GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 8, 2025

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

RE: License #: AS340089081
Investigation #: 2025A0464040
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 #:	2025A0464040
Complaint Receipt Date:	05/12/2025
Investigation Initiation Date:	05/12/2025
Report Due Date:	07/11/2025
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?
Resident A was left unsupervised on 05/02/2025.	Yes

III. METHODOLOGY

05/12/2025	Special Investigation Intake 2025A0464040
05/12/2025	Special Investigation Initiated - Telephone Ronald Griffin, ORR
05/12/2025	APS Referral
05/20/2025	Inspection Completed On-site Brandi Moore, Program Manager Chris Hayes, Staff
05/20/2025	Contact-Document received Facility Records
07/07/2025	Contact-Telephone call made Ciera Bowden, Staff
07/07/2025	Exit Conference Andre Pelletier, Licensee Designee

ALLEGATION: Resident A was left unsupervised on 05/02/2025.

INVESTIGATION: On 05/12/2025, I received a complaint from the Detroit Office of Recipient Rights (ORR), which alleged on 05/02/2025, staff Ciera Bowden was supposed to be Resident A's one-to-one staff member; however, before her shift ended, she went out to her car, leaving him unattended.

On 05/12/2025, I exchanged emails with ORR worker, Ronald Griffin to coordinate the investigation.

On 05/12/2025, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) complaint per policy.
On 05/20/2025, I completed an onsite inspection at the facility. I interviewed program manager Brandi Moore. Mrs. Moore stated the incident was reported to her

by staff, Chris Hayes. She was informed that on 05/02/2025, Ms. Bowden left her shift earlier than she was supposed to, leaving Resident A unattended. Ms. Moore explained Resident A is nonverbal; therefore, an interview was not completed.

I then interviewed staff Chris Hayes, privately. Mr. Hayes reported that Resident A always requires a one-to-one staff ratio. Mr. Hayes explained this is outlined in Resident A's Individual Plan of Service (IPOS). Mr. Hayes reported on 05/02/2025, when he pulled into the parking lot for his shift, he saw Ms. Bowden leaving her shift earlier than she was supposed to. When Mr. Hayes went inside the facility, he noticed Resident A's bedroom door was shut, and he was inside asleep.

On 05/20/2025, I received and reviewed Resident A's Functional Behavior Assessment Positive Behavior Support Plan which was completed and signed on 01/16/2025. Under the Proposed Restrictive/Intrusive Intervention section of the plan, it states Resident A requires a line of sight, one-to-one staff ratio.

On 07/07/2025, I interviewed Ms. Bowden by telephone. Ms. Bowden denied the allegation and stated she did not leave Resident A unattended before leaving her shift. She stated there were already two staff inside the facility and Resident A was in line of sight.

On 07/07/2025, I completed an exit conference with licensee designee Andre Pelletier. He was informed of the investigation findings and recommendations. A corrective action plan will be submitted.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	On 05/12/2025, a complaint was received alleging that on 05/02/2025, staff Cierra Bowden left Resident A unattended. On 05/20/2025, an onsite inspection was completed at the facility. Staff Chris Hayes reported that on 05/02/2025, he witnessed Ms. Bowden leaving Resident A unattended. Resident A's Behavior Assessment was reviewed and reflected Resident A requires a one-to-one staff person assist at all times. Ms. Bowden was interviewed and denied the allegation. Resident A is nonverbal; therefore, an interview could not be completed.

	Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Bowden left Resident A unattended.
CONCLUSION:	**VIOLATION ESTABLISHED**

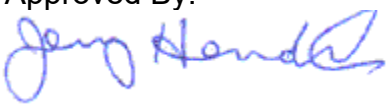
IV. RECOMMENDATION

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

07/08/2025

Megan Aukerman Date
Licensing Consultant

Approved By:



07/08/2025

Jerry Hendrick Date
Area Manager