GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 31, 2022

Alexandra Kruger
Hope Network Behavioral Health Services
11652 Grand River Ave
Lowell, MI 49331

RE: License #: AS340379225
Investigation #: 2023A0464008
Westlake I

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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS340379225
Investigation #:	2023A0464008
Complaint Receipt Date:	10/11/2022
Investigation Initiation Date:	10/11/2022
Report Due Date:	12/10/2022
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	11652 Grand River Ave Lowell, MI 49331
Licensee Telephone #:	(616) 430-7952
Administrator:	Alexandra Kruger
Licensee Designee:	Heather Burnell
Name of Facility:	Westlake I
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:	04/14/2022
Expiration Date:	04/13/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 10/08/2022, staff were heard yelling and swearing at Resident A. The same staff watched Resident A fall out of his wheelchair and refused to assist him.	Yes

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A0464008
10/11/2022	APS Referral
10/11/2022	Special Investigation Initiated - Telephone Brandi Moore, Facility Administrator
10/11/2022	Contact - Document Sent Ed Wilson, ORR
10/11/2022	Contact-Document received Michelle Richardson, ORR
10/22/2022	Inspection Completed-Onsite Alexandra Kruger (Licensee Designee), Ruby Porter (Staff), Meghan Thelen (Program Manager), Alexis Cherpes (Staff), Jeff Prangi (Staff) & Resident A
10/31/2022	Exit Conference Alexandra Kruger, Licensee Designee

ALLEGATION: On 10/08/2022, staff, Ruby Porter were heard yelling and swearing at Resident A. The same staff watched Resident A fall out of his wheelchair and refused to assist him.

INVESTIGATION: On 10/11/2022, I received an incident report (IR) that stated on 10/08/2022, Resident A was intentionally falling out of his wheelchair. Staff, Ruby Porter told the other staff to not assist Resident A and just let him fall. Ms. Porter was also heard yelling and swearing at Resident A, stating, “are you fucking serious”. An investigation was opened, and a referral was made to the Office of Recipient Rights.

On 10/11/2022, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 10/11/2022, I exchanged emails with Kent County Network 180 Office of Recipient Rights Director, Ed Wilson. Mr. Wilson stated the complaint would be assigned to Michelle Richardson for investigation.

On 10/11/2022, I exchanged emails with Kent County ORR worker, Michelle Richardson to coordinate the investigation.

On 10/11/2022, I exchanged emails with facility administrator, Brandi Moore. Mrs. Moore stated the staff accused has been suspended, pending the investigation.

On 10/22/2022, I completed an onsite inspection at the facility. I met with licensee designee, Alexandra Kruger. Mrs. Kruger confirmed Ms. Porter is currently suspended, pending the outcome of the investigation. Ms. Kruger called her into the facility to be interviewed. Ms. Kruger stated Ms. Porter has worked at the facility for several years. She has not had any prior investigations or disciplinary actions in her personnel file.

I then interviewed Ms. Porter privately. Ms. Porter was aware of the allegations. Ms. Porter stated she has worked at the facility for over ten years. She stated she does not have any reprimands in her employee file. Ms. Porter denied she has ever sworn at a resident. She stated that she, “loves the residents like family”. Ms. Porter stated on 10/08/2022, Resident A was in a “mood”. He refused his evening medication. Resident A was constantly getting in and out of bed. He was moving about the facility in his wheelchair, leaning over the armrest, trying to throw himself onto the ground. Ms. Porter denied telling other staff to, “just let him fall”. She also denied saying, “are you fucking serious”. Ms. Porter stated she told the staff to assist her with lowering Resident A to the ground so that he would not hurt himself.

I then interviewed program manager, Meghan Thelen. Ms. Thelen stated on 10/08/2022, she was the program manager on call. She stated staff, Alexis Cherpes called her in the evening and reported Resident A was agitated and refused his medication, including a PRN. Ms. Porter contacted Ms. Thelen later in the evening and informed her they got Resident A into bed. Ms. Thelen stated she reminded Ms. Porter they cannot make Resident A stay in bed. Ms. Thelen stated Ms. Porter never reported Resident A was trying to throw himself out of his chair.

I then interviewed facility staff, Jeff Prangi and Alexis Cherpes, individually. Both staff stated they were working with Ms. Porter during the evening of 10/08/2022. Both Mr. Prangi and Ms. Cherpes stated Resident A was having a difficult night. Ms. Porter appeared to be very irritated with Resident A, as he was very restless. Resident A kept leaning over the side of his wheelchair trying to throw himself to the ground. Mr. Prangi and Ms. Cherpes both stated they assisted Resident A so that he would not fall out of his chair. Both stated Ms. Porter just stood off to the side and told them, “Just let him fall he is going to just keep doing it". Both staff stated Ms. Porter also repeatedly said, “(Resident A), are you fucking kidding me”. Mr. Prangi and Ms. Cherpes stated Resident A eventually calmed down.

I then attempted to interview Resident A, however Resident A was napping in his bed. When staff went to get him, he stated he wanted to keep sleeping and did not want to talk.

On 10/26/2022, I exchanged emails with Ms. Richardson. She stated she went to the facility to interview Resident A. Ms. Richardson stated Resident A was in his bedroom and told staff he did not want any visitors. Ms. Richardson stated she was unable to interview him regarding the allegations.

On 10/31/2022, I completed an exit conference with Mrs. Kruger and informed her of the investigation findings and recommendations. Mrs. Kruger stated a corrective action plan will be completed.

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 10/11/2022, a complaint was received that alleged staff, Ruby Porter was heard yelling, and swearing at Resident A. On Ms. Porter was interviewed and denied the allegation. Attempts were made to interview Resident A, however, he declined to speak to licensing. Staff, Alexis Cherpes and Jeff Prangi both stated they worked with Ms. Porter the day of the incident, 10/08/2022. Both staff stated they heared Ms. Porter say to Resident A, “(Resident A), are you fucking kidding me”. Ms. Cherpes and Mr. Prangi also reported Ms. Porter told them to just let Resident A fall out of his wheelchair, because he will just continue to throw himself out of his chair. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff, treated Resident A poorly.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/31/2022

Megan Aukerman Date
Licensing Consultant

Approved By:

10/31/2022

Jerry Hendrick Date
Area Manager