GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2025

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

RE: License #: AS700066637
Investigation #: 2025A0357050
Summerside

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 #:	AS700066637
Investigation #:	2025A0357050
Complaint Receipt Date:	08/06/2025
Investigation Initiation Date:	08/06/2025
Report Due Date:	10/05/2025
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 Zvigzds
Licensee Designee:	Tracey Hamlet
Name of Facility:	Summerside
Facility Address:	386 Felch Street Holland, MI 49424
Facility Telephone #:	(616) 399-1134
Original Issuance Date:	10/01/1995
License Status:	REGULAR
Effective Date:	04/01/2024
Expiration Date:	03/31/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Two Direct Care Staff who were untrained in medication administration were left to administrator resident medications on 08/03/2025. The residents' medications were placed in plastic baggies by the Home Supervisor, who had signed her initials on the Resident's Medication Administration Record, indicating she had passed the medications.	Yes

III. METHODOLOGY

08/06/2025	Special Investigation Intake 2025A0357050
08/06/2025	Special Investigation Initiated - Letter Contacted Recipient Rights at Ottawa CMH.
08/15/2025	Contact - Telephone call made to Sheryl William, Resident Care Coordinator.
08/25/2025	Contact - Document Received Email from Briana Fowler, MPA, LBSW, Director of Recipient Rights, Ottawa County CMH.
09/15/2025	Inspection Completed On-site Unannounced inspection.
09/15/2025	Contact - Face to Face Interview with Assistant Home Supervisor, Autumn Rozeboon.
09/15/2025	Contact - Document Received Received and reviewed Medication Administration Records and Administration History on Resident A, B, C, D, and E.
09/23/2025	Contact - Telephone call made I conducted a telephone interview with Direct Care Staff, Camarae Bierlein and with the (former) House Supervisor, Gabriela Johnson.
09/29/2025	Telephone exit conference conducted with Tracey Hamlet the Licensee Designee.

ALLEGATION: Two Direct Care Staff who were untrained in medication administration were left to administrator resident medications on 08/03/2025. The residents' medications were placed in plastic baggies by the Home Supervisor, who had signed her initials on the Resident's Medication Administration Record, indicating she had passed the medications.

INVESTIGATION: On 09/15/2025, I made an unannounced inspection of the Summerside AFC home. I met with the Assistant Home Supervisor, Autumn Rozeboon. I explained that I was there about a complaint our department had received, and asked to speak to the Home Supervisor, Gabriela Johnson. Ms. Autumn explained that Ms. Johnson had set up residents' medications ahead of the administration times and she had one, not two, Direct Care Staff administer the resident medications. She reported that Direct Care Staff, Camarae Bierlein had administered medications at her former job. She had taken the on-line medication class, but she had not taken the demo class, and she was not recorded in the CMH system. Ms. Rozeboon stated that Ms. Johnson has been terminated because of the medication issue. Ms. Rozeboon stated that they have been short staffed for over a year and there have been occasions when 2nd shift staff were not trained in medication administration. She also explained that staff from other MOKA homes have filled in when they could and they also used agency staff, when it has been approved by the administration.

I asked Ms. Rozeboon if the Resident's medications were set up on 08/03/2025 and she reported no, but she understood they did find the dates July 26, & 27/2025. She said she never saw resident medications being set up ahead of time, but she had heard the medications had been set-up in Ziplock bags. She said she had heard that the dates that Ms. Johnson had set up resident medications were on July 26 & 27/2025

Ms. Rozeboon reported that she had set up one medication for Resident D, one time. She said she had to pick up her brother from work and take him home and there was no trained staff to administer Resident D's 5:00PM medication. She said she spoke with Ms. Johnson who told her it was okay to set it up for another staff to administer and told her to sign her initials on Resident D's MAR, like she had passed it herself. She stated that Ms. Johnson had told her that is what she had done in the past. She stated that it was Resident D's Mirtazapine tab 15MG. No date or name of the staff that had administered it was provided. She said she came back and administered all of the bedtime medications for the residents that evening. She said she learned through the investigation that what she had done was wrong and she would not do it again.

On 09/15/2025, I telephoned Cheryl Willimas who is the Residential Coordinator for MOKA South, while I was at the facility. She confirmed that the home has been short staffed for a long time, and they had difficulty finding staff to work in the home. She reported they had five staff for three shifts, and one staff member was part-time. She

stated that they have a good core of staff who have worked there a long time and many of them fill in. She stated that they terminated Ms. Johnson's employment.

On 09/15/2025, after I had spoken with Ms. Williams, I asked Ms. Rozenboon to print the resident's MAR's which she did for July and August 2025. She said that she had seen where Ms. Johnson had typed in a note that said something like 'no staff were med trained after 6:30.' She searched and she found the "Administration History" of each resident and was able to print them for me. As I reviewed them, I found a typed noted that read: "Early: No Med trained person after 6:30." I reviewed all of the five residents MAR's and recorded the dates where her initials were recorded and then matched that to her typed note on the Admin History.

On 09/23/2025, I spoke by telephone with Direct Care Staff, Camarae Bierlein. She explained that she had worked at Caring Hearts Community in Allegan before she came to Summerside and that she had passed medications in this facility. She said she had completed the medication class online but had not completed the class in person. She stated in the middle of July she had passed the resident medications that Ms. Johnson had set up in baggies which were in the med cart. She explained that it was straightforward with the instructions written out with the name of the resident and what to do and the time to pass the medications on each baggie. She said Ms. Johnson had put the paper cup in the baggie with the spoon and had left written instructions to use yogurt or applesauce. I asked her how many times she had passed the medications for Ms. Johnson, and she said two times. She said she passed the resident medications at bedtime between 7:00 and 8:00 PM. She stated that she did not sign the residents' MAR's, which were on the computer. She said Ms. Johnson had signed the MAR's. She said she now knows that what she did was wrong, but her boss had asked her to pass the resident medications, so she thought it was acceptable. Now she said she knows better. She reported that she has recently completed the medication class.

On 09/23/2025, I conducted a telephone interview with the former Home Supervisor, Gabriela Johnson. She stated she did not have staff to administer resident medications at bedtime and was told by her supervisor, 'just figure it out yourself.' She acknowledged that she asked Direct Care Staff, Ms. Bierlein, to pass the resident medications because she had experience passing medications at her former employer, but she had not taken the med class through Lake Shore Entity yet. She explained that she prepared each resident's medication in Ziplock bags with all the written instructions, including the name of the medication, the time to be administered and even putting them in with the cups for yogurt or applesauce with the spoon inside the baggie. She said she made it very clear. She stated that no one was hurt and everyone got their medications.

I asked Ms. Johnson to provide the dates that she had set up the resident medications for a non-trained staff member to administer them. She reported 07/12 & 13/2025 and on 07/26/2025. She acknowledged that she had typed in the

statement “Early: No Med trained person after 6:30.” She said it was a total of three times. She denied the date of 07/25/2025 and the date of 08/03/2025.

On 09/23/2025, I matched the dates that Ms. Johnson had provided to the med sheet and the Admin History, and what I had found in the way of dates was the same as she provided.

Resident A nighttime medications: With the initials of Ms. Johnson on the MAR for 07/12 & 13/2025 and on 07/26/2025.
8:00 pm, Divalproex Tab 500MG DR,
Mirtazapine Tab 15 MG,
Olanzapine Tab 10MG,
Stool Softener Cap 100mg,
Tamsulosin Cap 0.4MG,
Zonisamide Cap 100MG.

Resident B nighttime Medications: With the initials of Ms. Johnson on the MAR for 07/12 & 13/2025 and on 07/26/2025.
8:00 PM. Acetaminophen Tab 325, MG,
Levetiracetam Tab 750MG,
Lorazepam Tab 0.5MG,
Mirtazapine Tab 45MG,
Quetiapine Tab 25MG,
Senexon-S Tab 8.6-50MG.

Resident C nighttime Medications: With the initials of Ms. Johnson on the MAR for 07/12 & 13/2025 and on 07/26/2025.
8:00 PM. Melatonin Tab 1MG,
Olanzapine Tab 5MG,
Oxcarbazepine Tab 300MG,
Propranolol Tab 40 MG.

Resident D nighttime Medications: With the initials of Ms. Johnson on the MAR for 07/12 & 13/2025 and on 07/26/2025.
8:00 PM. Clonazepam Tab 0.5MG,
Docusate Sod Cap 100MG,
Donepezil Tab 10MG,
Mirtazapine Tab 15MG,
Risperidone Tab 1MG.

Resident E nighttime Medications: With the initials of Ms. Johnson on the MAR for 07/12 & 13/2025 and on 07/26/2025.
8:00 PM. Donepezil Tab 10MG,
Donepezil Tab 5MG,
Loratadine Tab 10MG,
Risperidone Tab 1MG,

There was a total of 25 medications per med pass for five residents that Ms. Johnson had set up in Ziplock baggies and she had initialed for in the residents' MAR's when she had not administered these medications. In addition, with no med-passer on 2nd shift the residents could not receive any PRN (as needed medications) during the shift.

On 09/29/2025 I conducted a telephone exit conference with the Licensee Designee, Tracey Hamlet and she agreed with my findings.

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:	Ms. Johnson, former Home Supervisor, Ms. Rozeboon, Assistant Home Supervisor, and Direct Care Staff, Camarae Bierlein all stated that Ms. Johnson had instructed Ms. Bierlein to administer resident medications even though she had not completed her medication administration class. During this investigation I found evidence that Ms. Bierlein had not successfully completed the class in medication administration, yet she administered resident medications on 7/12, 7/13 and 07/26/2025. Therefore, there is a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts, of 1978, as amended, being S333.1101 et seq. of the Michigan

	Complied Laws, kept with the equipment to administer it in a locked cabinet or drawer and refrigerated if required.
ANALYSIS:	Ms. Johnson, Former Home Supervisor, and Direct Care Staff, Ms. Bierlein both acknowledged that Ms. Johnson had set up resident medications from the original pharmacy-supplied container, into a Ziplock baggie for Ms. Bierlein to administer on 07/12, 7/13 and 07/26/2025. During this investigation I found that Ms. Johnson had taken residents' medications from the original pharmacy-supplied containers and transferred them into a Ziplock bag for Ms. Bierlein to the administrator. Therefore, there is a violation to this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Ms. Johnson, Ms. Bierlein and Ms. Rozeboon all acknowledged that Ms. Johnson had initialed the residents' Medication Administration Record, but she had not administered the medications. Ms. Bierlein acknowledged that she had administered the residents' medications, but she did not sign the residents MAR's. During this investigation I found that there was evidence that Ms. Johnson had signed the residents' MAR's when in fact she had not administered the residents' medications. Therefore, there is a violation to this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee Designee provide an acceptable plan of correction and then the complaint will be closed.

Arlene B. Smith 09/29/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 09/29/2025

Jerry Hendrick Date
Area Manager