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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 3, 2021

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

RE: License #: AS340358904
Investigation #: 2021A0355025
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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 #:	2021A0355025
Complaint Receipt Date:	02/23/2021
Investigation Initiation Date:	02/23/2021
Report Due Date:	04/24/2021
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 Johnson
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:	01/07/2021
Expiration Date:	01/06/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff told Resident A that Resident B is a rapist and Resident B beat up another staff in the past over denying Resident B sex.	Yes

III. METHODOLOGY

02/23/2021	Special Investigation Intake 2021A0355025
02/23/2021	APS Referral
02/23/2021	Contact - Document Received Incident report
02/23/2021	Special Investigation Initiated - Telephone network 180, Office of Recipient Rights
02/23/2021	Contact - Telephone call made Administrator
02/26/2021	Contact - Document Received Interview notes from Recipient Rights
03/01/2021	Inspection Completed On-site Interviewed staff; attempted to interview Resident A
03/02/2021	Exit Conference Licensee designee by telephone

ALLEGATION: Staff told Resident A that Resident B is a rapist and Resident B beat up another staff over a denial of sex in the past.

INVESTIGATION: On 02/23/2021, I received a referral stating that Resident A reported to staff Chrisi Hawley that on 02/14/2021, staff Persephone Dorrian told Resident A to be careful around Resident B because Resident B might rape Resident A and that Resident B has beaten up a staff member in the past over a denial of sex.

On 02/23/2021, I received an incident report (IR) completed by staff Christi Hawley. Ms. Hawley wrote that Resident A reported to her on 02/14/2021, staff Persephone Dorrian told Resident A to be careful around Resident B as Resident A might get raped. Ms. Hawley wrote that Resident A reported to her that Ms. Dorrian told Resident A that Resident B had beaten up a staff in the past over denying Resident

B sex. Ms. Hawley wrote that the program manager on call was notified of the report and the IR was completed.

On 02/26/2021, I received a written summary from Recipient Rights staff Bob Patterson of his telephone interview with Resident A on 02/26/2021. Resident A told Mr. Patterson that Ms. Dorrian told Resident A the information when the two were on a shopping outing and this occurred in the van. Resident A told Mr. Patterson that Ms. Dorrian stated that Resident B is “really sexually aggressive” and will, “try to come on to you.” Resident A reported to Mr. Patterson that Ms. Dorrian told Resident A that Resident B had beat up a staff in the past for denying the staff sex. Resident A also reported to Mr. Patterson that Ms. Dorrian asked Resident A not to discuss what Ms. Dorrian had shared as Ms. Dorrian, “would lose her job.”

On 03/01/2021, I conducted an on-site investigation and interviewed staff Persephone Dorrian. Program manager, Brandi Moore, sat in on the interview. After the interview, I attempted to interview Resident A but she was in the shower with the intent of leaving immediately afterward to go on an outing.

Ms. Dorrian stated that she recalled talking to Resident A when they were on a van ride. Ms. Dorrian stated that Resident A told her that Resident A was going with Resident B. Ms. Dorrian stated that Resident A told Ms. Dorrian that Resident B had confided to Resident A that he had a history of getting into trouble but was different now. Ms. Dorrian stated that she told Resident A to, “be careful” with Resident B. Ms. Dorrian stated that at that response, Resident A began asking a lot of questions about Resident B and his sexual history. Ms. Dorrian stated that she told Resident A that due to HIPPA rules on confidentiality, Ms. Dorrian could not give details on Resident B’s history to Resident A. Ms. Dorrian denied giving any details of Resident B’s history to Resident A because of confidentiality but Ms. Dorrian acknowledged that due to Ms. Dorrian’s lack of response to Resident A’s questions, Resident A could easily have interpreted the lack of answers once Ms. Dorrian warned Resident A as a “yes” to Resident B having a negative history.

After I completed my interview with Ms. Dorrian, Ms. Moore coached Ms. Dorrian on more appropriate kinds of responses to Resident A’s questions that Ms. Dorrian could have utilized to redirect Resident A from the topic.

On 03/02/2021, I completed by telephone an exit conference with the licensee designee, Amanda Johnson. Ms. Johnson accepted the findings of my investigation.

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:	Resident A reported to staff that staff Persephone Dorrian had warned Resident A about Resident B having a history of sexually aggressive behavior. Resident A reported the same to Recipient Rights staff, Bob Patterson. Staff Persephone Dorrian acknowledged that she told Resident A to, “be careful” with Resident B and acknowledged that even though Ms. Dorrian did not give specific information to Resident A, Resident A could have interpreted Ms. Dorrian’s lack of follow up response as a confirmation of Resident B’s behavior. I find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

03/03/2021

Grant Sutton Date
Licensing Consultant

Approved By:

03/03/2021

Jerry Hendrick Date
Area Manager