GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 23, 2026

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

RE: License #: AS340379256
Investigation #: 2026A0464060
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 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, 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 #:	2026A0464060
Complaint Receipt Date:	08/14/2026Megan Pena, Designee
Investigation Initiation Date:	08/14/2026
Report Due Date:	10/13/2026
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 301-8000
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:	04/14/2026
Expiration Date:	04/13/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 08/09/2026, facility staff used excessive force to move Resident A, resulting in bruises on her bicep.	Yes

III. METHODOLOGY

08/14/2026	Special Investigation Intake 2026A0464060
08/14/2026	APS Referral
08/14/2026	Special Investigation Initiated - Telephone Michelle Richardson, ORR
08/27/2026	Inspection Completed On-site Brandi Moore (Program Manager), Deise Moles (Staff), Jamie Lewis (Staff) and Resident A
09/23/2026	Exit Conference Stephanie Herzhaft, Licensee Designee

ALLEGATION: On 08/09/2026, facility staff used excessive force to move Resident A, resulting in bruises on her bicep.

INVESTIGATION: On 08/14/2026, I received a complaint from Adult Protective Services (APS), which stated on 08/09/2026, two unknown staff members conducted a two-person assist to move Resident A back into the facility. The two staff used excessive force to move Resident A, resulting in bruising on her biceps. Resident A is diagnosed with schizoaffective disorder, bipolar disorder, intellectual disability, obstructive pulmonary disease and prediabetic.

On 08/14/2026, I contacted Network 180's Office of Recipient Rights (ORR) director, Michelle Richardson. She reported Resident A is not one of their residents; therefore, they will not be investigating the complaint.

On 08/27/2026, I completed an onsite inspection at the facility. I interviewed program manager Brandi Moore. Mrs. Moore reported she did not witness the incident; however, it was reported to her. Mrs. Moore reported staff, Denise Moles is one of the staff who assisted Resident A on 08/09/2026. Mrs. Moore reported she is currently suspended, pending the investigation. Mrs. Moore reported she met with Resident A the day the incident was reported and noticed bruising on her bicep.

I then interviewed Ms. Moles. She reported she was working on 08/09/2026. Ms. Moles reported Resident A was by the gym and refusing to return to the facility. Ms. Moles stated she went to Resident A to try to calm her down and redirect her back to

the facility. Eventually, Ms. Moles was able to get Resident A back to the facility, but then Resident A refused to go inside. Ms. Moles reported staff Jamie Lewis then came outside to assist with getting Resident A inside the facility. Ms. Moles reported she was on one side of Resident A and Ms. Lewis was on the other. She reported they held Resident A's arms and guided her back into the facility. Ms. Moles denied using excessive force. Ms. Moles denied Resident A was exhibiting aggressive or violent behaviors.

I then interviewed Ms. Lewis. Ms. Lewis reported she was also working on 08/09/2026 when she heard Resident A screaming and walking outside. Ms. Lewis reported she went outside to assist Ms. Moles with getting Resident A back inside the facility as it was starting to get late. Ms. Lewis reported she assisted Ms. Moles with a two-person assist, guiding Resident A back into the facility. Ms. Lewis denied excessive force was used. She reported Resident A told them that they hurt her arm, but Ms. Lewis did not notice any bruising.

I then interviewed Resident A. Resident A reported that a month ago she was walking outside when "Denise" came outside and made her go inside the facility. Resident A reported staff hurt her arm and left bruises. Resident A reported she showed another staff member the bruise. Resident A then lifted her sleeves. I observed a faint, quarter-sized bruise on Resident A's left bicep.

On 09/23/2026, I completed an exit conference with licensee designee, Stephanie Herzhaft. I informed her of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(a) Use any form of punishment.**
ANALYSIS:	On 08/14/2026 a complaint was received alleging staff used excessive force with Resident A, resulting in Resident A sustaining bruising on her bicep. Staff Denise Moore and Jamie Lewis both reported that on 08/09/2026, Resident A was outside, refusing to go inside; therefore, they conducted a two-person staff assist to get Resident A back inside the facility. Both denied they used excessive force. Ms. Lewis reported Resident A did complain her arm hurt but she did not observe any bruises. Program Manager, Brandi Moore reported she noticed bruising on Resident A's bicep.

	Resident A reported Ms. Moore hurt her arm and left bruising. A faint, quarter-size bruise was observed on Resident A's left bicep. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff used excessive force on Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

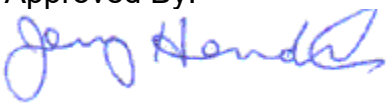
Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.



09/23/2026

Megan Leavitt Date
Licensing Consultant

Approved By:



09/23/2026

Jerry Hendrick Date
Area Manager