GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 9, 2023

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

RE: License #: AS340089072
Investigation #: 2023A0464056
Westlake IV

Dear Ms. Leone:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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, MSW

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 #:	AS340089072
Investigation #:	2023A0464056
Complaint Receipt Date:	07/17/2023
Investigation Initiation Date:	07/18/2023
Report Due Date:	09/15/2023
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 430-7952
Administrator:	Heather Burnell
Licensee Designee:	Stephanie Leone
Name of Facility:	Westlake IV
Facility Address:	11652 Grand River Lowell, MI 49331
Facility Telephone #:	(616) 897-5900
Original Issuance Date:	11/09/1999
License Status:	REGULAR
Effective Date:	09/28/2021
Expiration Date:	09/27/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident B reported that Resident A has been coming into her bedroom at night and touching her private area. There are concerns regarding staff supervision of Resident A and B.	No

III. METHODOLOGY

07/17/2023	Special Investigation Intake 2023A0464056
07/17/2023	APS Referral
07/18/2023	Special Investigation Initiated - Face to Face Heather Burnell, Administrator
07/18/2023	Inspection Completed On-site Ryleigh Kelley, Staff Lidia Wynalda, Staff
08/02/2023	Contact-Document sent Sergeant Jacob Sommer, Ionia County Sherriff's Department
08/04/2023	Contact-Document received Police Report
08/09/2023	Exit Conference Stephanie Leone, Licensee Designee

ALLEGATION: Resident B reported that Resident A has been coming into her bedroom at night and touching her private area. There are concerns regarding staff supervision of Resident A and B.

INVESTIGATION: On 07/17/2023, I received an online BCAL complaint from Adult Protective Services (APS), which alleged Resident B reported Resident A has been coming into her room at night and touching her private area. It is unknown the last time or how many times this occurred. There is concern facility staff are not supervising the resident appropriately. APS did not assign the complaint for investigation.

On 07/18/2023, I met with facility administrator, Heather Burnell. Mrs. Burnell denied witnessing Resident A go into Resident B's room at night. Ms. Burnell stated Resident B reported the incident to another staff person. Ms. Burnell stated they immediately reported the allegations to law enforcement. An officer came out to interview Resident B and she denied Resident A came into her room at night and

touched her private area. Ms. Burnell stated even though law enforcement closed their investigation, they decided to still move Resident A to a different bedroom so that the two women do not have rooms next to each other or share a bathroom.

On 07/18/2023, I completed an onsite inspection at the facility. I interviewed facility staff, Ryleigh Kelley, and Lidia Wynalda, individually. Ms. Kelley stated Resident B was having an "off" day, so it may not be best to interview her as it would escalate her behaviors. Both staff stated Resident B has been diagnosed with Schizophrenia and struggles with delusions. She has made sexual statements in the past. Ms. Kelley and Ms. Wynalda stated a few days ago, Resident B reported Resident A snuck into her bedroom at night and touched her private area. Resident B did not provide additional details. Ms. Kelley and Ms. Wynalda stated the incident was immediately reported, the residents were separated, and Resident A was placed on "line of sight" supervision at all times while the investigation was conducted. Ms. Kelley and Ms. Wynalda stated officers came to the facility the same day the allegations were reported. They interviewed Resident B and informed staff Resident B did not disclose Resident A came into her bedroom and touched her private areas. Law enforcement closed their investigation. Ms. Kelley and Ms. Wynalda denied ever witnessing Resident A go into Resident B's bedroom. Ms. Kelley and Ms. Wynalda stated they were surprised Resident B stated Resident A touched her, because Resident A has never demonstrated sexualized behaviors or made statements about any resident. They could not see Resident A doing such a thing. Ms. Kelley and Ms. Wynalda stated even though the investigation was closed, staff were instructed to still move Resident A's bedroom so that they were not right next to each other.

On 08/02/2023, I exchanged emails with responding officer, Sergeant Jacob Sommer from the Ionia County Sherriff's Department. Sergeant Sommer stated his investigation was closed due to lack of evidence and provided information on how to request a copy of the police report.

On 08/04/2023, I received and reviewed police report #SH23-04381. The report stated that on 07/14/2023 at approximately 9:58 pm Sergeant Sommer responded to a call at the facility regarding allegations consisting of Resident A going into Resident B's bedroom at night and touching her on the private area. Sergeant Sommer interviewed Resident B privately. Resident B stated she "believed" Resident A was touching her at night. When Resident B was asked why she believed this, she responded, "because she laughs at me a lot and makes comments about my snoring". Resident B denied having any memory of sexual assault and denied anyone else would have information regarding the allegations. The case was closed due to lack of evidence.

On 08/09/2023, I completed an exit conference with licensee designee, Stephanie Leone. She was informed of the investigation findings and recommendations.

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:	On 07/17/2023, a complaint was received alleging Resident B stated Resident A comes into her bedroom at night and touches her private area. There are concerns facility staff are not supervising appropriately. Facility staff, Heather Burnell, Ryleigh Kelley, and Lidia Wynalda all denied witnessing Resident A go into Resident B's room at night and touch her private area. Staff reported Resident B initially disclosed Resident A snuck into her bedroom at night and touched her private area. Staff immediately separated the residents and contacted law enforcement. Resident B did not report this allegation to the responding officer but as a precautionary measure, Resident A's bedroom has been moved. Contact was made with the Ionia County Sherriff's Department and Sergeant Jacob Sommer confirmed the investigation has been closed due to lack of evidence. Based on the investigative findings, there is insufficient evidence to support a rule violation that facility staff did not adequately supervise Resident A and Resident B.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that the licensing status remain unchanged.

Megan Aukerman, MSW 08/09/2023

Megan Aukerman Date
Licensing Consultant

Approved By:

08/09/2023

Jerry Hendrick Date
Area Manager