GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2025

Stephanie Herzhaft
11652 Grand River Avenue
Lowell, MI 49331

RE: License #: AS340358904
Investigation #: 2025A0464054
Westlake II

Dear Mrs. Herzhaft:

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 #:	AS340358904
Investigation #:	2025A0464054
Complaint Receipt Date:	07/29/2025
Investigation Initiation Date:	07/29/2025
Report Due Date:	09/27/2025
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	11652 Grand River Avenue Lowell, MI 49331
Licensee Telephone #:	(616) 430-7952
Administrator:	Stephanie Herzhaft
Licensee Designee:	Stephanie Herzhaft
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, Melissa Hoshaw left the residents unattended on 07/14/2025.	Yes

III. METHODOLOGY

07/29/2025	Special Investigation Intake 2025A0464054
07/29/2025	Special Investigation Initiated - Telephone Michelle Richardson, ORR
07/29/2025	APS Referral
07/30/2025	Contact-Telephone call made Resident B
08/11/2025	Contact-Telephone call made Melissa Hoshaw, Staff Resident A
08/28/2025	Inspection Completed On-site Brandi Moore (Program Manager)
08/28/2025	Contact-Document received Facility Records
09/25/2025	Exit conference Stephanie Herzhaft, Licensee Designee

ALLEGATION: Staff, Melissa Hoshaw left the residents unattended on 07/17/2025.

INVESTIGATION: On 07/29/2025, I received a complaint from the Office of Recipient Rights (ORR), which alleged on 07/14/2025, staff Melissa Hoshaw locked the keys in the van. She went inside a store and left the residents unattended, next to the vehicle.

On 07/29/2025, I exchanged emails with ORR director, Michelle Richardson. She stated the complaint has been assigned to Ashton Byrne for investigation.

On 07/29/2025, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 07/30/2025, Mr. Byrne interviewed Resident B by telephone. Resident B reported that on 07/14/2025, Ms. Hoshaw locked her cell phone and van key in the vehicle. Ms. Hoshaw then went inside the store to find help. Resident B reported she and the other residents were left waiting outside, unsupervised. Resident B could not recall how long they were left outside.

On 08/11/2025, ORR worker, Ashton Byrne interviewed staff, Melissa Hoshaw by telephone. Ms. Hoshaw reported that she took three residents to store Five Below. Ms. Hoshaw later realized she locked her cell phone and key fob in the vehicle. Ms. Hoshaw reported she then went back into the store to ask if she could use their phone, but they refused to allow her to do so. She then walked over to another store and asked a customer if she could use their cell phone. Ms. Hoshaw acknowledged she left the residents outside, waiting by the vehicle. Ms. Hoshaw stated she was so focused on getting help to get the keys out that she didn't think to have the residents walk with her. Eventually her coworker and a locksmith came to help her retrieve the key.

On 08/28/2025, I completed an unannounced, onsite inspection at the facility. I interviewed facility manager, Brandi Moore. Mrs. Moore reported she did not witness the incident; however, it was reported to her by the facility manager. Mrs. Moore reported Network 180 ORR substantiated a violation regarding the incident and a corrective action plan was submitted. Mrs. Moore reported Ms. Hoshaw received disciplinary action for the incident.

I then interviewed Resident A. Resident A reported she recalls going to the store with Ms. Hoshaw. She reported Ms. Hoshaw realized she locked her cell phone and van keys in the vehicle. Ms. Hoshaw then went inside TJ Max for several minutes and went shopping. Resident A reported she and the other residents were left outside waiting by the vehicle. Resident A reported she was scared being left without staff.

On 08/28/2025, I reviewed the Assessment Plans for both Resident A and B. Resident A's assessment plan was completed and signed on 09/05/2024. Resident B's Assessment Plan was completed and signed on 04/16/2025. Both Assessment Plans state Residents A and B require 24-hour staff supervision, while in the community.

On 09/25/2025, I completed an exit conference with licensee designee, Stephanie Herzhaft. She was informed of the investigation findings and recommendations. A corrective action plan will be submitted to licensing.

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:	On 07/29/2025, a complaint was received alleging on 07/14/2025, staff Melissa Hoshaw left the residents unattended. Ms. Hoshaw was interviewed and reported on 07/14/2025, while on an outing with residents, she realized she locked her cell phone and keys inside the vehicle. Ms. Hoshaw went inside the store, leaving the residents unattended, by the vehicle. Residents A and B were interviewed. Both residents reported on 07/14/2025 they were left unattended, in a parking lot. Resident A reported they were left outside for several minutes. Network 180 Office of Recipient Rights also investigated the complaint and substantiated the allegations for neglect. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Hoshaw left the residents unattended.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Megan Aukerman, LMSW

09/25/2025

Megan Aukerman, Licensing Consultant Date

Approved By:

Jerry Hendrick

09/25/2025

Jerry Hendrick, Area Manager Date