STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 12, 2021

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

RE: License #: AS340379256
Investigation #: 2021A0467023
Westlake VIII

Dear Mrs. Kruger:

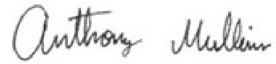
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS340379256
Investigation #:	2021A0467023
Complaint Receipt Date:	09/29/2021
Investigation Initiation Date:	09/30/2021
Report Due Date:	11/28/2021
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:	Alex Kruger
Name of Facility:	Westlake VIII
Facility Address:	11652 Grand River Avenue Lowell, MI 49331
Facility Telephone #:	(616) 897-5978
Original Issuance Date:	11/09/2015
License Status:	REGULAR
Effective Date:	05/09/2020
Expiration Date:	05/08/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The home was not properly staffed on 09/25/2021.	Yes

III. METHODOLOGY

09/29/2021	Special Investigation Intake 2021A0467023
09/30/2021	Special Investigation Initiated - On Site
10/12/2021	Exit Conference completed with licensee designee, Alex Kruger.

ALLEGATION: The home was not properly staffed on 09/25/2021.

INVESTIGATION: On 9/30/21, I received a BCAL online complaint stating that on 9/25/21, Resident A gained access to a butter knife after being left unattended, resulting in him self-harming. Resident A requires 1:1 supervision by staff at all times.

On 9/30/21, I made an unannounced onsite investigation to the home. Upon arrival, introductions were made with the program director, Alex Kruger. Mrs. Kruger confirmed that Resident A and staff member Nicole Chaput were available to speak today. Resident A was asleep, and Mrs. Kruger woke him to allow me to interview him. Introductions were made with Resident A and he was interviewed in his room. It should be noted that an unknown staff member was present just outside of the room and observed the interview as Resident A requires 1:1 supervision.

I asked Resident A if he could explain what happened this past weekend (9/25/21) that resulted in him harming himself. Resident A stated that on 9/25/21 during 3rd shift, he was able to obtain a butter knife from the dishwasher. Resident A stated that staff member Brandon White was the only staff member working on the day in question. Resident A stated that Mr. White was assigned to him to provide 1:1 and line of sight supervision. Resident A stated that since he requires 1:1 and Mr. White was the only staff member working, “it’s technically illegal.” Mr. White was reportedly not observing him when he obtained the butter knife from the dishwasher. Resident A used the butter knife to cut himself on his left forearm. Resident A lifted his left arm sleeve and I observed superficial cuts to his forearm. He was unable to recall if a staff member observed the cut on his forearm. Resident A stated that he cut himself because “I had a lot of dark emotions.” Resident A also stated, “I’m a self-harmer. That’s why I’m here.” Resident A stated that he has self-harmed since he was 8 years old, and I encouraged him to utilize his coping skills to prevent a similar incident from occurring.

After speaking to Resident A, I spoke to the case manager clinician, Nicole Chaput. Ms. Chaput stated on 9/27/21, she participated in Resident A's individualized plan of service (IPOS) meeting. During the meeting, Resident A stated that on 9/25/21, he told Mr. White that he was going to make a pot of coffee. While making coffee, Resident A stated that he was able to obtain the knife because Mr. White did not follow him. Ms. Chaput confirmed that Resident A does require 1:1 and line of sight supervision. Ms. Chaput provided me with a copy of Resident A's assessment plan and Acute Risk Intervention plan (ARIP), both of which confirm that Resident A does require 1:1 supervision. Ms. Chaput provided me with contact information for Mr. White.

After speaking to Ms. Chaput, I spoke to Mrs. Kruger again. Mrs. Kruger informed me that Resident A was served with a 30-day eviction notice on 9/10/21 due to the facility not being able to meet his level care. Mrs. Kruger has sent this information to Megan Aukerman, licensing consultant and sent me a copy as well. I later contacted Mrs. Kruger via phone to discuss staffing at the home. Mrs. Kruger informed me that Mr. White was the only staff member assigned to the home on 9/25/21. Mrs. Kruger informed me that Westlake Cottage 1 and Cottage 8 are connected and on the day in question, the door that connects the two homes was opened so staff in Cottage 1 could assist if needed. Mrs. Kruger stated that there are no residents in Cottage 1 that require 1:1 supervision. I then explained to Mrs. Kruger that the homes are not permitted to share staff and if Resident A requires 1:1 supervision, Cottage 8 is required to always have 2 staff members as the staff member with Resident A would be unable to attend to other resident's needs. Mrs. Kruger stated that she understands, and this is not a situation that occurs often.

On 9/30/21 and 10/1/21, I left Mr. White voicemails requesting a call back.

On 10/1/21, the complainant returned my call and confirmed that Resident A requires 1:1 and line of sight supervision and this has been in place for more than a year. The complainant stated that Resident A's behavioral treatment plan reflects this.

On 10/1/21, I spoke to Angela Wend, Recipient Rights staff member through the Community Mental Health (CMH) of Central Michigan. Ms. Wend informed me that she has interviewed all parties involved and will cite the facility per the mental health code for the lack of staffing as Resident A requires 1:1 supervision and there were no other staff members working. As I have been unable to connect with Mr. White from the AFC home, Ms. Wend agreed to send me her interview notes with him and I will add it to my report.

The contact below was authored by Ms. Wend, Recipient Rights Advisor for Community Mental Health for Central Michigan. I modified the report to refer to the client involved as "Resident A" as opposed to his full name.

‘On 10/1/21, Recipient Rights Advisor, Ms. Wend completed a phone interview with Mr. White, Program Manager. Mr. White said there was no third shifters willing to work at Cottage 8. Mr. White said it was a “struggle to staff nights.” Mr. White said he was aware of Resident A’s standard of care to include his Behavior Treatment Plan (BTP). Mr. White said Resident A is a 1:1 line of sight with his staff support. Mr. White said Resident A is up most of the night and slept “maybe 2 hours” on the night of the 9/25/2021.

Mr. White said on the night of the 25th, two other recipients got up. One recipient asked Mr. White to light his cigarette and the other recipient asked for soap. Mr. White said he was with Resident A the whole night.

Mr. White said he did not stay on the couch when Resident A said he was going to get coffee. Mr. White said he went with Resident A and was “within arm’s reach in the kitchen.” This Advisor asked Mr. White how Resident A could have acquired a butter knife during his (Mr. White’s) shift. Mr. White said Resident A handed him (Mr. White) a butter knife approximately between 2AM and 4 AM during his shift. Mr. White said that Resident A told him that he was making a good choice by giving him the butter knife. Resident A said he did not see any marks on Resident A. Mr. White said he did not check for marks due to seeing him naked about 30 minutes prior to Resident A handing him the butter knife. Mr. White said Resident A told him that he did not self-harm.

This advisor asked Mr. White how Resident A could have acquired the butter knife. Mr. White said on Friday (9/24/21), Resident A asked staff if he could help clean the kitchen. Mr. White said he thinks he may have acquired it then. Mr. White said it was out of Resident A’s character to offer to clean.’

On 10/4/21, I received a voicemail from Brandon White, program manager at Westlake Cottage 8. Mr. White requested a call back. On 10/6/21, Mr. White and I spoke via phone. I informed him that due to receiving Mr. White’s interview with Ms. Wend regarding the same incident, I no longer need to ask him similar questions. I informed Mr. White that I will contact him with follow-up questions if they arise.

On 10/12/21, I conducted an exit conference with licensee designee, Alex Kruger. I informed Mrs. Kruger of the investigative findings and she was accepting of the outcome. Mrs. Kruger agreed to complete a corrective action plan as a result of this investigation.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services

	specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A, Mr. White, and Mrs. Kruger all confirmed that Mr. White was the only staff member working 3rd shift on 9/25/21. I reviewed Resident A's assessment plan and acute risk intervention plan (ARIP) and confirmed that he requires 1:1 and line of sight supervision. Therefore, Mr. White's sole responsibility should have been to provide care for Resident A on 9/25/21. Resident A stated that he obtained a knife and cut himself on his forearm on 9/25/21 after being left unattended by Mr. White. Mr. White denied leaving him unattended. However, Mr. White was responsible for other residents as well. Therefore, a preponderance of evidence does exist to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/12/2021

Anthony Mullins — Date
Licensing Consultant

Approved By:

10/12/2021

Jerry Hendrick — Date
Area Manager