GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

09/12/2022

Tracey Hamlet
MOKA Non-Profit Services Corp
Suite 201
715 Terrace St.
Muskegon, MI 49440

RE: License #: AS700252511
Investigation #: 2022A0357028
Ferris Street Home

Dear Ms. Hamlet:

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,

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 #:	AS700252511
Investigation #:	2022A0357028
Complaint Receipt Date:	07/14/2022
Investigation Initiation Date:	07/14/2022
Report Due Date:	09/12/2022
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(231) 830-9376
Administrator:	Tracey Hamlet
Licensee Designee:	Tracey Hamlet
Name of Facility:	Ferris Street Home
Facility Address:	17189 Ferris Street Grand Haven, MI 49417
Facility Telephone #:	(616) 850-0449
Original Issuance Date:	11/01/2002
License Status:	REGULAR
Effective Date:	05/20/2021
Expiration Date:	05/19/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Kailey Morgan, was driving the van when she lost control and had an accident. Two residents were in the van at the time of the accident.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/14/2022	Special Investigation Intake 2022A0357028
07/14/2022	APS was not contacted because the original complaint came from APS and they had denied the complaint.
07/14/2022	Special Investigation Initiated - Telephone With the Home Supervisor, William (Frank) Grotenhuis on 07/13/2022.
07/14/2022	Contact - Telephone call made Telephone interview with the Home Manager, Frank Grotenhuis. I requested pass Incident/Accident Reports and received them on 07/13/2022.
07/14/2022	Contact - Document Received On 07/13/2022, Mr. Frank Grotenhuis sent me the following documents: IR on Resident A, IR dated 06/21/2022 on Resident A, Traffic Ticket on Kailey Morgan (Direct Care Staff), Traffic Crash Report, and IR.
07/15/2022	Contact - Document Received Additional information from BCAL, Online Complaints.
07/15/2022	Contact - Telephone call made To Recipient Rights, Ottawa County CMH.
07/26/2022	Contact - Telephone call made Recipient Rights, Ottawa County CMH.
08/09/2022	Contact - Telephone call made To Brianna, CMH for Ottawa County.
09/08/2022	Contact - Telephone call made Conducted a phone interview with Frank Grotenhuis, Home Manager and Direct Care Staff, Alisha Ramthun. Mr. Grotenhuis

	reported that the staff involved in the accident, Kailey Nicole Morgan had been terminated by MOKA.
09/08/2022	Contact – Telephone call made To Tracey Thorns, Property Manager for MOKA.
09/12/2022	On 06/03/2022, I conducted a telephone exit conference with the Licensee Designee, Tracey Hamlet.

ALLEGATION: Direct Care Staff, Kailey Morgan was driving the van when she lost control and had an accident. Two residents were in the van at the time of accident.

INVESTIGATION: On 07/13/2022 I conducted a telephone interview with Frank Grotenhuis, Home Manager and he stated he would call Centralized Intake concerning the accident with the company van. He reported that he had worked the first shift and that Ms. Kailey Morgan arrived to work her second shift (2:30 PM). He reported that Ms. Morgan looked tired. He asked her "what's up," and she reported that she was up most of the night and had not slept well. He said that her obvious tiredness did not register with him, and she thought she could work her shift. He stated that MOKA had a copy of her valid driver's license in her personal file and to his knowledge she had no history of driving issues known to MOKA prior to this accident. He stated he had not heard any complaints about her work with the residents in fact she was appreciated by her fellow staff members. He reported that upon their internal investigation, the new GPS system indicated that Ms. Morgan was swerving on the road by crossing the center line several times before she had the accident. Mr. Grotenhuis stated that neither Resident A or Resident B could have a conversation with me because of their cognitive disabilities. He said there were no other witnesses.

On 07/13/2022, I received the Incident/Accident Reports (IR) from Mr. Grotenhuis. I reviewed the IR on Resident A dated 06/04/2022, at 11:00AM. The document read as follows: *'Kailey Morgan took (Resident A) and another housemate on a van ride (6/3/22) when she lost control of the vehicle and went the side [sic] of the road. No one appeared to be injured.'* Action Taken by staff/treatment given*: 'As a follow-up we went to the NOCH (North Ottawa Community Hospital) to get checked out. We ended up coming back home due to a 4 hour wait in the ER (Emergency Room). Resident A was sore on Saturday morning. Staff gave her Tylenol and will continue to monitor her heath.'* Corrective measures taken: *'We will continue to ensure driver safety at all times when operating our vehicles. We will follow up with medical providers if pain or injury is noted or worsens.'*

On 07/14/2022 our department received a complaint from BCAL Online Complaints. Adult Protective Services of Kent County denied the complaint. The complaint read that Resident A was on a van ride on 06/03/2022 at 3:15 PM, about 2.5 to 3 miles

from the AFC home. Kailey Morgan, direct care staff lost control of the van causing it to go off the road. As the van crossed the road against traffic on the opposite lane, they went up an embankment and the van ran over an apartment complex sign and came to a stop. Law enforcement was on the scene. Mr. Grotenhuis, Home Manager, arrived and asked Ms. Morgan if she had fallen asleep, which she denied. She was not able to explain why the accident occurred. The residents appeared to be stable. Ms. Morgan did not have her driver's license with her, and she was aware of this when she initially got into the van to transport two of the Residents. Ms. Morgan appeared to be tired on her shift. She received a ticket for reckless driving. MOKA completed an internal investigation where they referred to their navigation system and they found Ms. Morgan had been weaving in and out of the lane several times before the accident. The van was checked out for any faulty issues with the functioning of the van and the van had been used a few times prior. Ms. Morgan was terminated by MOKA. Residents A and B were taken to North Ottawa Community Hospital, Emergency Room from 5:15 PM to 9:45PM without being seen by any medical staff. Mr. Grotenhuis was with the two residents, and he decided to take the two residents back to the AFC home so they could receive their supper meal and their medications, and he planned to seek treatment in the morning and guardians were notified. Resident A's Guardian had planned to pick her up in the morning of 06/04/2022, and take Resident A to her primary care physician on 06/06/2022. Her physician prescribed some ibuprofen to help with pain. Resident A could not be interviewed due to her cognitive impairment. On 06/20/2022, Resident A seemed "off" and was taken back to her physician who ordered and completed a CT scan, and they found a compound fracture of one vertebra. She was taken to Savory Pain Institute on 06/22/2022 and they administered a trans formal injection. She will have a follow-up on 07/20/2022.

On 07/15/2022, BCAL Online Complaints sent our department more information for the original intake. This additional information was related to Resident B. The complaint contained the same information concerning the van accident as presented above. On 06/03/2022, after waiting for four hours and not being seen Mr. Groetenhuis took her back to the AFC. On 06/04/2022, in the morning Resident B was taken to Spectrum Health Pointe in Grand Haven and found to have no injuries.

On 07/14/2022 I reviewed the 'State Of Michigan Traffic Crash Report,' that was sent on 07/13/2022. This document reported the Crash Date as 06/03/2022 at 15:06. Primary Road 168th Ave., Intersecting Road Name, Comstock St. Driver's condition appeared normal. The 2019 Ford van was disabled and had to be towed. The driver of the van was recorded as Kailey Morgan. Both Residents A and B were listed as in the van. The Narrative read as follows: *'Driver of vehicle # 1 said she was traveling n/b on 168th just north of Comstock when she started to get tired. Driver of vehicle # 1 said the vehicle went off the roadway and into the yard of Piper Lakes Apartments when she noticed what was happening. Driver of vehicle # 1 said she attempted to hit the brakes but it was too late and struck a large sign in the lawn. Driver # 1 said the van continued over a ditch where it came to a stop in the lawn of R-Stor Lock.'* This document illustrated pictures of small vehicles showing the path that the vehicle

had taken and it shows/demonstrates that the van was crossing over the center line of the oncoming traffic, but there were no cars in that oncoming lane.

On 07/14/2022, I reviewed the Uniform Law Citation for Ms. Morgan that I had received on 07/13/2022. Ms. Morgan was given a ticket for: *'Drove left of Center and No Operators License on Person.'*

On 07/14/2022, I reviewed Incident/Accident Report (IR) from Mr. Grotenhuis that I had received on 07/13/2022. The IR on Resident A was dated 06/04/2022, at 11:00AM. The document read as follows: *'Kailey Morgan took (Resident A) and another housemate on a van ride (6/3/22) when she lost control of the vehicle and went the side [sic] of the road. No one appeared to be injured.'* Action Taken by staff/treatment given*: 'As a follow-up we went to the NOCH (North Ottawa Community Hospital) to get checked out. We ended up coming back home due to a 4 hour wait in the ER (Emergency Room). (Resident A) was sore on Saturday morning. Staff gave her Tylenol and will continues to monitor her heath.'* Corrective measures taken: *'We will continue to ensure driver safety at all times when operating our vehicles. We will follow up with medical providers if pain or injury is noted or worsens.'*

On 07/14/2022, I reviewed the Incident/Accident Report from Mr. Grotenhuis that I had received on 07/13/2022. The IR was on Resident B, dated 06/04/2022 at 11:00 AM. The document read as follows: *'Kailey Morgan took (Resident B) and a housemate out on a van ride (6/3022). While on the outing, Kailey lost control of the van and went off the side of the road. There were no apparent injuries. No marks or cuts.'* Action taken by staff/treatment given: *'As a precaution the ladies were taken to NOCH ER for a follow-up. After 4 hours, we decided to leave. (Resident B) was monitored through the night and has resumed her Saturday morning routine without any issues.'* Corrective measures taken: *'We will continue to work with drivers to enforce safe driving practices. We will follow up with medical provider if pain or injury is noted.'*

On 07/14/2022 I reviewed the IR sent on 07/13/2022, on Resident A. The date was recorded as 06/21/2022. The IR read as follows: *'(Resident A's) mom called and said that (Resident A) has a compression fracture and she needed a high rise toilet seat per doctor, she also said that (Resident A) needs a CAT Scan and will need to go to a spine clinic soon!'* Corrective Measure Taken: *'X-ray results came back from (Resident A's) 6/20 follow-up appointment with Dr. Hoekstra. Mom said the x-rays showed a compression fracture in her vertebrae. For now, staff are to keep her comfortable, monitor her activity, and allow her to take time off of regular activities. CT scan will be set up and the house notified. We will be adding a toilet seat as well as a shower chair to help relieve possible back stress…'*

On 09/08/2022, I conducted a telephone interview with Mr. Grotenhouis. He stated that Resident A has been followed by the Savory Pain Institute and they were giving her pain shots. He stated that he could tell that Resident A was not comfortable

because she did not walk as well, and she did not sit in her chair as comfortable as before. He reported that they have encouraged her to use her walker in the home. I asked him about the afternoon of 06/03/2022. He stated that Ms. Morgan had forgotten her phone and she wanted to take the residents on a van ride, and she planned to stop and pick up her phone on the way. He also reported that after he brought the two residents back to the home from the Emergency Room, he went back to give Ms. Morgan a ride back to the AFC home where her car was. He said the Social Worker asked him to please see Ms. Morgan who was still in the ER. I asked for the name of the staff that worked with Ms. Morgan on 06/03/2022 and he reported there was no one working with her, but he said I could call the staff from first shift on 06/03/2022, Alisha Ramthun and she was working today. He reported that he understood that Resident A was in the far back seat and Resident B was in the front seat on the van.

On 09/08/2022, I called the AFC home and conducted a phone interview with Direct Care Staff, Alisha Ramthun. She reported that she has worked shifts with Ms. Morgan and that she is good to the residents and cares very much for them. She stated she works very hard and does a good job. I asked her about the afternoon of 06/03/2022. She stated that when she saw Ms. Morgan, “something was not right. She looked really tired and was not with it.” She said that Ms. Morgan had reported to her that she had she did not sleep and had called another staff member to work for her, but that staff could not work for her. Ms. Ramthun stated that Ms. Morgan did not call the Home Manager (Mr. Grotenhuis) to tell him how she was feeling. She continued to explain that Ms. Morgan had left her phone at home and was really wanting to pick it up. She reported that Ms. Morgan chose Resident A and Resident B to go on the van ride and she was planning to stop at her home to get her phone. Ms. Ramthun stated that she had learned that Resident A was in the far back seat of the van and Resident B was in the front seat which she said it should have been opposite. She wondered if that was the reason that Resident A was injured where most of the impact had occurred, and Resident B was not injured because she was in the front seat. She stated that she left the AFC home shortly after 2:30 PM when her shift ended on 06/03/2022.

On 09/08/2022, I conducted a telephone interview with Tracey Thorns, the Property Manager for MOKA. Ms. Thorns explained to me that they put a new GPS system called “Geo Tab” in their vehicles in February 2022, that allows them to monitor how fast the vehicle is going, where it is on the road and many other details of the staff driving including wearing the seat belts. She stated that she remembered upon their review that Ms. Morgan had crossed over the center line of the oncoming traffic, but there were no cars coming at the time when she had the accident. She was unsure about her weaving across the road including the center line before the accident.

On 09/08/2022, I reviewed again the Traffic Crash Report. This report indicated that Resident A was in the front middle seat and that Resident B was in the left side of the 4th. Row seat.

On 09/12/2022, I conducted a telephone exit conference with the Licensee Designee, Tracey Hamlet and she agreed with my finding.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(1) A licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household shall be in such physical and mental health so as not to negatively affect either the health of the resident or the quality of his or her care.
ANALYSIS:	On 06/03/2022, Ms. Kailey Morgan came to work on second shift at 2:30 PM and looked obviously tired to the Home Manager. He asked her what was up, and she said she was tired and had not slept well the night before, but she thought she could do her shift. Direct Care Staff, Alisha Ramthun who had worked the first shift on 06/03/2022 reported that Ms. Morgan had reported to her that she had not slept well the previous night. Ms. Ramthun stated Ms. Morgan “looked really tired and was not with it”. She stated Ms. Morgan had called another staff to work for her, but that person could not work. On 06/03/2022, Direct Care Staff, Kailey Morgan took Resident A and Resident B on a van ride, lost control of the van and had an accident. The Traffic Report stated that Ms. Morgan informed law enforcement that she started to get tired. During this investigation there was evidence that Ms. Kailey Morgan was not in good physical and mental health when she came to work on 2nd shift on 06/03/2022. She chose to take two residents on a van ride without her driver’s license and caused an accident while she was driving. Ms. Morgan received a ticket for driving left of center and not having an operator’s license on her person. The van had disabling damage and had to be towed away. Resident A was injured and found to have a compression fracture of a vertebrae.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.
ANALYSIS:	Direct Care Staff, Kailey Morgan came to work on 06/03/2022 after not sleeping the night before. She reportedly showed obvious signs of being tired. She came to work without her driver's license, and took two residents for a van ride. She lost control and crashed the van into a sign and over a ditch. During this investigation there was evidence that Ms. Morgan should not have been driving the van with so little sleep and not having her driver's license with her. Resident A and B's protection and safety were not attended to when they were transported in the home's van by Ms. Morgan, who had exhibited obvious signs that she should not be driving residents. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 07/13/2022, after I had learned there had been an accident, I called the Home Manger**,** Frank Grotenhuis. Mr. Grotenhuis confirmed that he had taken Resident A and Resident B to the hospital ER where they waited for four hours without being seen so he took the residents back to AFC home. He reported Resident A had subsequently seen her physician and then later on they sent her for a CT scan and x-rays and discovered she had been injured with a compression fracture in her vertebrae in her back. I asked Mr. Grotenhuis if he had completed the Incident/Accident reports for both residents and he stated that he did, but he did not remember to send them to the AFC Licensing Division. Mr. Grotenhuis apologized and said he would forward them to me. He also reported that he had not notified Recipient Rights about the accident or Resident A's injury.

On 09/12/2022, I conducted a telephone exit conference with the Licensee Designee, Tracey Hamlet and she agreed with my finding.

APPLICABLE RULE	
R 400. 143311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) (ii) Hospitalization,** **(a) (iv) Instances of destruction to property.**
ANALYSIS:	The adult foster care licensing division was not notified of the accident, the injury of Resident A or that the van, property of MOKA, had disabling damage. The IR's were completed, but were not sent to adult foster care licensing division until 07/13/2022 which was per my request.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: (a) The name of the person who was involved in the accident or incident. (b) The date, hour, place, and cause of the accident or incident. (c) The effect of the accident or incident on the person who was involved and the care given. (d) The name of the individuals who were notified and the time of notification. (e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.

	(f) The corrective measures that were taken to prevent the accident or incident from happening again.
ANALYSIS:	On 06/21/2022, Resident A was found with compression fracture in her vertebrae in her back. It was noted that she needed to go to a spine clinic and receive shots in her spine for pain. At the time of the accident (06/03/202) the Home Manager did not send us the required Accident record for Resident A who was involved in a van accident, was found injured, with all of the required information. We did receive the IR on 07/13/2022. Therefore, a violation to the rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION:

I recommend that the Licensee provide us with an acceptable plan of correction and the license remain the same.

Arlene B. Smith 09/12/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 09/12/2022

Jerry Hendrick Date
Area Manager