GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 20, 2025

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

RE: License #: AS340305684
Investigation #: 2025A0464021
Westlake Cottage III

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

I. IDENTIFYING INFORMATION

License #:	AS340305684
Investigation #:	2025A0464021
Complaint Receipt Date:	01/22/2025
Investigation Initiation Date:	01/22/2025
Report Due Date:	03/23/2025
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 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:	01/05/2024
Expiration Date:	01/04/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/20/2025, staff Todd Patrick physically assaulted Resident A.	Yes

III. METHODOLOGY

01/22/2025	Special Investigation Intake 2025A0464021
01/22/2025	APS Referral
01/22/2025	Special Investigation Initiated - Telephone Vicki Pohl, Ionia County APS
01/31/2025	Inspection Completed On-site Brandi Moore (Program Manager), Todd Patrick (Staff) and Brook Warner (Staff)
03/20/2025	Contact-Telephone call made Joe Jensen, Staff
03/20/2025	Exit Conference Andre Pelletier, Licensee Designee

ALLEGATION: On 01/20/2025, staff Todd Patrick physically assaulted Resident A.

INVESTIGATION: On 01/22/2025, I received a complaint from Adult Protective Services (APS), which alleged that staff, Todd Patrick was using unnecessary physical force and verbal aggression while redirecting Resident A. Resident A was attempting to pinch Mr. Patrick. As a result, Mr. Patrick forcefully grabbed Resident A's arm and pushed him away.

On 01/22/2025, I exchanged emails with Ionia County APS worker, Vicki Pohl to coordinate the investigation.

On 01/31/2025, I completed an unannounced, onsite inspection at the facility. I interviewed facility program manager, Brandi Moore. Mrs. Moore stated Resident A is diagnosed with Autism and is nonverbal. Mrs. Moore denied witnessing the incident between Mr. Patrick and Resident A, but stated it was reported to her by staff. Mrs. Moore denied Mr. Patrick had any past employee disciplinary issues. She stated he does very well with the residents. Mrs. Moore explained that due to the nature of the allegations, Mr. Patrick is currently suspended until the investigation is complete.

I then interviewed Mr. Patrick. Mr. Patrik stated Resident A becomes very aggressive towards staff and will often try to hit and pinch staff. Mr. Patrick stated on 01/20/2025, he was sitting down in a chair. Resident A became agitated, as he often does. Resident A went up to Mr. Patrick and began screaming and yelling. He then proceeded to pinch Mr. Patrick, breaking the skin. Mr. Patrick stated he spoke to Resident A in a calm voice and put his hand on Resident A's elbow to redirect him. Mr. Patrick denied using physical or verbal aggression towards Resident A. Mr. Patrick denied witnessing other staff use physical or verbal aggression towards Resident A.

I then interviewed staff, Brook Warner. Ms. Warner stated she was working with Mr. Patrick the day of the incident. She stated Resident A was agitated and was trying to pinch Mr. Patrick. Ms. Warner witnessed Mr. Patrick become agitated with Resident A and yelled at Resident A to stop pinching him. She then witnessed Mr. Patrick shove Resident A away from him. Ms. Warner felt Mr. Patrick was too aggressive with Resident A. Ms. Warner stated staff, Joe Jensen also witnessed the incident and had a conversation with Mr. Patrick. He told Mr. Patrick he used excessive force towards Resident A.

On 03/20/2025, I spoke to staff, Joe Jensen by telephone. Mr. Jensen stated that he worked with both Ms. Warner and Mr. Patrick the day of the incident. Mr. Jensen denied witnessing Mr. Patrick shove Resident A, but stated he did witness Mr. Patrick become irritated and yell at Resident A. Mr. Jensen stated Mr. Patrick appeared to be in a "pissy mood that day".

On 03/20/2025, I completed an exit conference with licensee designee, Joe Jensen. He was informed of the investigation findings and recommendations. A corrective action plan will be submitted to licensing.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	On 01/22/2025, a complaint was received alleging staff Todd Patrick used excessive physical force and verbal aggression towards Resident A. Resident A was not interviewed as he is nonverbal. Staff Brooke Warner was interviewed and stated she witnessed Mr. Patrick shove Resident A. Staff Joe Jensen was interviewed

	and reported he witnessed Mr. Patrick irritated with Resident A and yell at him. Mr. Patrick was interviewed and denied the allegation. Based on the investigative findings, there is sufficient evidence to support a rule violation that Mr. Patrick used excessive physical force towards Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

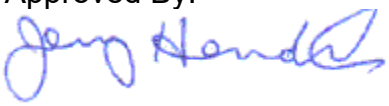
IV. RECOMMENDATION

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

03/20/2025

Megan Aukerman Date
Licensing Consultant

Approved By:



03/20/2025

Jerry Hendrick Date
Area Manager