GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 2, 2024

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

RE: License #: AS340089084
Investigation #: 2024A0464008
Westlake VI

Dear Ms. Leone:

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 feel free to 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 #:	AS340089084
Investigation #:	2024A0464008
Complaint Receipt Date:	11/03/2023
Investigation Initiation Date:	11/03/2023
Report Due Date:	01/02/2024
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 VI
Facility Address:	11652 Grand River Lowell, MI 49331
Facility Telephone #:	(616) 897-5900
Original Issuance Date:	11/09/1999
License Status:	REGULAR
Effective Date:	06/09/2023
Expiration Date:	06/08/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A reported that staff call him names.	Yes

III. METHODOLOGY

11/03/2023	Special Investigation Intake 2024A0464008
11/03/2023	Special Investigation Initiated - Telephone
11/03/2023	APS Referral
12/20/2023	Inspection Completed-Onsite Brandi Moore, Program Manager Heather Burnell, Administrator
12/20/2023	Contact-Document received ORR Report
01/02/2024	Exit Conference Stephanie Leone, Licensee Designee

ALLEGATION: Resident A reported that staff call him names.

INVESTIGATION: On 11/03/2023, I received a complaint from the Wayne County Office of Recipient Rights (ORR) alleging facility staff, Shea Moore and JD Zamarron called Resident A “weak” as well as other names.

On 11/03/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 12/20/2023, I completed an onsite inspection at the facility and interviewed program manager, Brandi Moore and administrator, Heather Burnell. Mrs. Moore stated Resident A was not currently home. He was on leave, staying with his family for the holidays. Mrs. Moore stated she did not have much information on the investigation as it was considered a conflict of interest. One of the accused is her spouse. Mrs. Moore stated ORR did substantiate, as she received the corrective action plan.

I then interviewed Ms. Burnell. Ms. Burnell stated ORR did substantiate the investigation. Resident A had an audio recording of Mr. Moore and Mr. Zamarron

calling him names. Ms. Burnell denied having any firsthand knowledge of the incident. Ms. Burnell provided a copy of the ORR investigation report.

On 12/20/2023, I received and reviewed the ORR investigation summary, completed by Katie Smith. Ms. Smith talked to case manager, Shelbi Diamond over the phone. Ms. Diamond reported that on 10/26/2023, Resident A told her Mr. Moore and Mr. Zamarron were calling him names and told him he was “gay”. On 10/30/2023, Ms. Smith interviewed Resident A by telephone. Resident A informed Ms. Smith there was one day when Mr. Moore and Mr. Zamarron called him a “dirty ass kid, weak, gay and mentally weak”. Resident A stated this was the first time the incident occurred. Resident A then played the audio recording for Ms. Smith. She stated the staff were difficult to hear and only heard them say, “you’re not very strong at all”.

Ms. Smith interviewed Mr. Moore by telephone on 11/07/2023. Mr. Moore stated on the day of the incident Resident A was home, as he was suspended from school. Resident A was talking in a very disrespectful, sexual manner that was making other residents uncomfortable. Mr. Moore admitted to Ms. Smith that Resident A got “under his skin”. The only comment he recalled making to Resident A was, “and how well did that work out for your”. Mr. Moore was then informed there was a recording of the incident. He told Ms. Smith he couldn’t deny what was said in the recording. Mr. Moore stated he responded inappropriately and should have taken a step back from the situation.

Ms. Smith then interviewed Mr. Zamarron by telephone. Mr. Zamarron stated Resident A was making inappropriate comments towards other residents, which was making them feel uncomfortable. Mr. Zamarron stated he was trying to calm Resident A down and redirect his behavior. Mr. Zamarron stated the only comment he recalls making was that when Resident A stated he was the strongest on campus, Mr. Zamarron told him he wasn’t the strongest on campus. Mr. Zamarron stated he was unaware Resident A was recording the conversation.

On 01/02/2023, 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 will be submitted.

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 11/03/2023, a complaint was received alleging facility staff Shae Moore and JD Zamarron called Resident A names. Program manager Brandi Moore and administrator Heather Burnell both reported the Wayne County Office of Recipient Rights substantiated the investigation. Katie Smith from Wayne County ORR interviewed both Mr. Moore and Ms. Zamarron. Both staff admitted to making inappropriate statements towards Resident A. Based on the investigation findings, there is sufficient evidence to support a rule violation that staff mistreated Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/02/2024

Megan Aukerman Date
Licensing Consultant

Approved By:

01/02/2024

Jerry Hendrick Date
Area Manager