GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 10, 2025

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

RE: License #: AS340379256
Investigation #: 2025A0464010
Westlake VIII

Dear Mr. Pelletier:

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 PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS340379256
Investigation #:	2025A0464010
Complaint Receipt Date:	11/12/2024
Investigation Initiation Date:	11/12/2024
Report Due Date:	01/11/2025
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:	Andre Pelletier
Licensee Designee:	Andre Pelletier
Name of Facility:	Westlake VIII
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:	04/14/2024
Expiration Date:	04/13/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/10/2024, staff Alexis Cherpes pushed Resident A and then became verbally aggressive.	Yes

III. METHODOLOGY

11/12/2024	Special Investigation Intake 2025A0464010
11/12/2024	APS Referral
11/12/2024	Special Investigation Initiated - Telephone Vicki Pohl, Ionia County APS
11/20/2024	Inspection Completed On-site Brandi Moore (Program Manager), Leah Drake (Staff), Resident A
11/20/2024	Contact-Telephone call made Alexis Cherpes, Staff
01/08/2025	Contact-Telephone call made Alexis Cherpes, Staff
01/08/2025	Inspection Completed-Onsite Andre Pelletier (Licensee Designee), Brandi Moore (Program Manager)
01/10/2025	Exit Conference Andre Pelletier, Licensee Designee

ALLEGATION: On 11/10/2024, staff Alexis Cherpes pushed Resident A and then became verbally aggressive.

INVESTIGATION: On 11/12/2024, I received a complaint from Adult Protective Services (APS) alleging that on 11/10/2024, staff Alexis Cherpes pushed Resident A out of the way, while she was trying to get to the bathroom. Resident A reported the incident. Ms. Cherpes then started “bullying” Resident A for reporting the incident. Resident A did not sustain any injuries from the alleged incident.

On 11/12/2024, I exchanged emails with Ionia County Adult Protective Services (APS) worker, Vicky Pohl to coordinate the investigation.

On 11/20/2024, I completed an onsite inspection at the facility and interviewed program manager, Brandi Moore. Mrs. Moore stated the incident was reported to

her by Resident A. Mrs. Moore stated Ms. Cherpes abruptly quit working at the facility.

I then interviewed Resident A, privately. Resident A was observed to be clean and appropriately dressed. She had no observable marks or bruises. Resident A reported that during the incident she had to go to the bathroom. Ms. Cherpes was also trying to get into the bathroom. Resident A reported she was using the staff bathroom. Ms. Cherpes then pushed Resident A out of the way, so that she could get into the bathroom. Resident A stated she hurt her hip on the bathroom counter. Resident A stated that when Ms. Cherpes pushed her out of the way, she told Resident A, “get out of the fucking way”. Resident A denied anyone had witnessed the incident. Resident A denied anything like this has happened before.

I then interviewed staff, Leah Drake about the incident. Ms. Drake stated she was working with Ms. Cherpes the day of the incident; however, she did not witness it. Ms. Drake stated the incident was reported to her by Resident A. Ms. Drake stated she asked Ms. Cherpes about the incident and Ms. Cherpes denied pushing Resident A. Ms. Drake denied witnessing Ms. Cherpes treat Resident A or any other resident poorly.

On 11/20/2024, I attempted to contact Ms. Cherpes by telephone. A voice message was left requesting a return phone call.

On 01/08/2025, I completed an onsite inspection at the facility. I met with licensee designee, Andre Pelletier. Mr. Pelletier denied witnessed the incident and stated the incident was reported to him, by staff. Mr. Pelletier confirmed Ms. Cherpes no longer works at the facility.

On 01/08/2025, I attempted to contact Ms. Cherpes by telephone. A voice message was left requesting a return phone call.

On 01/10/2025, I completed an exit conference with Mr. Pelletier. He was informed of the investigation findings and recommendations and agreed to submit a corrective action plan.

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 11/12/2024, a complaint was received alleging staff, Alexis Cherpes pushed Resident A and then harassed her for reporting the incident. On 11/20/2024 and 01/08/2025, onsite inspections were completed at the facility. Licensee designee, Andre Pelletier and program manager, Brandi Moore both confirmed Ms. Cherpes quit working at the facility after the alleged incident. Both denied witnessing the incident, but stated it was reported to them by staff. Resident A was interviewed and reported Ms. Cherpes yelled at her and pushed her out of the way, when she was trying to get to the restroom. Resident A denied anything similar had occurred in the past. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Cherpes pushed and used profanity towards Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/10/2025

Megan Aukerman Date
Licensing Consultant

Approved By:

01/10/2025

Jerry Hendrick Date
Area Manager