GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 11, 2026

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

RE: License #: AS030312249
Investigation #: 2026A0464030
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) 356-0100.

Sincerely,

Megan Leavitt, LMSW

Megan Leavitt, 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 #:	2026A0464030
Complaint Receipt Date:	03/09/2026
Investigation Initiation Date:	03/09/2026
Report Due Date:	05/08/2026
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:	10/08/2025
Expiration Date:	10/07/2027
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff failed to ensure Resident A attended medical appointments with his neurologist.	Yes

III. METHODOLOGY

03/09/2026	Special Investigation Intake 2026A0464030
03/09/2026	APS Referral
03/09/2026	Special Investigation Initiated - Telephone Ashton Byrne, ORR
03/09/2026	Inspection Completed On-site Henry Primer, Facility Manager Resident A
03/20/2026	Contact - Telephone call made Dr. Mahamud Farooq, Neurologist
03/20/2026	Contact - Document Received Ashton Byrne, ORR
05/07/2026	Inspection Completed-BCAL Sub. Compliance
05/08/2026	Exit Conference Tracey Hamlet, Licensee Designee

ALLEGATION: Staff failed to ensure Resident A attended medical appointments with his neurologist.

INVESTIGATION: On 03/09/2026, I received a complaint from Network 180, Office of Recipient Rights (ORR), alleging facility staff failed to ensure Resident A participated in medical appointments with his neurologist. As a result, several virtual and in-person appointments were missed.

On 03/09/2026, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 03/09/2026, I exchanged emails with ORR worker Ashton Byrne to coordinate the investigation. Mrs. Byrne stated she spoke to Resident A's mother, who is also

his guardian. Resident A's mother expressed concern regarding the number of missed neurological appointments. Mrs. Byrne explained Resident A suffered from a stroke and that is why it is imperative for him to have follow-up appointments with the neurologist.

On 03/09/2026, Mrs. Byrne and I completed an unannounced, onsite inspection at the facility. We interviewed facility manager, Henry Primer. Mr. Primer confirmed Resident A missed two virtual appointments, but it was due to the doctor not coming on for the appointments. Mr. Henry explained another appointment was missed, because they were having technical problems logging on. He explained the appointment was rescheduled for 05/19/2026 and it will be in-person.

Mrs. Byrne and I then interviewed Resident A privately. Resident A confirmed he did miss a few neurology appointments, but he was not certain of the dates. Resident A reported facility staff typically ensure he makes it to all scheduled appointments. Resident A reported he suffered from his stroke prior to moving into the facility. He stated he has been feeling much better.

On 03/20/2026, I contacted the office of Dr. Mahamud Farooq. Staff reported Resident A had a scheduled appointment on 12/16/2026. The appointment was missed due to the facility having connection issues during the virtual appointment. Resident A had rescheduled virtual appointments for 12/30/2026 and 01/26/2026, but missed both appointments. Staff reported Resident A has another appointment scheduled for in-person on May 19, 2026, at 1:00 PM.

On 03/20/2026, I exchanged emails with Mrs. Byrne informing her of my conversation with Dr. Farooq's office.

On 03/07/2026, I completed an exit conference with licensee designee, Tracey Hamlet and informed her of the investigation findings and recommendations. Ms Hamlet stated a corrective action plan will be submitted.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	On 03/09/2026, a complaint was received alleging Resident A missed several appointments with his neurologist. Facility manager, Henry Primer reported Resident A missed a total of three neurology appointments. Resident A was also interviewed and confirmed he has missed some neurology appointments.

	Dr. Mahamud Farooq's neurological office confirmed Resident A missed appointments on 12/16/2026, 12/30/2026 and 01/26/2026. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff failed to ensure Resident A attended appointments with his neurologist.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Megan Leavitt, LMSW 05/08/2026

Megan Leavitt Date
Licensing Consultant

Approved By:

05/11/2026

Jerry Hendrick Date
Area Manager