Nuir stated that he was in the process of putting on the gloves when Resident A yelled again for assistance and Mr. Nuir told Resident A to "be patient". Mr. Nuir stated he then assisted Resident A up from her bed without incident. Mr. Nuir denied yelling at Resident A or telling her to wait a "damn minute".

On 02/27/2025 I interviewed staff Chloe Rush via telephone. Ms. Rush stated that she worked at the facility the morning of 02/22/2025 with staff Thomas Nuir and Douglas Kelly. Ms. Rush stated that she was in the medication room when she

heard Resident A request assistance from Mr. Nuir with getting out of bed. Ms. Rush stated that Mr. Nuir proceeded to get a pair of gloves when Resident A requested assistance a second time. Ms. Rush stated that she then overheard Mr. Nuir yell, "give me a damn minute". Ms. Rush stated that she left the medication room and observed that Resident A was upset and crying because of Mr. Nuir's comment. Ms. Rush stated that she told Mr. Nuir that she would assist Resident A because Resident A was upset.

On 02/27/2025 I interviewed staff Douglas Kelly via telephone. Mr. Kelly stated that he worked at the facility the morning of 02/22/2025 with Chloe Rush and Thomas Nuir. Mr. Kelly stated that he was in the kitchen when he overheard Resident A ask for assistance from Mr. Nuir with getting out of bed. Mr. Kelly stated that Mr. Nuir went to get a pair of gloves when Resident A requested assistance a second time. Mr. Kelly stated that he overheard Mr. Nuir yell, "I'll be there in a minute, damn it". Mr. Kelly stated that Resident A started to cry and was upset after Mr. Nuir's response. Mr. Kelly stated that Ms. Rush asked Mr. Nuir to take a minute to smoke a cigarette and calm down. Mr. Kelly stated that Ms. Rush then proceeded to assist Resident A with getting out of bed.

On 02/28/2025 I completed an exit conference with Licensee Designee Andre Pelletier via telephone. Mr. Pelletier did not dispute the Special Investigation Findings and stated that he would submit a satisfactory Corrective Action Plan in a timely manner.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	<p>It was alleged that staff Thomas Nuir verbally mistreated Resident A.</p> <p>Resident A stated that she could not recall the incident in which Mr. Nuir allegedly verbally mistreated her.</p> <p>Staff Thomas Nuir stated that on the morning of 02/22/2025, Resident A was in her bed and yelled for assistance getting up. Mr. Nuir stated that he told Resident A he needed a moment to put on gloves to assist Resident A because she often urinates in her bed. Mr. Nuir stated that he was in the process of putting on the gloves when Resident A yelled again for assistance and Mr. Nuir told Resident A to "be patient". Mr. Nuir stated that he then proceeded to assist Resident A up from her bed without</p>

	<p>incident. Mr. Nuir denied yelling at Resident A and denied he instructed her to wait a “damn minute”.</p> <p>Staff Chloe Rush stated that she worked at the facility the morning of 02/22/2025 with Thomas Nuir and Douglas Kelly. Ms. Rush stated that she was in the medication room when she heard Resident A request assistance from Mr. Nuir with getting out of bed. Ms. Rush stated that Mr. Nuir proceeded to get a pair of gloves when Resident A requested assistance a second time. Ms. Rush stated that she then overheard Mr. Nuir yelled “give me a damn minute”. Ms. Rush stated that she left the medication room and observed that Resident A was upset and crying because of Mr. Nuir’s comment.</p> <p>Staff Douglas Kelly stated that he was in the kitchen when he overheard Resident A ask for assistance from Mr. Nuir with getting out of bed. Mr. Kelly stated that Mr. Nuir went to get a pair of gloves when Resident A requested assistance a second time. Mr. Kelly stated that he overheard Mr. Nuir yell, “I’ll be there in a minute, damn it”. Mr. Kelly stated that Resident A started to cry and was upset after Mr. Nuir’s response.</p> <p>There is a preponderance of evidence to support the allegation that Mr. Nuir verbally mistreated Resident A.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



02/28/2025

Toya Zylstra
Licensing Consultant

Date

Approved By:



02/28/2025

Jerry Hendrick
Area Manager

Date

