GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 28, 2020

Amanda Johnson
Hope Network Behavioral Health Services
PO Box 890
3075 Orchard Vista Drive
Grand Rapids, MI 49518-0890

RE: License #: AS340358904
Investigation #: 2020A0355068
Westlake II

Dear Ms. Johnson:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS340358904
Investigation #:	2020A0355068
Complaint Receipt Date:	09/25/2020
Investigation Initiation Date:	09/25/2020
Report Due Date:	11/24/2020
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890, 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 726-1998
Administrator:	Heather Burnell
Licensee Designee:	Amanda Green
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:	01/07/2019
Expiration Date:	01/06/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff took Resident A to Meijer, left Resident A at the door to park, and Resident A wandered away for 15-20 minutes.	Yes

III. METHODOLOGY

09/25/2020	Special Investigation Intake 2020A0355068
09/25/2020	APS Referral Received from; declined
09/25/2020	Special Investigation Initiated - Telephone Administrator
09/25/2020	Contact - Telephone call made Interviewed staff x 3
09/25/2020	Contact - Document Received Resident A's Assessment Plan
09/25/2020	Contact - Document Received Written statements x 2 from staff involved.
09/25/2020	Exit Conference Licensee designee, by telephone

ALLEGATION: Staff took Resident A to Meijer, left Resident A at the door to park, and Resident A wandered away for 15-20 minutes.

INVESTIGATION: On 09/25/2020, I received an incident report (IR) that stated on 09/24/2020, staff Kendra Billings took Resident A to Meijer, left Resident A at the door to park the van, and when Ms. Billings returned, Resident A had wandered off.

On 09/25/2020, I contacted by telephone the administrator, Heather Burnell. Ms. Burnell stated that Ms. Billings was supposed to take Resident A on a van ride only, reminding me that Resident A's current psychiatric status continues to be unstable, and Resident A's moods are very labile and when in the community, Resident A is to have 1:1 staffing. Ms. Burnell stated that Ms. Billings has been suspended pending the outcome of the investigation.

On 09/25/2020, I interviewed staff Mikayla Veneman. Ms. Veneman was working in the facility when Ms. Billings took Resident A out. Ms. Veneman was aware that Resident A was not to be taken on an outing, only a van ride. Ms. Veneman stated that Resident A is supposed to be supervised when in the community at all times. Ms. Veneman stated that Ms. Billings called the facility and told Ms. Veneman what had occurred.

On 09/25/2020, I interviewed by telephone the program manager, Brandi Moore, who was on-call when Ms. Billings lost Resident A in Meijer. Ms. Moore stated that on the date in question, Ms. Billings contacted Ms. Moore by telephone to report that Ms. Billings had left Resident A at the door at Meijer and parked the van. Ms. Moore stated that Ms. Billings reported that when she returned to where she had left Resident A, Resident A was gone and Ms. Billings didn't know if Resident A had gone into the store or walked off. Ms. Moore stated that prior to the incident, she had personally reminded the staff at the facility that they were only to take Resident A on a van ride, not into the Meijer store and not even to sit in the Meijer parking lot to listen to music as even that would lead to problems with Resident A.

On 09/25/2020, I interviewed by telephone staff Kendra Billings. Ms. Billings acknowledged that she had dropped Resident A off at the door at Meijer and gone to park the van. When Ms. Billings returned, Resident A had walked away. Ms. Billings stated that she searched the parking lot and then the store and found Resident A at the Service Desk after about 15-20 minutes. Ms. Billings stated that she didn't know she wasn't supposed to take Resident A to Meijer and pointed out that this was the first time she had taken Resident A out. Ms. Billings added that she thought it would be okay to go to Meijer because Resident A had been having a good day that day.

On 09/25/2020, I reviewed Resident A's Assessment Plan and related treatment plans. Resident A's Plan states that she is allowed to go into the community with 1:1 staffing at all times. Even on group outings, Resident A it to have 1:1 staffing.

On 09/25/2020, I received a written statement from staff Christi Hawley. Ms. Hawley wrote that on the date in question, she reminded staff Kendra Billings that Resident A was to have a van ride only before Ms. Billings left the facility with Resident A. Ms. Hawley wrote that she specifically told Ms. Billings that Ms. Billings was not to take Resident A to Meijer as Ms. Billings had been joking earlier in the day with Resident A that the two would "race scooters" at Meijer. Ms. Hawley wrote that she repeated the instruction to Ms. Billings and told Resident A that they were to have a van ride only.

On 09/25/2020, I received a written statement from the licensee designee, Amanda Johnson. Ms. Johnson wrote that on today's date, the administrator, Heather Burnell, had called staff Kendra Billings on speaker phone with Ms. Johnson and Ms. Moore present. During the call, Ms. Billings acknowledged that she had taken Resident A to Meijer and left Resident A at the door, resulting in Resident A walking

off so Ms. Billings had to look for ResidentA. The statement said that Ms. Billings acknowledged that, “she {Ms. Billings} shouldn’t have done that.”

On 09/25/2020, I conducted by telephone an exit conference with the licensee designee, Amanda Johnson. Ms. Johnson accepted the findings of my investigation.

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:	Resident A’s Assessment Plan states that when in the community, Resident A is to have 1:1 staffing at all times. Staff Christi Hawley stated that she specifically reminded staff Kendra Billings that Ms. Billings and Resident A were to go on a van ride only and not to Meijer on the date in question. On 09/24/2020, staff Kendra Billings acknowledged to me that she took Resident A to Meijer, left Resident A alone at the door while parking, and Resident A walked off. Ms. Billings also acknowledged the same by telephone to staff Mikayla Veneman and the administrator, Heather Burnell, the designee, Amanda Johnson, and program manager, Brandi Moore.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

09/28/2020

Grant Sutton, Licensing Consultant Date

Approved By:

09/28/2020

Jerry Hendrick, Area Manager Date