GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 10, 2025

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

RE: License #: AS700095745
Investigation #: 2025A0357028
Pierce Street 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,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700095745
Investigation #:	2025A0357028
Complaint Receipt Date:	03/18/2025
Investigation Initiation Date:	03/19/2025
Report Due Date:	05/17/2025
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(616) 719-4263
Administrator:	Sergejs Toms Zvirgzds
Licensee Designee:	Tracey Hamlet
Name of Facility:	Pierce Street Home
Facility Address:	6421 Pierce Street Allendale, MI 49401
Facility Telephone #:	(616) 895-5216
Original Issuance Date:	04/29/2001
License Status:	REGULAR
Effective Date:	10/29/2023
Expiration Date:	10/28/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff, Sierra Peer, bathed Resident A with water that contained his fecal material.	Yes

III. METHODOLOGY

03/18/2025	Special Investigation Intake 2025A0357028 This complaint came from Adult Protective Services. Therefore, there was not a referral to APS.
03/19/2025	Special Investigation Initiated - Telephone To Recipient Rights of Ottawa County.
05/16/2025	Inspection Completed On-site Interview with McKenna Onkea, Direct Care Staff.
06/02/2025	Contact - Telephone call made Telephone interview with Elizabeth Stoffers, the Home Manager.
06/02/2025	Contact - Telephone call made Telephone interview with Direct Care Staff, Melissa Meidema.
06/10/2025	Telephone exit conference with Licensee Designee, Tracey Hamel.

ALLEGATION: Staff, Sierra Peer, bathed Resident A with water that contained his fecal materia

INVESTIGATION: On 03/18/2025, we received a complaint from the Department of Health and Human Servies on the Pierce Street home. The complaint read as follows: *'(Resident A) lives in the MOKA home. (Resident A) is diagnosed with an intellectual development disability and Autism. (Resident A has a legal guardian,) MOKA staff are responsible for caring for (Resident A). On 02/21/2025, a MOKA home staff member Sierra Peer gave Resident A a bath due to him defecating on himself. Sierra put (Resident A) in the tube without cleaning him first, so his butt had feces on it. Sierra washed his body and hair with water that contained feces on it and did not rise him off afterwards. There is concern Sierra did not clean (Resident A) properly. Serria is no longer employed with MOKA.'*

On 05/162025, I made an unannounced inspection of the home. Direct Care Staff, McKenna Onkea, was working at this time. She stated that she did not have any

firsthand information about the incident. She stated that the issue was discussed at their staff meeting (date unknown) and the staff were told to make sure they rinse the resident off after a resident had defecated on themselves and then give them a bath with clean water. She stated that the staff involved Sierra Peer no longer works at the home. I asked Ms. Onkea if I could review Resident A's file, and she said she did not have a key to the storage cabinet that the documents were stored in. I met Resident A, and he is nonverbal, so he could not contribute to the investigation. Ms. Onkea explained that Resident A is unable to care for his own personal care needs such as bating or cleaning himself after he as defecated. She reported that he wears adult protection.

On 06/02/2025, I telephoned the home and conducted a telephone interview with the Home Manager, Elizabeth Stoffers. I explained the complaint to her, and she reported that there was an eyewitness, Direct Care Staff, Melissa Meidema. Ms. Meidema was new at the time, and she was shadowing Ms. Peer. She had come to her to report that she was with Ms. Peer and she (Ms. Peer) had not rinsed Resident A off after he had defecated on himself and then bathed Resident A in bath water that contained fecal material. Ms. Stoffers reported that they had made a report to Centralized Intake. She reported that Ms. Peer quit before they completed disciplinary action against her.

On 06/02/2025, I conducted a telephone interview with Ms. Melissa Meidema, Direct Care Staff. She confirmed the date of the incident as 02/21/2025, and explained that she was new to the job, and she was job shadowing with Sierra Peer on first shift. She explained that Resident A had defecated on himself, and Ms. Peer took him to the bathroom and helped him into the tub to take a bath. Ms. Meidema stated that Ms. Peer did not rinse Resident A off first but put the water in the tub with pieces of fecal material floating in the water. She said she questioned Ms. Peer about getting clean water and Ms. Peer said we are not going to do that. Ms. Meidema stated that Ms. Peer washed Resident A's, face, his hair and his body with the dirty water and at the end of the bath Ms. Peer did not rinse him off. She reported that she was upset about this incident. She stated that she had contacted the home Manager, Ms. Stoffers who told her to write an Incident/Accident Report, dated 02/21/2025. She confirmed that Resident A is non-verbal and that he requires staff help with all of personal care needs. She also confirmed that he wears adult protection and needs to be cleaned after he has eliminated.

On 06/10 /2025, I conducted a telephone exit conference with the Licensee Designee, Tracey Hamlet. She agreed with my findings.

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:	It was alleged that staff, Sierra Peer, bathed Resident A with water that contained his fecal material, which included washing his face and hair. On 02/21/2025, Melissa Meidema, Direct Care Staff, stated that on 02/21/2025 as she shadowed Direct Care Staff, Sierra Peer, she observed that Resident A had defected on himself and Ms. Peer did not rinse him off but bathed him in the water that contained the fecal material. She washed his face and his hair, and she never rinsed him off. The Home Manager Elizabeth Stoffers confirmed that Ms. Meidema had reported to her that Ms. Peer had not rinsed Resident A off before she bathed him. She reported that Ms. Peer is no longer employed by MOKA. During this investigation there was an eyewitness who reported what Ms. Peer had done to Resident A by not rinsing him off after he had soiled himself and bathed him in the fecal contained water. Therefore Ms. Peer did not treat Resident A with dignity and failed to protect him and provide for his safety. There is a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the licensee provide a written acceptable plan of correction and the license remain the same.

Arlene B. Smith 06/10/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 06/10/2025

Jerry Hendrick Date
Area Manager