GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 14, 2023

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

RE: License #: AS610395835
Investigation #: 2023A0350036
Crescent AFC 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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610395835
Investigation #:	2023A0350036
Complaint Receipt Date:	09/13/2023
Investigation Initiation Date:	09/13/2023
Report Due Date:	10/13/2023
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:	Crescent AFC Home
Facility Address:	472 W. Hile Rd. Norton Shores, MI 49444
Facility Telephone #:	(231) 894-4975
Original Issuance Date:	09/17/2018
License Status:	REGULAR
Effective Date:	03/17/2023
Expiration Date:	03/16/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOP- MENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was left at a restaurant by staff on September 11.	Yes

III. METHODOLOGY

09/13/2023	Special Investigation Intake 2023A0350036
09/13/2023	Special Investigation Initiated - Telephone I called and spoke with Rhenee Ratcliff, Home Manager
09/13/2023	Contact - Telephone call made I spoke with Constance Woodfork, DCW
09/13/2023	Contact - Telephone call made I called and spoke with Devlon Briggs, DCW
09/14/2023	Exit conference – Held with Tracey Hamlet, Licensee Designee

ALLEGATION: Resident A was left at a restaurant by staff on September 11.

INVESTIGATION: On 09/13/2023, I called and spoke with Rhenee Ratcliff, Home Manager. Ms. Ratcliff stated that on 09/11 she received a phone call from Officer Scott Bykman of the Muskegon Police Department, informing her that adult foster care staff had left Resident A at Pizza Ranch by himself. Shortly after that call, Constance Woodfork, Direct Care Worker (DCW), Devlon Briggs, DCW, and five of the six residents returned to the home. When Ms. Ratcliff confronted Ms. Woodfork and Ms. Briggs about this, they admitted that they neglected to make sure they had all of the residents in the van before leaving the restaurant. Ms. Ratcliff informed me that she called Resident A's mother and told her about this incident, and his mother said that Resident A will often walk away from the group. Ms. Ratcliff also told me that she will be speaking with her supervisor about this to determine how these employees will be disciplined. She further told me that the police brought Resident A back to the home and he was physically and emotionally fine. Ms. Ratcliff said that Ms. Woodfork was there at the time of this call, and I requested to speak with her, and she got on the phone.

On 9/13/2023, I spoke with Ms. Woodfork, who stated that she, Ms. Briggs, and all six of the residents were at Pizza Ranch in a private room. When they were done eating and getting ready to leave, she and Ms. Briggs had the residents get into a single-file line and they left to go to the van. Ms. Woodfork reported that she was

holding one of the resident's hands to assist him in walking to the van. She informed me that it was Ms. Briggs job to make sure all the residents had their seatbelts on and to assist any of them if needed. Ms. Woodfork said that she was the driver and during the 9-to-10-minute drive home, neither she nor Ms. Briggs noticed that Resident A was not in the van. She stated that when they got back to Crescent AFC Home, she had to document the trip, and when she was done, all of the residents who were in the van and Ms. Briggs were already in the house. Ms. Woodfork told me she was very upset that this happened, and that it hasn't happened in the over 20 years she has worked there, which was the whole time Resident A has lived in this home.

On 09/13/2023, I called and spoke with Devlon Briggs, DCW. Ms. Briggs had a similar explanation as Ms. Woodfork as to what happened. She told me that as they were getting ready to leave the restaurant, the residents got into a single-file line, and Ms. Woodfork was holding another resident's hand to assist him. Ms. Briggs informed me that all of the residents except for one can get in and out of the van without assistance, and that she helped the one who needed assistance get into the van. She said she also assisted two residents with fastening their seatbelts. Ms. Briggs stated that neither she nor Ms. Woodfork noticed that Resident A was not with them, including on the 10-to-12-minute ride back home. Ms. Briggs told me that she did not look back towards the residents from the front passenger seat she was in the whole drive back. Ms. Briggs reported that when they got back to Crescent AFC Home, she helped one of the residents out of the van and all the others got out by themselves and went into the home. Ms. Briggs said that after she took a bag out of the van she immediately clocked out and left the home as it was the end of her shift.

On 09/14/2023, I called and held an exit conference with Tracey Hamlet, Licensee Designee. I informed Ms. Hamlet that I was citing a violation of this rule. She understood, and wanted to read my report to find out more details about what happened.

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:	During an outing, staff members Constance Woodfork and Devlon Briggs did not make sure all six residents who were with them were in the van and returned to the home. They failed to notice Resident A was not with them. Resident A was left at the restaurant they were at, and the police were called, who brought him back to Crescent AFC Home.

	My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

September 14, 2023

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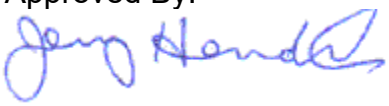
Ian Tschirhart Date
Licensing Consultant

Approved By:



September 14, 2023

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Jerry Hendrick Date
Area Manager