GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 15, 2022

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

RE: License #: AS340089081
Investigation #: 2022A0464034
Westlake V

Dear Ms. Kruger:

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) 356-0183.

Sincerely,

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 #:	AS340089081
Investigation #:	2022A0464034
Complaint Receipt Date:	05/16/2022
Investigation Initiation Date:	05/16/2022
Report Due Date:	07/15/2022
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(161) 643-0795
Administrator:	Alexandra Kruger
Licensee Designee:	Alexandra Kruger
Name of Facility:	Westlake V
Facility Address:	11652 Grand River Lowell, MI 49331
Facility Telephone #:	(616) 897-5373
Original Issuance Date:	11/09/1999
License Status:	REGULAR
Effective Date:	09/17/2020
Expiration Date:	09/16/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 05/08/2022, Dillion Wolthuis (direct care staff) was observed blocking Resident A in his room and vaping in Resident A's face.	Yes

III. METHODOLOGY

05/16/2022	Special Investigation Intake 2022A0464034
05/16/2022	Special Investigation Initiated - Telephone Brandi Moore, Program Manager
05/16/2022	APS Referral Referral received from APS
05/18/2022	Contact-Document sent Jeri Sterrett, Recipient Rights
06/01/2022	Inspection Completed-Onsite Brandi Moore (Program Manager), Heather Burnell (Supervisor), Michael O'Neal (Management), Dillion Wolthuis (Staff), Paula Huffman (Staff) and Summer Worthington (Staff)
06/10/2022	Contact-Telephone call made Jeremy Zamarron, Staff
06/14/2022	Exit Conference Alexandra Kruger, Licensee Designee

ALLEGATION: On 05/08/2022, Dillion Wolthuis (direct care staff) was observed blocking Resident A in his room and vaping in Resident A's face.

INVESTIGATION: On 05/16/2022, I received a complaint from Adult Protective Services (APS). The complaint alleged that on 05/08/2022, staff, Dillion Wolthuis was observed blocking Resident A from coming out of his bedroom. Mr. Wolthuis was also observed vaping in Resident A's bedroom and blowing the smoke in Resident A's face. Resident A has been diagnosed with Autism and is completely nonverbal.

On 05/16/2022, I exchanged emails with program manager, Brandi Moore. Mrs. Moore stated Mr. Wolthuis is working in a different facility until the investigation is resolved.

On 05/18/2022, I exchanged emails with Wayne County Recipient Rights worker, Jeri Sterrett to coordinate the investigation.

On 06/01/2022, I spoke with Brandi Moore (Program Manager), Heather Burnell (Facility Manager) and Michael O'Neal (Administration Staff). Mrs. Moore stated Mr. Wolthuis has only been working at the facility for a few months; however, he was a re-hire, meaning he previously worked for Hope Network and has returned. Mrs. Moore, Mr. O'Neal and Ms. Burnell denied physically witnessing any incidents where Mr. Wolthuis treated Resident A or any other resident inappropriately. All three denied Mr. Wolthuis had any disciplinary action in his personnel file.

I then interviewed Mr. Wolthuis. He stated he was aware there was an investigation; however, he was not made aware of the exact allegations. Mr. Wolthuis was asked about the incident that occurred on 05/08/202022. Mr. Wolthuis denied he has ever vaped in the facility or blew smoke, from the vape, into Resident A's face. Mr. Wolthuis stated that on 05/08/2022, he was working as Resident A's one-on-one staff. He stated during the evening he put Resident A to bed, then Mr. Wolthuis sat on the foam pad located on Resident A's bedroom floor. Mr. Wolthuis stated Resident A got out of bed several times and tried to leave his room. Mr. Wolthuis denied he ever blocked Resident A from leaving his bedroom and stated he tried to redirect Resident A, multiple times, to get him back into bed. Mr. Wolthuis denied he has ever treated a resident poorly.

I then interviewed staff, Paula Huffman. Ms. Huffman stated she has only worked with Mr. Wolthuis when she has gone to the facility to administer resident medications. Ms. Huffman denied she has directly witness Mr. Wolthuis treat any resident poorly. Ms. Huffman stated she did notice Resident B would act very "skittish" around Mr. Wolthuis, as if Resident B was afraid of him. Ms. Huffman thought this to be concerning as that is not how Resident B typically acts. Ms. Huffman stated she spoke with Mr. Wolthuis and reminded him that the residents are nonverbal, and they cannot communicate their wants/needs as others.

I then interviewed staff, Summer Worthington. She stated she has worked several shifts with Mr. Wolthuis. Ms. Worthington stated on 05/08/2022 between 7:00 pm and 8:00 pm, she witnessed Mr. Wolthuis put Resident A to bed. Ms. Worthington stated since Resident A is often very restless and moves throughout the night, he does not have a set bedtime schedule. If Resident A wants to be awake and walking, staff will allow him to do so, therefore Ms. Worthington thought it was strange Mr. Wolthuis was putting Resident A to bed. When he put Resident A to bed, she noticed Mr. Wolthuis moved the foam pad that is located on the bedroom floor, in front of the bedroom door, blocking the entrance. She watched Mr. Wolthuis grab his computer and phone, then proceed to sit on the pad. Resident A then attempted to get out of bed multiple times and leave the room. Mr. Wolthuis did not let Resident A leave. Resident A then became agitated and started throwing his toys. When Ms. Worthington went into the bedroom to check what was happening, she saw Mr. Wolthuis sitting on the bed with Resident A. She asked him what was

going on. Mr. Wolthuis proceeded to inhale his vape while speaking with her, then let the smoke out, which blew into Resident A's face. This appeared to bother Resident A. Ms. Worthington stated the facility has a "no smoking" policy, which includes vaping.

On 06/14/2022, I completed an exit conference with licensee designee, Alexandra Kruger. She was informed of the investigation findings and recommendations. Ms. Kruger stated she understood the reasons for the rule violation.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 05/16/2022, a complaint was received alleging staff, Dillion Wolthuis was observed blocking Resident A in his bedroom and blowing smoke in Resident A's face. On 06/01/2022, staff, Brandi Moore, Heather Burnell and Michael O'Neal were interviewed. All three stated Mr. Wolthuis only worked at the facility for a few months. All three denied witnessing Mr. Wolthuis treat any resident poorly. Mr. Wolthuis was interviewed and denied the allegations. He stated he was trying to get Resident A to bed but denied blocking him in his bedroom. Mr. Wolthuis also denied vaping in the facility and blowing smoke in Resident A's face. Staff, Summer Worthington was interviewed and stated on 05/08/2022, she directly witnessed Mr. Wolthuis blow smoke into Resident A's face as well as physically block Resident A in his bedroom. Staff, Paula Huffman was also interviewed. Ms. Huffman denied witnessing anything directly from Mr. Wolthuis but stated Resident B appears fearful of Mr. Wolthuis. Residents A and B were not interviewed as they are nonverbal. Based on the investigative findings there is sufficient evidence to support a rule violation that Mr. Wolthuis treated Resident A inappropriately.

CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Megan Aukerman, MSW 06/15/2022

Megan Aukerman Date
Licensing Consultant

Approved By:

06/15/2022

Jerry Hendrick Date
Area Manager