GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 26, 2025

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

RE: License #: AS340379256
Investigation #: 2025A0357033
Westlake VIII

Dear Mrs. Pena, Mr. Pelletier:

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) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS340379256
Investigation #:	2025A0357033
Complaint Receipt Date:	04/13/2025
Investigation Initiation Date:	04/13/2025
Report Due Date:	06/12/2025
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:	Megan Pena/Aandre Pelletier
Licensee Designee:	Megan Pena/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?
Resident A reported that staff Brittany Linsley put her hands around her neck and twisted her arms behind her back. Resident A does not like staff at Hope Network Westlake because they are mean.	No

III. METHODOLOGY

04/13/2025	Special Investigation Intake 2025A0357033 Department of Health and Human Services, Kent County, Adult Protective Services Denied the complaint. Therefore, I did not make a referral to APS, because it came from them,
04/13/2025	Special Investigation Initiated - Telephone Licensing Consultant who has the home, Megan Aukerman, and discussed the case. She provided me with the name of the contact Brandi Moore.
04/13/2025	Contact - Document Sent I sent an email to Brandi Moore and it came back undeliverable.
05/14/2025	Contact - Document Sent I sent Brandi Moore an email and it came back undeliverable.
06/25/2025	Contact - Telephone call made Telephoned the facility and there was no answer.
07/28/2025	Contact - Document Sent Email sent to Brandi Moore, and it was undeliverable.
08/14/2025	Inspection Completed On-site Unannounced inspection. Met with Will K. Dawdy, BA, SST. Case Manager for Resident A, from Hope Network.
08/14/2025	Contact - Document Received Mr. Dawdy provided me with copies of Resident A's Individual Plan of Service and Functional Behavior Assessment which I reviewed.
08/14/2025	Contact - Face to Face With Resident A's Case Manager from Hope Network, Will Dawdy.
08/14/2025	Contact - Face to Face

	With Direct Care Staff, Brittany Linsey.
08/22/2025	Contact - Telephone call made With Resident A's guardian/Aunt, Tina Edwards.
08/26/2025	Telephone exit conference with the Licensee Designee.

ALLEGATION: Resident A reported that staff Brittany Linsley put her hands around her neck and twisted her arms behind her back. Resident A does not like staff at Hope Network Westlake because they are mean.

INVESTIGATION: On 04/13/2025, I contacted Megan Aukerman, the Licensing Consultant assigned to Westlake. She provided the contact person as Brandi Moore with the email address. I attempted to reach Ms. Moore but the email was returned as undeliverable.

On 08/14/2025, I made an unannounced inspection of the home. I met Will Dawdy who explained that he has been Resident A's Hope Network Case Manager. He explained that Resident A was admitted to the home on 07/31/2024. He explained that Resident A is 20 years old and was diagnosed with schizoaffective disorder-bipolar type, autistic disorder, post-traumatic stress disorder (unspecified), attention-deficit hyperactivity disorder, sexual abuse and significant history of trauma. She had been referred to Hope Network-West Lake from Bay Arenac Behavioral Health Services. He reported that Resident A had had many psych hospitalizations in her history, typically due to not taking her medications, which resulted in increased symptoms and behaviors. She was most recently hospitalized at Bay Arenac Behavioral Health for 63 days before being discharged to Westlake. Mr. Dawdy reported that Resident A does not tell the truth and makes things up. He said it was hard to tell the truth from fiction and her story changes very often.

On 08/14/2025, I conducted a face-to-face interview with Direct Care Staff, Brittany Linsley. She stated that Resident A asked her for a hug and Resident A would not let her go. She prompted her to let go and said: 'Please let me go.' She said she told Resident A several times to let her go but she would not, so she implemented a "wrist release." She said she had her arms and hands out in front of her, and her hands were not touching Resident A. She stated that Resident A would not listen to her, and she would not follow directions. Ms. Linsley said: "I did not hurt her." Ms. Lindsey stated that Resident A made false allegations towards the staff. She stated that Resident A made false accusations with every employee that worked with her. She said she would embellish, and she would have grains of truth in her statement. Ms. Linsley stated that Resident A had a behavioral treatment plan, and she followed it. She stated that Resident A was not a good communicator. Staff would offer to assist her, and she would get so upset and the other residents would be angry at how she reacted. I asked Ms. Linsley if she had ever put her hands around

Resident A's neck or twisted her arms behind her back. She denied the allegation and she would never hurt Resident A.

On 08/14/2025, I reviewed Resident A's Individual Plan of Service effective date 08/30/2024. This document read that Resident A was scheduled for brain surgery on 01/20/2025 to remove a cancerous brain tumor. "During recovery, she will require enhanced staff support as she won't be able to bring her head past her heart or lift anything heavier than a gallon of milk. Therefore, it's recommended that Resident A receive 1:1 staffing for up to 16 hours a day during waking hours for 4-6 weeks post-surgery." The document went on to report that she was scheduled for a second surgery on 02/28/2025 to remove a cancerous brain tumor. Again, they planned for enhanced staff support. Then Resident A would undergo radiation treatment for six weeks. "Given the intensity of radiation treatment and appointments, it's recommended that (Resident A) have 8 hours of 1:1 staffing on 1st shirt (6am-2pm) once radiation treatment begin."

On 08/22/2025, I telephoned Resident A's guardian. She reported that she is Resident A's guardian and Aunt. I asked her about the allegation of staff having their hands around her neck and pulling her arms around her back and she stated "(Resident A) is my niece and she exaggerates and lies, and she has done this her whole life. She likes to get people in trouble. No one has hit her or hurt her. She is in a locked home now at Flat Rock."

On 08/26/2025, I conducted a telephone exit conference with the Licensee Designee, and he agreed with my findings.

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.
	Resident A reported that staff Brittany Linsley put her hands around her neck and twisted her arms behind her back. Resident A does not like staff at Hope Network Westlake because they are mean. Direct Care Staff, Brittany Linsley denied that she had put her hands around Resident A's neck and she denied that that she had put Resident A's arms behind her back. Will Dawdy, Resident A's case manager, reported that Resident A does not tell the truth, and her story changed very often.

	Resident A's guardian/aunt reported that Resident A exaggerates and lies and likes to get people in trouble, and she has not been hit and no one hurt her. During this investigation I did not find evidence that Direct Care Staff, Brittany Linsley put her hands around Resident A's neck or twisted her arms behind her back. Therefore, there is no violation of the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend the complaint be closed and the license remains the same.

Arlene B. Smith 08/26/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 08/26/2026

Jerry Hendrick Date
Area Manager