GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2025

Andre Pelletier
Hope Network Behavioral Health Services
11652 Grand River Ave.
Lowell, MI 49331

RE: License #: AS340089081
Investigation #: 2025A0464037
Westlake V

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) 356-0100.

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 #:	AS340089081
Investigation #:	2025A0464037
Complaint Receipt Date:	04/24/2025
Investigation Initiation Date:	04/24/2025
Report Due Date:	06/23/2025
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	11652 Grand River Ave. Lowell, MI 49331
Licensee Telephone #:	(616) 430-7952
Administrator:	Andre Pelletier
Licensee Designee:	Andre Pelletier
Name of Facility:	Westlake V
Facility Address:	11652 Grand River Lowell, MI 49331
Facility Telephone #:	(616) 897-5373
Original Issuance Date:	11/09/1999
License Status:	REGULAR
Effective Date:	09/15/2024
Expiration Date:	09/14/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 04/21/2025, staff Landon Trieweiler grabbed and restrained Resident A in his bedroom for having a bowel movement in his brief.	Yes

III. METHODOLOGY

04/24/2025	Special Investigation Intake 2025A0464037
04/24/2025	Special Investigation Initiated - Telephone Brandi Moore, Program Manager
04/24/2025	APS Referral
05/20/2025	Inspection Completed On-site Brandi Moore (Program Manager)
06/18/2025	Contact-Telephone call made Ashley Wells, Staff
06/18/2025	Contact-Telephone call made Samantha Walker, Staff
06/17/2025	Contact-Telephone call made Landon Trierweiler, Staff
06/18/2025	Exit Conference Andre Pelletier, Licensee Designee

ALLEGATION: On 04/21/2025, staff Landon Trieweiler grabbed and restrained Resident A in his bedroom for having a bowel movement in his brief.

INVESTIGATION: On 04/24/2025, I received a complaint alleging that on 04/21/2025 staff Landon Trieweiler grabbed, restrained and shoved Resident A in his room while two other staff were trying to assist with getting him cleaned.

On 04/24/2025, I exchanged emails with program manager, Brandi Moore.

On 04/24/2025 a referral was made to Adult Protective Services (APS).

On 05/20/2025, I completed an onsite inspection at the facility. I interviewed Mrs. Moore. Mrs. Moore denied witnessing the incident but heard about it. She reported Resident A is nonverbal therefore an interview was not conducted.

On 06/17/2025, I interviewed Mr. Trieweiler by telephone. Mr. Trieweiler adamantly denied the allegation. He stated he was working on 04/21/2025. He stated Resident A became aggressive and hit one of the other staff. Mr. Trieweiler stated he could not recall if it was staff, Samantha Walker or Ashley Wells. Mr. Triewiler intervened and redirected Resident A into his bedroom. He denied restraining or shoving Resident A.

On 06/18/2025, I interviewed staff, Samantha Walker by telephone. She reported on 04/21/2025, she was training staff, Ashley Wells. They were working with Resident A, when Resident A hit Ms. Walker. Mr. Trieweiler witnessed the incident. He then came and aggressively grabbed Resident A by the wrist, lead him to his bedroom, pushed him in there and shut the door.

On 06/18/2025, I interviewed Ms. Wells. She reported her first day of work was on 04/21/2025. She was being trained by Ms. Walker. Ms. Wells reported she witnessed Mr. Trieweiler come up to Resident A, grab his arm and push him into his bedroom. Ms. Wells stated she watched a training video and what she witnessed is exactly what staff are not supposed to do with a resident.

On 06/18/2025, I completed an exit conference with licensee designee, Andre Pelletier. He was informed of the investigation findings and recommendations. Mr. Pelletier indicated 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 04/24/2025, I received a complaint alleging staff Landon Trieweiler grabbed, restrained and shoved Resident A. Staff Ashley Wells and Samantha Walker both staff stated that on 04/21/2025, they witnessed Mr. Trieweiler grab Resident A, escort him to his room and push him into the room.

	Mr. Trieweiler was interviewed and adamantly denied the allegations. He reported that on 04/21/2025, Resident A hit another staff; therefore Mr. Trierweiler intervened and redirected Resident A back into his bedroom. Based on the investigative findings, there is sufficient evidence to support a rule violation that Mr. Trieweiler used excessive force towards Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/18/2025

Megan Aukerman Date
Licensing Consultant

Approved By:

06/18/2025

Jerry Hendrick Date
Area Manager