



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2025

Stephanie Hertzhaft
Hope Network Behavioral Health Services
11652 Grand River Ave.
Lowell, MI 49331

RE: License #: AS340305684
Investigation #: 2025A0464056
Westlake Cottage III

Dear Mrs. Hertzhaft:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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, LMSW

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 #:	AS340305684
Investigation #:	2025A0464056
Complaint Receipt Date:	09/10/2025
Investigation Initiation Date:	09/10/2025
Report Due Date:	11/09/2025
Licensee Name:	Hope Network Behavioral Health Services
LicenseeAddress:	11652 Grand River Ave. Lowell, MI 49331
Licensee Telephone #:	(616) 430-7952
Administrator:	Stephanie Hertzhaft
Licensee Designee:	Stephanie Hertzhaft
Name of Facility:	Westlake Cottage III
Facility Address:	11652 Grand River Ave. Lowell, MI 49331
Facility Telephone #:	(616) 897-5087
Original Issuance Date:	05/25/2010
License Status:	REGULAR
Effective Date:	01/05/2024
Expiration Date:	01/04/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 09/07/2025, Resident A reported she was inappropriately touched by Resident B during an outing.	No

III. METHODOLOGY

09/10/2025	Special Investigation Intake 2025A0464056
09/10/2025	APS Referral Referral came from APS
09/10/2025	Special Investigation Initiated - Telephone ORR
09/23/2025	Inspection Completed On-site Brandi Moore (Program Manager), Resident A and Resident B
10/29/2025	Contact-Telephone call made Melissa Hoshaw, Staff
10/29/2025	Exit Conference Stephanie Hertzhaft, Licensee Designee

ALLEGATION: On 09/07/2025, Resident A reported she was inappropriately touched by Resident B during an outing.

INVESTIGATION: On 09/10/2025, I received a complaint from Adult Protective Services (APS), that alleged on 09/07/2025, Resident A was touched inappropriately by Resident B. It is unclear the context or whether staff were aware.

On 09/10/2025, I exchanged emails with Network 180 Office of Recipient Rights (ORR) Director, Michelle Richardson. Ms. Richardson stated neither resident was one of their contracted residents; therefore, they would not be investigating the complaint.

On 09/23/2025, I completed an onsite investigation at the facility. I interviewed program manager, Brandi Moore. Mrs. Moore stated she was working the weekend when the alleged incident occurred. Mrs. Moore reported Resident A has a long history of making up allegations regarding staff or residents touching her inappropriately. Mrs. Moore reported that on 09/07/2025 the residents were going on an outing to a White Caps baseball game. It was decided Resident A would ride with residents from another cottage to the game. Due to Resident A's history of

making up allegations, Resident A was assigned the back seat of the van. Mrs. Moore reported Resident B was sitting in the front passenger seat of the van. Mrs. Moore reported Resident A was very upset about the fact that she had to ride in a van with residents from another cottage. Mrs. Moore reported later that day Resident A informed staff that Resident B had touched her breast while in the vehicle. Mrs. Moore explained this was impossible as Resident B was riding in the front passenger seat and Resident A was all the way in the back of the van.

I then interviewed Resident A privately. Resident A reported a few weekends ago, they went to a baseball game. Resident A reported Resident B touched her “inappropriately, in her private area”. Resident A was asked to clarify, and she reported Resident B touched her breast, over her clothing. Resident A reported this happened in the back of the van, while Resident B was sitting next to her. Resident A reported Resident B did not say anything to her when this occurred. Resident A denied Resident B had ever previously touched her. Resident A reported she told staff but could not recall who. Resident A reported Resident B got in trouble for touching her.

I then interviewed Resident B privately. Resident B reported he remembered going to the baseball game. Resident B reported that staff drove the van to the game. He reported that he sat in the front passenger seat on the way to and from the game. He reported Resident A also rode with them to the game, but she sat all the way in the back of the van. Resident B denied any physical contact with Resident A.

On 10/29/2025, I interviewed staff Melissa Hoshaw by telephone. She reported she was in the van the day of the alleged incident. Ms. Hoshaw stated Resident B sat up in the front passenger seat of the van and she sat in the back of the van with Resident A. Ms. Hoshaw denied witnessing Resident B touch Resident A.

On 10/29/2025, I completed an exit conference with licensee designee, Stephanie Hertzhaft. She was informed of the investigation findings and recommendations.

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 09/10/2025, a complaint was received that while on an outing, Resident A was touched inappropriately by Resident B. Program Manager, Brandi Moore stated Resident A was upset she had to ride in a van with other cottage residents. Resident

	<p>A has a history of making false allegations about staff and other residents.</p> <p>Resident A reported Resident B touched her breast over her clothing. Resident A stated she reported this to staff and Resident B got in trouble.</p> <p>Resident B reported he sat in the front seat of the van on the day of the alleged incident. Resident A sat in the back seat. Resident B denied touching Resident A.</p> <p>Staff, Melissa Hoshaw confirmed that on 09/07/2025, Resident B was sitting in the front of the van, while Resident A was in the back of the van. Ms. Hoshaw denied witnessing Resident B touched Resident A.</p> <p>Based on the investigative findings, there is insufficient evidence to support a rule violation that staff failed to protect Resident A from being inappropriately touched by Resident B.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that the licensing status remain unchanged.

Megan Aukerman, LMSW

10/29/2025

Megan Aukerman
Licensing Consultant

Date

Approved By:

Jerry Hendrick

10/30/2025

Jerry Hendrick
Area Manager

Date