



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 13, 2025

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

RE: License #: AS340089084
Investigation #: 2025A0464061
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

License #:	AS340089084
Investigation #:	2025A0464061
Complaint Receipt Date:	09/17/2025
Investigation Initiation Date:	09/17/2025
Report Due Date:	11/16/2025
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	11652 Grand River Lowell, MI 49331
Licensee Telephone #:	(616) 430-7952
Administrator:	Stephanie Herzhaft
Licensee Designee:	Stephanie Herzhaft
Name of Facility:	Westlake VI
Facility Address:	11652 Grand River Lowell, MI 49331
Facility Telephone #:	(616) 897-5900
Original Issuance Date:	11/09/1999
License Status:	REGULAR
Effective Date:	06/09/2025
Expiration Date:	06/08/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 07/02/2025, staff Adrian Evans pushed Resident A into the side of the garage.	Yes

III. METHODOLOGY

09/17/2025	Special Investigation Intake 2025A0464061
09/17/2025	APS Referral
09/17/2025	Special Investigation Initiated - Telephone Michelle Richardson, ORR Director
09/23/2025	Inspection Completed On-site Brandi Moore (Program Manager), Paula Huffman (Staff) & Resident A
09/24/2025	Contact-Telephone call made Adrian Evans, Staff
11/13/2025	Exit Conference Stephanie Herzhaft, Licensee Designee

ALLEGATION: On 07/02/2025, staff Adrian Evans pushed Resident A into the side of the garage.

INVESTIGATION: On 09/17/2025, I received a complaint from Adult Protective Services (APS) alleging that on 07/02/2025, Resident A was standing by the facility garage. Staff, Adrian Evans stood up, walked over to Resident A and pushed him into the wall of the garage. Resident A did not sustain any injuries from the incident. Resident A is nonverbal.

On 09/17/2025, I exchanged emails with Network 180 Office of Recipient Rights (ORR) Director, Michelle Richardson. Ms. Richardson explained Resident A is not one of their contracted Residents, therefore they would not be investigating the complaint.

On 09/23/2025, I completed an onsite inspection at the facility. I interviewed program manager, Brandi Moore. Mrs. Moore reported another staff, Paula witnessed the incident that occurred on 07/02/2025. Mrs. Moore reported Adrian

Evans' employment was terminated on 08/01/2025. Mrs. Moore explained Resident A is not able to be interviewed as he is completely nonverbal.

I then interviewed Paula Huffman privately. Ms. Huffman reported that on 07/02/2025, she was outside, sitting on the patio. She saw that Resident A was standing up against the facility garage. She then saw Mr. Evans stand up, walk over to Resident A and push him up against the garage "for no reason". Ms. Huffman stated she was in disbelief from what she saw and could not believe a staff did that to a resident. Ms. Huffman stated she then called law enforcement and notified management. Ms. Huffman denied witnessing this type of behavior previously from Mr. Evans but reported "he was not a pleasant person".

On 09/24/2025, I attempted to contact Mr. Evans by telephone, requesting a return phone call.

On 11/13/2025, 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.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	<p>On 09/17/2025, a complaint was received alleging on 07/02/2025 staff, Adrian Evans pushed Resident A up against the garage.</p> <p>Program manager, Brandi Moore reported another staff witnessed the incident. Mr. Evan's employment was terminated on 08/01/2025. Attempts were made to contact Mr. Evans; however, they were unsuccessful. Resident A was not interviewed as he is nonverbal.</p> <p>Staff, Paula Huffman was interviewed and reported on 07/02/2025, she was sitting outside when she saw Mr. Evans stand up, walk over to Resident A and push him against the garage for no apparent reason.</p> <p>Based on the investigative findings, there is sufficient evidence to support a rule violation that Mr. Evans physically assaulted Resident A.</p>

CONCLUSION:	VIOLATION ESTABLISHED
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IV. RECOMMENDATION

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

Megan Aukerman, LMSW

11/13/2025

Megan Aukerman
Licensing Consultant

Date

Approved By:

Jerry Hendrick

11/13/2025

Jerry Hendrick
Area Manager

Date