



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

November 12, 2025

Stephanie Herzhaft  
Hope Network Behavioral Health Services  
11652 Grand River  
Lowell, MI 49331

RE: License #: AS340089084  
Investigation #: 2025A0464060  
Westlake VI

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, 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**

<b>License #:</b>	AS340089084
<b>Investigation #:</b>	2025A0464060
<b>Complaint Receipt Date:</b>	09/15/2025
<b>Investigation Initiation Date:</b>	09/15/2025
<b>Report Due Date:</b>	11/14/2025
<b>Licensee Name:</b>	Hope Network Behavioral Health Services
<b>Licensee Address:</b>	11652 Grand River Lowell, MI 49331
<b>Licensee Telephone #:</b>	(616) 430-7952
<b>Administrator:</b>	Stephanie Herzhaft
<b>Licensee Designee:</b>	Stephanie Herzhaft
<b>Name of Facility:</b>	Westlake VI
<b>Facility Address:</b>	11652 Grand River Lowell, MI 49331
<b>Facility Telephone #:</b>	(616) 897-5900
<b>Original Issuance Date:</b>	11/09/1999
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	06/09/2025
<b>Expiration Date:</b>	06/08/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Staff allowed Resident A to go into the store unsupervised, which is a violation of his Individual Plan Of Service.	Yes

**III. METHODOLOGY**

09/15/2025	Special Investigation Intake 2025A0464060
09/15/2025	APS Referral Referral came from APS
09/15/2025	Special Investigation Initiated - Telephone Michelle Richardson, ORR
09/23/2025	Inspection Completed On-site Brandi Moore (Program Manager), Resident A
09/23/2025	Contact-Telephone call made Deshanae Mckinney, Staff
09/25/2025	Contact-Document received Facility Records
11/10/2025	Contact-Telephone call made Shiri Darnell, Staff
11/10/2025	Exit Conference Stephanie Herzhaft, Licensee Designee

**ALLEGATION: Staff allowed Resident A to go into the store unsupervised, which is a violation of his Individual Plan Of Service.**

**INVESTIGATION:** On 09/15/2025, I received a complaint from Adult Protective Services (APS), which alleged that on 09/09/2025 staff, Deshanae Mckinney, stayed in the vehicle and allowed Resident A to go into the gas station store alone. Resident A is not allowed to be unsupervised. APS did not assign the complaint for investigation.

On 09/15/2025, I exchanged emails with Network 180 Office of Recipient Rights (ORR) director, Michelle Richardson. Ms. Richardson stated Resident A is not one of their contracted residents; therefore, the complaint would not be investigated.

On 09/23/2025, I completed an onsite inspection at the facility. I interviewed program manager, Brandi Moore. Mrs. Moore stated it was reported to her that on 10/09/2025, Ms. Mckinney sat in the vehicle and allowed Resident A to go into the gas station, alone. Mrs. Moore explained this is against Resident A's Individual Plan of Service (IPOS) as Resident A has a history of stealing and panhandling. Mrs. Moore reported Detroit Wayne ORR is investigating the complaint. Mrs. Moore agreed to provide a copy of Resident A's IPOS.

I then interviewed Resident A. Resident A was able to recall the incident on 10/09/2025. He stated Ms. Darnell took him up to Wild Bills to get tobacco. Ms. Darnell then received a phone call and told Resident A to just go into the store. Ms. Darnell never ended up coming into the store. Resident A bought what he needed, and Ms. Darnell transported him back to the facility. Resident A stated Ms. Darnell no longer works at the facility because she "walked off the job".

On 09/23/2025, I attempted to contact Ms. Darnell, however, there was no answer.

On 09/25/2025, I received and reviewed Resident A's IPOS which was completed and signed on 02/26/2025. The IPOS reflects Resident A requires general staff supervision while in the community.

On 11/10/2025, I spoke to Mrs. Moore. Mrs. Moore reported that Ms. Mckinney admitted to allowing Resident A to go into the store unsupervised. Ms. Mckinney's employment was terminated. Mrs. Moore stated that Ms. Mckinney reported to Mrs. Moore that house manager, Shiri Darnell has also allowed Resident A to go into stores unsupervised.

On 11/10/2025, I spoke with Shiri Darnell by telephone. Ms. Darnell reported she has never witnessed staff leaving Resident A unsupervised. Ms. Darnell also denied she has ever left Resident A unsupervised at a store.

On 11/10/2025, I completed an exit conference with licensee designee, Stephanie Herzhaft. She was informed of the investigation findings and recommendations. Mrs. Herzhaft reported a corrective action plan would be submitted.

<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>
	<b>(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.</b>

<b>ANALYSIS:</b>	<p>On 09/15/2025, a complaint was received alleging facility staff, Deshanae Mckinney allowed Resident A to go into a store unsupervised.</p> <p>Program manager, Brandi Moore stated it was reported to her that Ms. Mckinney left Resident A unsupervised in the store on 09/09/2025. Ms. Mckinney reportedly admitted to leaving Resident A unsupervised.</p> <p>Resident A reported that Ms. Mckinney took him to the store to buy tobacco. He stated Ms. Mckinney stayed in the vehicle while he went into the store.</p> <p>Resident A's Individual Plan of Service (IPOS) reflected he requires staff supervision while in the community.</p> <p>Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Mckinney left Resident A unsupervised.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Megan Aukerman, LMSW*

11/10/2025

Megan Aukerman  
Licensing Consultant

Date

Approved By:

*Jerry Hendrick*

11/12/2025

Jerry Hendrick  
Area Manager

Date