STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2026

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

RE: License #: AS340379256
Investigation #: 2026A0464033
Westlake VIII

Dear Mrs. Herzhaft:

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) 356-0100.

Sincerely,

Megan Leavitt, LMSW

Megan Leavitt, 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 #:	AS340379256
Investigation #:	2026A0464033
Complaint Receipt Date:	01/09/2026
Investigation Initiation Date:	01/09/2026
Report Due Date:	03/10/2026
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:	Stephanie Herzhaft
Licensee Designee:	Stephanie Herzhaft
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 01/02/2026, staff Shaila Peterson yelled at Resident A.	Yes
On 01/02/2026, Ms. Peterson failed to provide one-on-one supervision to Resident A, creating a safety risk.	Yes

III. METHODOLOGY

01/09/2026	Special Investigation Intake 2026A0464033
01/09/2026	Special Investigation Initiated - Telephone Michelle Richardson, ORR
01/09/2026	APS Referral Referral Came From APS
02/11/2026	Inspection Completed On-site Brandi Moore, Program Manager
02/11/2026	Contact - Document Received ORR Report
03/02/2026	Inspection Completed-BCAL Sub. Compliance
03/02/2026	Exit Conference Stephanie Herzhaft, Licensee Designee

ALLEGATION: On 01/02/2026, staff Shaila Peterson yelled at Resident A.

INVESTIGATION: On 01/09/2026, I received a complaint from Adult Protective Services (APS), which alleged Resident A requires one-to-one staff supervision. On 01/02/2026, Shayla Peterson failed to provide one-to-one supervision for Resident A. Additionally, it was reported that Ms. Peterson spoke to Resident A in a demeaning manner. APS did not assign the complaint for investigation.

On 01/09/2026, I exchanged emails with Network 180's Office of Recipient Rights (ORR) director, Michelle Richardson. Ms. Richardson reported Resident A is one of their contracted residents; therefore, Ashton Byrne will investigate the complaint.

On 02/11/2026, I received and reviewed the incident report (IR) completed and signed by staff, Chaise Schumacher. The IR noted on 01/02/2026 around 2:45 PM,

Shayla Peterson kept telling Resident A she needed to turn her music down. After multiple times asking Resident A to turn her music down, Ms. Peterson then grabbed Resident A's phone from her and said the music was not turned down enough. Mr. Schumacher documented that Ms. Peterson made the comments in a very demeaning manner. Mr. Schumacher also stated that Ms. Peterson failed to provide one-to-one staff supervision during her shift.

On 02/11/2026, I completed an onsite inspection at the facility and interviewed program manager, Brandi Moore. Mrs. Moore reported Resident A was not home. Mrs. Moore stated she did not witness the incidents; however, they were reported to her. Mrs. Moore reported Network 180, Office of Recipient Rights investigated the complaint and substantiated their findings. As a result, Ms. Peterson received a write up.

On 02/11/2026, I received and reviewed a copy of Ms. Byrne's investigation. On 01/08/2026, Ms. Byrne interviewed Resident A. She reported Resident A was very distracted and could not recall if Ms. Peterson treated her poorly. That same day Ms. Byrne also interviewed Resident B, who witnessed the incident. Resident B reported that Ms. Peterson took away Resident A's phone and spoke "very mean" to her.

The report reflected on 01/05/2026, Ms. Byrne interviewed staff Sheila Hawkins. Ms. Hawkins reported she was working with Ms. Peterson on 01/02/2026. Ms. Hawkins reported that Ms. Peterson was becoming very agitated with Resident A for how loud her music was playing on her cell phone. Ms. Hawkins then witnessed Ms. Peterson talk to Resident A in an "irritable and uncalled for" way, then proceeded to snatch Resident A's phone out of her hand.

The report also reflected that Ms. Byrne interviewed Ms. Peterson on 01/16/2026, by telephone. Ms. Peterson stated on 01/02/2026 she was suffering from a migraine. Ms. Peterson reported she politely asked Resident A to give her the phone, so she could turn down Resident A's music. Ms. Peterson denied she spoke to Resident A in a demeaning manner.

On 03/02/2026, an exit conference was completed with licensee designee, Stephanie Herzhaft. She was informed of the investigation findings and recommendations. A corrective action plan will be submitted to licensing.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.

ANALYSIS:	On 01/09/2026, a complaint was received alleging staff, Shayla Peterson, spoke to Resident A in a rude, demeaning manner. Program manager, Brandi Moore, reported Ms. Peterson was written up, following the substantiation of the Recipient Rights investigation. Network 180 Office of Recipient Rights report reflected Resident A was interviewed; however, she could not recall Ms. Peterson treating her poorly. The report did reflect that two witnesses, staff Shaila Hawkins and Resident B observed Ms. Peterson talk to Resident A in a demeaning manner, then snatch Resident A's cell phone out of her hand. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Peterson mistreated Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 01/02/2026, Ms. Peterson failed to provide one-on-one supervision to Resident A, creating a safety risk.

INVESTIGATION: On 02/11/2026, I completed an onsite inspection at the facility. I interviewed program manager, Brandi Moore. Mrs. Moore reported Resident A was not present in the home. Mrs. Moore stated she did not witness the incidents; however, they were reported to her. Mrs. Moore reported Network 180, Office of Recipient Rights investigated the complaint and substantiated their findings.

On 02/11/2026, I received and reviewed a copy of Ms. Byrne's investigation. On 01/08/2026, Ms. Byrne interviewed Resident A. Resident A reported she is allowed to walk around the facility without her one-to-one staff. Resident A could not recall who was assigned to her on 01/02/2026.

The report reflected Ms. Byrne interviewed Ms. Hawkins on 01/05/2026, by telephone. Ms. Hawkins reported that Ms. Peterson was assigned to be Resident A's one-to-one staff person on 01/02/2026. Ms. Hawkins reported throughout their shift Ms. Peterson failed to keep Resident A in her line of sight. Ms. Peterson allowed Resident A to go into a peer's room, the laundry room, bathroom and the common room, all without line-of-sight supervision.

Ms. Byrne interviewed Ms. Peterson on 01/16/2026. Ms. Peterson reported she had a terrible migraine on 01/02/2026. She stated even though she did not feel well she did in fact have Resident A in her line of sight her entire shift.

On 02/11/2026, I received and reviewed a copy of Resident A's behavior plan completed on 04/2025. The report reflected Resident A requires one-to-one staff supervision, twenty-four hours a day. Staff must always have Resident A in their line of sight.

On 03/02/2026, an exit conference was completed with licensee designee Stephanie Herzhaft. She was informed of the investigation findings and recommendations. A corrective action plan will be submitted to licensing.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	On 01/09/2026, a complaint was received, alleging staff, Shayla Peterson failed to provide one-to-one staff supervision to Resident A on 01/02/2026. Program manager, Brandi Moore denied witnessing the incident; however, she reported the Office of Recipient Rights substantiated the investigation. Network 180 Office of Recipient Rights reflected Resident A was interviewed; however, she reported she was allowed to freely walk around the facility. Staff, Sheila Hawkins reported she was working with Ms. Peterson on 01/02/2026. Ms. Hawkins witnessed Ms. Peterson failing to provide Resident A one-to-one staff supervision. Ms. Peterson was interviewed and denied the allegations. Resident A's Behavior Plan reflected Resident A always requires one-to-one staff supervision. Staff must always have Resident A in their line of sight. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff failed to provide one-to-one staff supervision for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Megan Leavitt, LMSW 03/02/2026

Megan Leavitt Date
Licensing Consultant

Approved By:

03/02/2026

Jerry Hendrick Date
Area Manager