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
11652 Grand River Ave
Lowell, MI 49331

RE: License #: AS340305684
Investigation #: 2023A0464055
Westlake Cottage III

Dear Ms. Leone:

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 #:	AS340305684
Investigation #:	2023A0464055
Complaint Receipt Date:	07/10/2023
Investigation Initiation Date:	07/10/2023
Report Due Date:	09/08/2023
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 Lenone
Name of Facility:	Westlake Cottage III
Facility Address:	11652 Grand River Ave. Lowell, MI 49331
Facility Telephone #:	(616) 897-5087
Original Issuance Date:	05/25/2010
License Status:	REGULAR
Effective Date:	01/05/2022
Expiration Date:	01/04/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had $190.95 missing from resident funds.	Yes

III. METHODOLOGY

07/10/2023	Special Investigation Intake 2023A0464055
07/10/2023	APS Referral
07/10/2023	Special Investigation Initiated - Telephone Brandi Moore, Program Manager
07/18/2023	Inspection Completed On-site Heather Burnell (Administrator), Sydney Martin (Staff), Logan Baeger (Staff), Michael O'Neal (Staff), Wesley Wilkins (Staff), Michelle Rocha (Staff), & Alyssa Atkins (Staff)
08/09/2023	Exit Conference Stephanie Leone, Licensee Designee

ALLEGATION Resident A had $190.95 missing from resident funds.

INVESTIGATION: On 07/10/2023, I received an online complaint from Adult Protective Services (APS), which alleged that on 07/07/2023, it was discovered Resident A had $190.95 missing from resident funds. There was no documentation to reflect where the money went or how it was spent. APS did not assign the complaint for investigation.

On 07/10/2023, I spoke to program manager, Brandi Moore who stated the facility is also conducting an internal investigation regarding the missing money.

On 07/18/2023, I completed an onsite inspection at the facility. I interviewed facility administrator, Heather Burnell. Ms. Burnell stated staff lead, Michael O'Neal discovered that the resident funds for Resident B were missing. He discovered there was $190.95 missing of Resident A's money. Ms. Burnell stated through their internal investigation, they discovered that staff had a difficult time opening the resident funds safe, therefore some staff were not counting resident funds during shift change. Ms. Burnell stated she was unable to determine when exactly the money went missing.

I then interviewed facility staff, Courtney Johnston. Ms. Johnston stated the safe with resident funds is kept in the medication room. The keys to the safe are kept hanging in the medication room. Ms. Johnston stated the safe is older and often sticks, so it is very difficult to open. Ms. Johnston stated resident funds are supposed to be counted every shift change. Ms. Johnston stated she is supposed to count funds during third shift; however, she has not had to count any resident funds since June 2023. Ms. Johnston stated she heard Resident A's money was missing, but she did not have any further information. Ms. Johnston stated since the money has gone missing, a new safe was purchased for the facility.

I then interviewed facility staff, Sydney Martin, Logan Baeger, and Alyssa Atkins, individually. All three staff stated they are not responsible for counting resident funds and denied having access to the case. Mr. Baeger, Ms. Martin, and Ms. Atkins denied having any information regarding Resident A's missing funds. They also denied hearing anything about the missing funds.

I then interviewed lead staff, Michael O'Neal. Mr. O'Neal stated he was the on-call lead staff scheduled for 07/07/2023 and was responsible for passing resident medication. Mr. O'Neal explained that after staff administer resident medication, they are also supposed to count the resident funds and sign off on them. Mr. O'Neal stated he administered resident medication during the evening of 07/07/2023. When he was finished administering resident medication, he went in the safe to count resident funds. Mr. O'Neal stated all of the money was accounted for except or Resident A's funds. Resident A had $190.95 missing from his envelope. Mr. O'Neal stated he checked everywhere to make sure the money did not fall or was incorrectly counted in the log. Mr. O'Neal stated he could not find the money or any supporting documentation that the money was spent. He even called another staff person, Abby Leland into the medication room to double check his findings. After speaking to several staff, Mr. O'Neal discovered that staff were initialing they were counting resident funds each shifts; however, they did not actually do so. Mr. O'Neal stated he was unable to determine where or when the money went missing.

I then interviewed staff, Abby Leland. Ms. Leland stated technically all staff have access to the safe containing resident funds. She stated the keys are left hanging in the medication room and any staff person has access to the medication room. Ms. Leland stated she was working the evening of 07/07/2023 when Mr. O'Neal called her into the medication room. He informed her Resident A had $190.95 missing from his funds and Mr. O'Neal asked Ms. Leland to double check. Ms. Leland stated she looked all around the safe and in the medication room, but the money was nowhere to be found.

I then interviewed staff, Wesley Wilkins and Michelle Rocha. Both stated they have been responsible for counting resident funds, however; they have not had to do so since June 2023. Both Mr. Wilkins and Ms. Rocha stated the money was accounted for the last time they were in the safe. Mr. Wilkins and Ms. Rocha stated they heard money was missing from the safe, but neither had information regarding the money.

On 08/09/2023, I completed an exit conference with licensee designee, Stephanie Leone. She was informed of the investigation findings and recommendations. Ms. Leone stated a corrective action plan would be completed.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(2) The care of any resident funds and valuables that have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	On 07/07/2023, a complaint was received alleging Resident A was missing $190.95 from resident funds. Facility staff, Michael O'Neal and Abby Leland stated they were working on 07/07/2023 and noticed Resident A's money was missing. Facility staff, Sydney Martin, Logan Baeger, Wesley Wilkins, Michelle Rocha, and Alyssa Atkins all reported they heard money was missing from the safe, but denied having any information regarding where the money went. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility could not account for Resident A's missing funds.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Megan Aukerman, MSW

08/09/2023

Megan Aukerman, Licensing Consultant Date

Approved By:

Jerry Hendrick

08/09/2023

Jerry Hendrick, Area Manager Date