GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 21, 2024

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

RE: License #: AS030312249
Investigation #: 2024A0464062
Simmons 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,

Megan Aukerman, 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 #:	AS030312249
Investigation #:	2024A0464062
Complaint Receipt Date:	09/25/2024
Investigation Initiation Date:	09/25/2024
Report Due Date:	11/24/2024
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:	Simmons Home
Facility Address:	444 32nd Street Holland, MI 49423
Facility Telephone #:	(616) 396-9084
Original Issuance Date:	04/08/2011
License Status:	REGULAR
Effective Date:	10/08/2023
Expiration Date:	10/07/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has been physically assaulted by Resident B on numerous occasions. Facility staff do not appear to be doing anything to prevent the assaults.	Yes

III. METHODOLOGY

09/25/2024	Special Investigation Intake 2024A0464062
09/25/2024	Special Investigation Initiated - Telephone Micheal McClellan, Allegan County APS
09/25/2024	APS Referral
09/27/2024	Inspection Completed On-site Micheal McClellan (APS), Henry Primer (Manager), Rachel Baker (Staff) & Resident B
09/27/2024	Contact-Document received Facility Records
09/30/2024	Contact-Document received Sheryl Williams, MOKA Residential Coordinator
11/21/2024	Exit Conference Tracey Hamlet, Licensee Designee

ALLEGATION: Resident A has been physically assaulted by Resident B on numerous occasions. Facility staff do not appear to be doing anything to prevent the assaults.

INVESTIGATION: On 09/25/2024, I received a complaint, which alleged Resident A has been assaulted numerous times by another resident in the facility. On 09/07/2024, Resident A was punched in the head by Resident B. There are concerns that the facility is not doing anything to prevent the assaults.

On 09/25/2024, I spoke to Allegan County Adult Protective Services (APS) worker, Michael McClellan to coordinate the investigation.

On 09/27/2024, Mr. McClellan and I completed an unannounced, onsite inspection at the facility and interviewed facility manager, Henry Primer. He stated Resident A was not present as he was at his day program. Mr. Primer confirmed that this past month, Resident B did hit Resident A on the head. Mr. Primer stated Resident A is

very small in stature and for some Reason Resident B targeted him, walked up to him and punched him in the head. Mr. Primer stated there was a previous incident when Resident A was hit, but it was a few years prior, and he was hit by a different resident. Mr. Primer stated Resident A did not sustain any injuries from the incidents. Mr. Primer stated Resident A is going to be moving to a different MOKA home, where he may be a better "fit".

Mr. McClellan and I then interviewed staff, Rachel Baker. Ms. Baker stated she has worked for MOKA for almost one year. Ms. Baker described Resident A as small and the "weakest link" of the home. Ms. Baker stated, "for some reason, (Resident B) likes to target (Resident A)". Ms. Baker stated the last incident occurred earlier this month, when Resident B just walked up to Resident A and hit him on the head. Resident A was left with a temporary red mark, but did not sustain any other injuries. Ms. Baker stated on other occasions, Resident B has just walked up to Resident A and "flicked" him for no reason. Ms. Baker stated staff have been instructed to keep Resident A and Resident B separated from each other. Ms. Baker stated Resident A is moving to a different facility and Resident B will be moving home with his sister.

Mr. McClellan and I then interviewed Resident B, privately. Resident B stated he is moving out of the facility and in with his sister. Resident B denied having any concerns regarding the facility. Resident B stated he gets along well with the staff and the other residents. Resident B stated sometimes one of the staff will talk "bossy" to him. Resident B stated he gets along well with Resident A and denied any physical altercations.

On 09/27/2024, I received and reviewed facility Incident Reports (IR). The most recent IR was completed on 09/07/2024, by staff, Robert Slaughter. The report reflected that around 1:15 pm, during an outing, Resident B walked up to Resident A and hit him "extremely hard" on the front of his head. Both residents were immediately separated. Resident A was noted to have a red bruise on his forehead. Other IRs were reviewed and reflected that between 06/01/2024 and 08/24/2024, Resident A was physically assaulted by other residents on seven different occasions. Resident A sustained minor injuries from two of the incidents.

On 09/27/2024, I received and reviewed Resident A's Psychosocial Assessment completed by Denise Radakovitz on 04/01/2024. The assessment states Resident A is diagnosed with autism and a moderate intellectual disability. Resident A also suffers from partial hearing and vision loss. The assessment states Resident A has a history of yelling at others, and at times becoming physically aggressive towards others; however, there have been no episodes of aggression in over a year. The assessment reflects that some of the other residents have been unfriendly towards Resident A. There was an incident in May 2023, when another resident pushed Resident A to the ground. Staff are to monitor and intervene if necessary.

I then reviewed the Psychosocial Assessment for Resident B completed and signed by Sandra Castle on 12/06/2022. The assessment states Resident B is diagnosed

with major depressive disorder, Asperger's disorder and a mild intellectual disability. The assessment reflects that Resident A has a history of physical aggression and stealing.

On 09/30/2024, I received an email from MOKA Residential Coordinator, Sheryl Willams, stating Resident A has been moved to his new facility.

On 11/21/2024, I completed an exit conference with licensee designee, Tracey Hamlet. She was informed of the investigation findings and recommendations. Ms. Hamlet stated a corrective action plan would be submitted.

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:	On 09/25/2024, a complaint was received, stating Resident A was assaulted by Resident B on multiple occasions. There were concerns staff were failing to protect Resident A from Resident B. Staff Henry Primer and Rachel Baker both confirmed Resident B recently hit Resident A on the head. As a result, Resident A is being moved to a new facility and Resident B is moving in with his sister. Resident B was interviewed and denied any physical altercations with Resident A. Resident B's Psychosocial Assessment reflected Resident B is diagnosed with major depressive disorder, Asperger's disorder and a mild intellectual disability. The assessment also reflects Resident B has history of becoming physically aggressive. Facility incident reports reflected that between 06/01/2024 and 09/07/2024, Resident A was assaulted by Resident B on eight separate occasions. Resident A sustained minor injuries from three of the incidents. Based on the investigative findings, there is sufficient evidence to support a rule violation that facility staff failed to protect Resident A from Resident B.

CONCLUSION:	**VIOLATION ESTABLISHED**

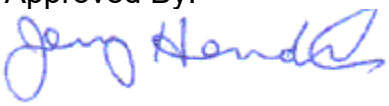
IV. RECOMMENDATION

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

11/21/2024

Megan Aukerman Date
Licensing Consultant

Approved By:



11/21/2024

Jerry Hendrick Date
Area Manager