GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2024

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

RE: License #:	AS410069045
Investigation #:	2024A0356050
	MOKA - Amanda

Dear Ms. Hamlet:

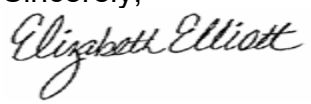
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410069045
Investigation #:	2024A0356050
Complaint Receipt Date:	08/01/2024
Investigation Initiation Date:	08/01/2024
Report Due Date:	09/30/2024
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(616) 719-4263
Administrator:	Tracey Hamlet
Licensee Designee:	Tracey Hamlet
Name of Facility:	MOKA - Amanda
Facility Address:	5102 Amanda Drive, SW Grandville, MI 49418-9766
Facility Telephone #:	(616) 719-2428
Original Issuance Date:	02/23/1996
License Status:	REGULAR
Effective Date:	08/26/2022
Expiration Date:	08/25/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was unsupervised in the community.	Yes

III. METHODOLOGY

08/01/2024	Special Investigation Intake 2024A0356050
08/01/2024	Special Investigation Initiated - Face to Face DCW Beatrice Nzayisenga.
08/01/2024	Contact - Face to Face Home manager, Brenda Peterson, DCW's LaStacia Wiley and Vickie Nyokayom, Resident A.
08/01/2024	Inspection Completed On-site
08/01/2024	Contact - Document Received Facility documents.
08/01/2024	Contact - Telephone call made Arlene Smith, Licensing Consultant.
08/13/2024	APS referral made. Centralized Intake.
08/13/2024	Exit conference-Tracey Hamlet, Licensee Designee.

ALLEGATION: Resident A was unsupervised in the community.

INVESTIGATION: On 08/01/2024, I opened a complaint on this facility after I received a BCAL (Bureau of Children and Adult Licensing) online complaint on 07/16/2024 alleging Resident A was sitting on the porch of a neighbor's home and that the home was providing unlicensed care to people living in the home. I investigated the unlicensed address, which is next door to this facility and determined the complainant had the wrong house. The complainant reported that Resident A had been walking around the neighborhood and sitting on the porches of the homes. The complainant reported that they called 911, but before the police arrived, the resident walked to another neighbor's house and sat on the chair on their porch. The complainant reported the police arrived and walked Resident A back down the street to the AFC home that she lives in.

On 08/01/2024, I conducted an unannounced inspection at the unlicensed address next door to this facility and interviewed Beatrice Nzayisenga. Ms. Nzayisenga was

not providing unlicensed care to any one in her home and stated the incident described in the complaint occurred at the licensed AFC MOKA home next door to her house. Ms. Nzayisenga stated she knew this had occurred because she works at the MOKA facility. Ms. Nzayisenga stated Resident A uses a walker and she walked to a neighbor's house and sat on their porch. Ms. Nzayisenga stated staff were busy and were unaware that Resident A had left the yard. Police responded and walked Resident A back to the facility knocking on the door and telling staff that Resident A was at the neighbor's house.

On 08/01/2024, I conducted an unannounced inspection at the facility and interviewed Brenda Peterson, home manager. Ms. Peterson stated staff Mary Mack and Rachel Sepa were working and Resident A had soiled her bed and urinated on the floor so once she was cleaned up, Resident A sat on the large swing on the back deck, which is in a fenced yard. Staff Mary Mack was cleaning up and Rachel Sepa was making lunch, when Resident A exited the fenced-in back yard and was walking in the neighborhood. Ms. Peterson stated Resident A had attempted to elope earlier that day, but staff were able to redirect her, and she did not leave the facility. Ms. Peterson confirmed that the Grandville Police returned Resident A to the facility.

On 08/01/2024, I interviewed Resident A, sitting on the swing on the back porch. Resident A stated she went out the fence, crossed the street and walked down the street. Resident A stated she crossed back over the street and went to a neighbor's house and sat on their front porch. Resident A stated they called 911 and gave her a bottle of water. Resident A stated the police brought her back to the facility and that no staff were looking for her. Resident A stated she has done this before at her mom & dad's house and "here at this house."

On 08/01/2024, I interviewed DCW's (direct care workers) Lastacia Wiley and Vickie Nyokayom at the facility. Ms. Wiley and Ms. Nyokayom were sitting inside the facility in the living room with the other residents who were watching TV. Ms. Wiley and Ms. Nyokayom area able to see Resident A while she is sitting on the swing on the back porch. Ms. Wiley and Ms. Nyokayom stated this is the first they have known of Resident A eloping from the facility.

On 08/01/2024, I reviewed a written statement dated 07/30/2024 by DCW Mary Mack. Ms. Mack documented the following information, *'On July 16th, (Resident A) woke up late, she refused to shower and cleanup her soiled bedding and floor. Did not listen to staff's prompts to take care of her soiled bedding and her hygiene. She got dressed and went out the front door. Rachel (staff) directed her to come back in. she told staff that she was going to sit on the back porch to work on her book. Mary (staff) then went in to (Resident A's) room to take care of her soiled things and clean her room. Rachel (staff) was making lunch for the individuals. (Resident A) went around the back and snuck out from the back gate and went down 3 houses to the neighbors and sat on their porch, asked them to call 911 because she was sick (Resident A did this at previous homes but has not done this since she has been in Amanda home). Police were called and attempted to have (Resident A) come back*

numerous attempts from staff, social worker and home supervisor to come home was failing, finally when the police officer told her that if she doesn't go on her own, they will carry her to the home, if need be, with more prompts, she agreed. She attempted to elope again later that evening and continued several times, but staff stopped her before she got out the door and monitored her and redirected her every time. The home supervisor, social worker and guardian are working on getting elopement in her behavioral plan.'

On 08/01/2024, I reviewed the Assessment Plan for AFC residents dated 02/20/2024. The assessment plan documented the following information, *'moves independently in the community, no, (Resident A's) whereabouts are to be known at all times. Because of (Resident A's) unsteady gait and lack of safety skills in the community she should be within sight at all times when outside of her home. She needs to be monitored in crossing the streets. (Resident A) needs to be reminded not to talk to strangers. She also has a high threshold of pain and so may not be aware of serious injuries to herself.'*

On 08/01/2024, I reviewed a Network 180 (Community Mental Health) face-to-face contact progress notes with Tara Dornan, supports coordinator dated 07/16/2024. Ms. Dornan documented the following information, *'This SC (supports coordinator) met face to face with (Resident A) and home staff at her Amanda AFC home to better link, coordinate, assess, plan and monitor the services she receives. When the SC arrived at the home a police officer was walking up to the home. The officer asked this SC if this SC worked at the home and this SC informed the officer that this SC was a support coordinator and visit the home today. The officer informed this SC that someone down the road called 911 because an individual was on their front porch and said they lived here at this AFC home. The officer gave a description of the individual and the home discovered that (Resident A) was not in the home. This SC went with the officer and found (Resident A) sitting in a lawn chair in a neighbor's driveway. This SC greeted (Resident A) and (Resident A) told this SC that she was lightheaded, and her legs were shaking. This SC asked (Resident A) if she left her home without letting anyone know she left, (Resident A) shook her head and responded that she did not let anybody know that she left the home. This SC asked (Resident A) if she knew when she left the home, (Resident A) shook her head and responded that she did not know. This SC asked a home staff member if they remembered when (Resident A) had gone out on the porch to read, and they did not know how long (Resident A) had been out on the porch. The staff member explained that (Resident A) had told staff that she was going to go on the porch to read and they thought she was still out there. (Resident A) told his SC that she went around back and exited through the fence and walked down the street. (Resident A) told this SC that she had not had breakfast yet and said that she refused to eat this morning. This SC went back to the AFC home and grabbed (Resident A) a snack. This Sc came back with muffins for (Resident A) and asked her if she felt better and see if she wanted to walk back to her AFC home, (Resident A) refused. The police informed this SC that EMT's were on the way to check her vitals and take her to the hospital. This SC spoke on the phone with (Resident A's) guardian (Relative #1) and*

filled her in on the situation at hand. (Relative #1) informed this SC that she would refuse transport for (Resident A) to go to the hospital and to have the EMT's call her once they finish with (Resident A's) vitals. This SC asked (Resident A) if she wanted to talk to her sister (Relative #1) and (Resident A) shook her head and refused. The EMT's arrived and took (Resident A's) vitals they reported that she had a slightly elevated blood pressure and asked (Resident A) if she wanted to go to the hospital. This SC gave the EMT's (Relative #1's) phone number and a EMT spoke with (Relative #1) in the phone. The EMT informed (Resident A) that (Relative #1) refused transportation to the hospital and that she would need to go home. (Resident A) shook her head and said that she was not going home, the EMT's called the police back over. This SC called home manager Brenda to try and convince (Resident A) to leave without the police escorting her home. (Resident A) again refused to get up and go home and the police had to escort (Resident A) back to the Amanda home. Once (Resident A) and this SC were back at the home, (Resident A) ate some lunch and drank water. This SC will set up a case consult with (Resident A's) guardian, home supervisor Brenda, Greenwood clinic and (Resident A's) behavioralist to better assist (Resident A) during this time.'

On 08/01/2024, I reviewed Resident A's IPOS (individual plan of service) dated 04/30/2024 and the biopsychosocial assessment dated 04/04/2024 through Network 180. These documents do not include any information that addressed a history of elopement by Resident A.

On 08/13/2024, I conducted an exit conference with Tracey Hamlet, Licensee Designee via telephone. Ms. Hamlet stated she will follow-up with support staff at Network 180 and the facility to make sure safety measures are put in place now that they are aware that Resident A can be an elopement risk. Ms. Hamlet stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

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:	The complainant reported that Resident A had been walking around the neighborhood and sitting on their porches. Ms. Nzayisenga, Ms. Peterson, Ms. Dornan and Ms. Mack verified that Resident A left the facility and walked to a neighboring home and sat on their porch without staff supervision or knowledge.

	Resident A stated she left the facility yard, walked down the street, crossed the street a couple of times and went to a neighbor's house and sat on their front porch. Resident A reported she has done this before. Ms. Wiley and Ms. Nyokayom stated they were previously unaware that Resident A had eloped from the facility. Resident A's assessment plan for AFC residents documented that Resident A cannot be without staff supervision, in the community and that her whereabouts are to always be known. Based on investigative findings, there is a preponderance of evidence to show that on 07/16/2024 Resident A left the fenced in backyard of the facility and walked to a neighboring house and sat on the porch. Resident A's assessed needs indicate that Resident A always requires staff supervision in the community, which did not occur on this date. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Elizabeth Elliott

08/13/2024

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

Jerry Hendrick

08/13/2024

Jerry Hendrick — Date
Area Manager