GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 29, 2024

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

RE: License #: AS610274835
Investigation #: 2024A0579030
Brookmere 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) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610274835
Investigation #:	2024A0579030
Complaint Receipt Date:	07/01/2024
Investigation Initiation Date:	07/03/2024
Report Due Date:	08/30/2024
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201, 715 Terrace St., Muskegon, MI 49440
Licensee Telephone #:	(616) 719-4263
Administrator:	Daniyel Baer
Licensee Designee:	Tracey Hamlet
Name of Facility:	Brookmere Home
Facility Address:	3086 Creekview Lane, Muskegon, MI 49444-7722
Facility Telephone #:	(231) 767-0583
Original Issuance Date:	04/27/2005
License Status:	REGULAR
Effective Date:	11/13/2023
Expiration Date:	11/12/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Female direct care workers are not always present to provide hygiene care for Resident A.	Yes
Untrained direct care workers are providing direct care to residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/01/2024	Special Investigation Intake 2024A0579030
07/03/2024	Special Investigation Initiated - Face to Face Resident B, Resident C, Lamaya Edwards (Direct Care Worker), Natasha Spaniola (Direct Care Worker)
07/09/2024	Contact- Telephone call received Daniyel Baer, Administrator
07/10/2024	Contact- Documentation received Daniyel Baer, Administrator
08/09/2024	Contact- Documentation sent Daniyel Baer, Administrator
08/12/2024	Contact- Documentation received Daniyel Baer, Administrator
08/15/2024	Contact- Documentation sent Tracey Hamlet, Licensee Designee
08/15/2024	Contact- Documentation received Ousman Fofana, Administrative Staff
08/15/2024	Contact- Telehphone call made William Davis, Direct Care Worker
08/29/2024	APS Referral
08/29/2024	Exit Conference Tracy Hamlet, Licensee Designee Daniyel Baer, Administrator

ALLEGATION: Female direct care workers are not always present to provide hygiene care for Resident A.

INVESTIGATION: On 7/1/24, I received this referral which alleged Resident A's "paperwork" notes she will not be toileted by male direct care workers (DCWs) but a new male DCW, William Davis, has been left alone overnight in the home. When he works overnight, he has to toilet and provide hygiene care for Resident A.

On 7/3/24, I completed an unannounced on-site investigation at the home. Interviews were completed with DCWs Lamaya Edwards and Natasha Spaniola. Resident B and Resident C were observed in the dining room of the home. It was reported Resident A was sleeping in her room and she is nonverbal, so an interview was not completed with her. It was reported the only verbal resident in the home was completing physical therapy activities while I was at the home, so he was not spoken to in order to not disrupt his therapy.

Ms. Edwards and Ms. Spaniola reported a newer male DCW named William Davis who works overnight is working alone at times. They stated it was verbally told to them by Resident A's relatives that they do not want a male DCW toileting Resident A but when Mr. Davis works alone, he has to toilet Resident A. They stated they are not certain it is written anywhere that Resident A cannot be toileted by male DCWs, but it has been verbally expressed to them by Resident A's family.

I reviewed the *Resident Care Agreement* in Resident A's file which has a line on the front page that was checked noting it was agreed Resident A may receive hygiene care from a member of the opposite sex if a member of the same sex is not available. The agreement was signed by Relative A and dated 6/1/23.

I reviewed the staff schedule in the home for June 2024 which was printed as well as handwritten with the names of DCWs who worked each shift. No one was documented as working with Mr. Davis on 6/15/24, 6/16/24, and 6/29/24.

On 7/9/24, I received a telephone call from Administrator, Daniyel Baer. She stated a DCW had brought the allegations to her attention, and she wanted to inform me the written schedule in the home is not always correct. She stated Mr. Davis has not worked alone. She stated if a shift opening is not filled, the female home manager will cover the shift and that may not be documented on the printed schedule. She agreed to send me a spreadsheet of the actual hours worked for DCWs in the home which she reported would be more accurate.

On 7/10/24, I received an Excel spreadsheet of the hours worked by DCWs each day. I reviewed the sheet and found no one was documented as working with Mr. Davis overnight on 6/15/24 and for two hours in the morning on 6/17/24.

On 8/9/24, I inquired with Ms. Baer and Tracey Hamlet, Licensee Designee, about an updated *Resident Care Agreement* for Resident A, due to the one I viewed on-

site having expired as of 6/1/24.

On 8/12/24, I received an updated *Resident Care Agreement* dated 12/20/23, which noted Resident A may not receive hygiene assistance from members of the opposite sex.

On 8/15/24, I exchanged emails with administrative staff, Ousman Fofana, who provided the contact information for Mr. Davis but reported he no longer is employed at the home as of 8/12/24.

On 8/15/24, I attempted a telephone interview with Mr. Davis. The call was not answered. A voicemail message was left requesting a return phone call. A return phone call was not received at the time of report disposition.

On 8/29/24, the allegations were forwarded to Adult Protective Services per policy.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(7) A department resident care agreement form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department. A resident shall be provided the care and services as stated in the written resident care agreement.
ANALYSIS:	Direct care workers (DCWs), Ms. Edwards and Ms. Spaniola, reported DCW, Mr. Davis, has at times worked alone overnight, and must provide hygiene care to Resident A when he works alone due to a female DCW not being present. They both stated Resident A is not authorized to receive hygiene care from members of the opposite sex. Resident A's *Resident Care Agreement* dated 12/20/23, noted Resident A may not receive hygiene assistance from members of the opposite sex. A staff schedule in the home documented that Mr. Davis was the only DCW in the home on 6/15/24, 6/16/24, and 6/29/24. Administrator, Ms. Baer, reported the schedule in the home is not correct. She reported Mr. Davis has not worked alone and that a female home manager was present but may not have documented her time correctly on the schedule in the home.

	Ms. Baer provided an Excel spreadsheet of employee workhours which documented Mr. Davis working alone overnight on 6/15/24 and for two hours in the morning on 6/17/24. Based on the interviews completed and documentation observed, there was one night where Mr. Davis was documented as being the only DCW in the home and therefore the only person available to provide direct/hygiene care to Resident A as a female DCW was not present in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Untrained direct care workers are providing direct care to residents.

INVESTIGATION: On 7/1/24, I reviewed the referral which alleged Mr. Davis is not trained but is left alone with residents. Mr. Davis does not have recipient rights training or CPR/First Aid training, but he is left alone with residents.

On 7/3/24, Ms. Edwards and Ms. Spaniola reported Mr. Davis was not fully trained when he was left alone with residents, but he may be now. They both reported recently he has been working with the new hire, Courtney Bowman, and Ms. Bowman is not fully trained. They expressed concern that Mr. Davis and Ms. Bowman do not have training in the personal care needs/care plan of residents, Resident Rights, CPR/First Aid, and Fire Safety but they are working together without supervision overnight with residents.

I reviewed the staff schedule in the home for June 2024 which was printed as well as handwritten with the names of DCWs who worked each shift. No one was documented as working with Mr. Davis on 6/15/24, 6/16/24, and 6/29/24. Ms. Bowman and Mr. Davis were noted as working together on 6/30/24 and 7/1/24.

On 7/10/24, I reviewed a spreadsheet of DCW workhours and found no one was documented as working with Mr. Davis overnight on 6/15/24 and for two hours in the morning on 6/17/24 and that Mr. Davis and Ms. Bowman were noted as working together on 6/29/24, 6/30/24, and 7/1/24.

On 8/9/24, I requested training confirmation in First Aid/CPR, personal care/supervision/protection, resident rights, and safety and fire prevention for Mr. Davis and Ms. Bowman from Ms. Hamlet and Ms. Baer.

On 8/15/24, I received training confirmation for Ms. Bowman and Mr. Davis: Ms. Bowman completed CPR/First Aid training on 3/29/24, Recipient Rights training on 7/9/24, Emergency Preparedness training on 7/10/24, and Introduction to Human Services/ Person Center Planning and Self Determination training on 7/10/24.

Mr. Davis completed Recipient Rights trainings on 9/12/23, Emergency Preparedness training on 7/3/23, Introduction to Human Services/ Person Center Planning and Self Determination training on 7/7/23.

On 8/15/23, Ousman Fofana reported Mr. Davis was scheduled for CPR/First Aid training on 7/15/24 but did not attend. Mr. Davis was rescheduled for 8/13/24 but ended his employment on 8/12/24.

On 8/15/24, I attempted a telephone interview with Mr. Davis who did not respond to a voicemail message requesting a return phone call by the time of report disposition.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.**
ANALYSIS:	Direct care workers (DCWs), Ms. Edwards and Ms. Spaniola, reported DCW, Mr. Davis, was untrained when working alone and that Mr. Davis and Ms. Bowman were working together although Ms. Bowman was also not fully trained. Mr. Davis was documented as working alone with residents overnight on 6/15/24 and for two hours in the morning on 6/17/24. He was noted as working with Ms. Bowman on 6/29/24, 6/30/24, and 7/1/24. At the time Ms. Bowman and Mr. Davis worked together, Ms. Bowman only had training in CPR/First Aid. She had not completed Resident Rights, Emergency Preparedness, or Introduction to Human Services/ Person Center Planning and Self Determination. At the time Mr. Davis was working alone and/or with Ms. Bowman, he did not have training in CPR/First Aid. He had completed Resident Rights, Emergency Preparedness, or

	Introduction to Human Services/ Person Center Planning and Self Determination. Mr. Davis is no longer employed at the home and did not respond to a voicemail request for a return phone call. Based on the interviews completed and documentation observed, Mr. Davis was not competent in CPR/First when he worked alone and/or with Ms. Bowman. Ms. Bowman was not competent in Resident Rights, Emergency Preparedness, or Introduction to Human Services/ Person Center Planning and Self Determination when working with Mr. Davis.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: On 7/3/24, while investigating the reported allegations, I reviewed a staff schedule in the home. The schedule was printed but also had handwritten names on the document. The schedule noted Mr. Davis worked alone on 6/15/24, 6/16/24, and 6/29/24.

On 7/9/24, Ms. Baer denied Mr. Davis working alone. She reported the schedule in the home may be incorrect. She stated the home manager may fill vacancies but not document it on that schedule. She agreed send me a spreadsheet of the actual hours worked for DCWs in the home which she reported would be more accurate.

On 7/10/24, I received an Excel spreadsheet of the hours worked by DCWs each day. I reviewed the sheet and found no one was documented as working with Mr. Davis overnight on 6/15/24 and for two hours in the morning on 6/17/24. The home manager was documented working hours with Mr. Davis on 6/16/24. It was noted Mr. Davis worked with Ms. Bowman on 6/29/24, which was not documented on the schedule.

On 8/15/24, a telephone interview was attempted with Mr. Davis who did not respond to a voicemail message request for a return phone call.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(c) Hours or shifts worked.**

	(e) Any scheduling changes.
ANALYSIS:	Ms. Baer denied Mr. Davis ever working alone, although the printed/written schedule noted him working alone on 6/15/24, 6/16/24, and 6/29/24. She stated the home manager would work with Mr. Davis but may not have documented her time. Ms. Baer provided a spreadsheet of employee work hours where it was noted the home manager worked hours with Mr. Davis on 6/16/24 and Ms. Bowman worked with Mr. Davis on 6/29/24, which was not noted on the schedule. Based on the interviews completed and documentation reviewed, there is sufficient evidence a daily schedule that includes the names of all staff on duty, the hours/shifts worked, and any scheduling changes was not accurately maintained in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/29/24, I completed an exit conference with Ms. Hamlet and Ms. Baer who did not dispute my findings or recommendations at the time of report disposition.

IV. RECOMMENDATION

Contingent upon receipt of acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 08/29/2024

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 08/29/2024

Jerry Hendrick Date
Area Manager