GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2024

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

RE: License #: AS610303022
Investigation #: 2025A0579007
Oxford Circle

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.
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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 #:	AS610303022
Investigation #:	2025A0579007
Complaint Receipt Date:	11/06/2024
Investigation Initiation Date:	11/08/2024
Report Due Date:	12/06/2024
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:	Oxford Circle
Facility Address:	3293 Orshal Rd. Whitehall, MI 49461
Facility Telephone #:	(231) 766-9286
Original Issuance Date:	07/21/2009
License Status:	REGULAR
Effective Date:	01/17/2024
Expiration Date:	01/16/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Lovely Jamison, worked alone with residents on 6/12/24 without being trained in CPR and First Aid.	Yes
Direct care worker, Lovely Jamison, was not trained to pass medication when working alone on 6/12/24.	No

III. METHODOLOGY

11/06/2024	Special Investigation Intake 2025A0579007
11/08/2024	Special Investigation Initiated - Face to Face Arlene Hines, Direct Care Worker Supervisor
11/08/2024	Contact - Face to Face Arlene Hines, Direct Care Worker Supervisor
11/08/2024	Contact - Document Received Daniyel Baer, Administrator
11/12/2024	Contact- Document Sent Tracey Hamlet, Licensee Designee Daniyel Baer, Administrator
11/13/2024	Contact- Telephone Call Received Emily Betz, MOKA Administration
11/14/2024	Contact- Document Sent Lovely Jamison, Former Direct Care Worker
11/18/24	Exit Conference Tracey Hamlet, Licensee Designee Daniyel Baer, Administrator

ALLEGATION: Direct care worker, Lovely Jamison, worked alone with residents without being trained in CPR and First Aid.

INVESTIGATION: On 11/6/24, I received this referral which alleged direct care worker (DCW), Lovely Jamison, worked from 11:00 p.m. to 7:00 a.m. on 6/12/24 by himself. He had only worked one, four-hour training shift prior to working alone overnight, and he did not have CPR/First Aid training on 6/12/24. He completed CPR/First Aid training on 7/15/24. The assistant supervisor, who was under the supervision of Arlene Hines, was aware Mr. Jamison was untrained when allowing

him to work alone. Ms. Hines was aware he was untrained and working alone as well. Mr. Jamison overheard Ms. Hines telling the assistant supervisor to assign him shifts. The assistant supervisor was terminated.

On 11/8/24, I completed a face-to-face interview with Ms. Hines who was assisting with a renewal inspection I was conducting at another AFC home. Ms. Hines reported she did not advise anyone that Mr. Jamison should work alone without training. She stated she is uncertain if Mr. Jamison worked alone on 6/12/24, but he should not have, because that is not the typical process for new employees. She stated she had met with Mr. Jamison for a few hours briefly and Mr. Jamison had completed “relationship building” with residents while supervised for a few hours the week prior. She stated on 6/11/24, Mr. Jamison shadowed in the home for a few hours. She stated typically DCWs do about a month of training and shadowing before working alone. She stated at that time, the assistant supervisor was struggling to manage the home, there was no home manager, and the assistant supervisor was terminated because of her performance. She stated it is possible the assistant supervisor made the poor choice of having Mr. Jamison work alone, but it should not have happened.

I reviewed the payroll spreadsheet which confirmed Mr. Jamison was the only employee paid for working overnight on 6/12/24.

Ms. Hines provided confirmation that Mr. Jamison completed CPR/First Aid training on 7/15/24.

Ms. Hines reported MOKA had switched to an electronic scheduling system around 6/12/24 so there should be an electronic copy of the schedule that she could not access at that time. She stated the assistant supervisor should have also kept a written schedule in the home which would have noted if she possibly came in to work with Mr. Jamison. She stated the new home manager likely would not know where the written schedule from June 2024 was left, and the home was recently painted, so it may not be able to be located. I agreed I would go to the home to attempt to obtain the written schedule and speak to residents.

On 11/8/24, I completed an unannounced on-site investigation. I completed an interview with Resident A. The other residents were observed eating a snack and did not express a willingness to speak to me.

Resident A denied any concern regarding his care or treatment in the home. He reported he feels safe in this home. He discussed that his room was recently painted, and he is happy with his room. He denied there is anything he wished to discuss with me.

Ms. Hines arrived at the home and attempted to locate the written schedule. She was unable to. She reported the current home manager did not start at this home until August 2024, so she did not know where the former assistant supervisor left the

prior schedules. She stated the electronic schedule would accurately document who worked on 6/12/24 and match the written schedule she could not locate. She attempted to gain access to the electronic schedule while I was at the home but could not. She agreed to have Administrator, Daniyel Baer, send the electronic schedule to me.

On 11/08/24, I received a copy of the electronic schedule from Ms. Baer. Mr. Jamison is listed as “shadowing” on 6/12/24, however the employee scheduled to work overnight was crossed out noting Mr. Jamison worked alone on 6/12/24.

On 11/14/24, I contacted Mr. Jamison to confirm I had received and investigated allegations relating to 6/12/24 and did not have further questions at this time. My contact information was provided. He responded expressing concerns that did not relate to specific licensing rules. I responded confirming his concerns were noted.

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.**
ANALYSIS:	A payroll spreadsheet and electronic schedule noted Mr. Jamison was the only employee listed on the schedule and on payroll overnight on 6/12/24. Ms. Hines reported she did not knowingly allow Mr. Jamison to work alone without being trained and if he worked alone, he should not have as that is not normal training protocol for MOKA. She stated the assistant supervisor was struggling to manage the home and may have allowed Mr. Jamison to work alone although he was not adequately trained, and she was terminated due to her performance. I verified Mr. Jamison completed CPR/First Aid training on 7/15/24. Based on the interviews completed and documentation reviewed, there is sufficient evidence Mr. Jamison was not competent in CPR/First Aid before performing assigned tasks unsupervised.

CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care worker, Lovely Jamison, was not trained to pass medication when working alone on 6/12/24.

INVESTIGATION: On 11/6/24, I received this referral which alleged Mr. Jamison did not have medication training when working alone on 6/12/24. Mr. Jamison did not complete medication training until 8/13/24.

On 11/8/24, Ms. Hines was able to obtain Mr. Jamison's training record and confirmed, after failing to attend his first medication training, he completed medication training on 8/13/24.

Ms. Hines reported it is not typical for DCWs who are not trained in medication administration to work alone but when Mr. Jamison worked alone overnight on 6/12/24, he would not have had to pass medications. She stated if he had needed to pass medications, there are on-call staff who would have been called to the home to do this.

On 11/8/24, Resident A denied any concern regarding not being able to receive medication from DCWs overnight and denied needing medication overnight.

On 11/12/24, I provided consultation to Ms. Baer and Licensee Designee, Ms. Hamlet, regarding on-call staff versus floating staff.

On 11/13/24, I completed a telephone interview with Emily Betz, who is in administration at MOKA. We discussed the use of on-call staff and documenting their time in the home on the schedule. She confirmed MOKA has regional on-call staff who are available to respond immediately to the home to assist and could have passed medication if someone working alone is not trained to do so. She stated it is not typical for an employee working alone to not be trained in medication administration even if they do not typically pass medications overnight.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Mr. Jamison worked alone on 6/12/24. I confirmed he completed medication training on 8/13/24.

	Ms. Hines and Resident A denied the home has any residents who receive overnight medications. Ms. Hines and Ms. Betz reported DCWs who work alone overnight are typically trained in medication administration however in this case, if a medication was needed, there is on-call staff available to immediately respond to the home to assist. Based on the interviews completed, there is insufficient evidence that Mr. Jamison was not medication trained before passing medication as he did not pass medication when working alone on 6/12/24 and on-call staff is available to assist should a resident have needed medication.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 11/18/24, I completed an exit conference with Ms. Hamlet and Ms. Baer who did not dispute my findings at the time of report disposition.

IV. RECOMMENDATION

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

Cassandra Duursma 11/18/2024

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 11/18/2024

Jerry Hendrick Date
Area Manager