



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 13, 2026

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

RE: License #: AS410069187
Investigation #: 2026A0579019
Lilly Home

Dear Tracey Hamlet:

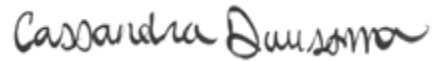
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in black ink that reads "Cassandra Duursma". The script is cursive and fluid.

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 #:	AS410069187
Investigation #:	2026A0579019
Complaint Receipt Date:	01/29/2026
Investigation Initiation Date:	01/29/2026
Report Due Date:	03/30/2026
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:	Lilly Home
Facility Address:	7249 Regal Avenue, SE, Grand Rapids, MI 49548-7761
Facility Telephone #:	(616) 455-7590
Original Issuance Date:	08/01/1996
License Status:	REGULAR
Effective Date:	12/15/2024
Expiration Date:	12/14/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A's nutritional needs were not met.	No
Resident A does not receive his diabetes medication correctly.	No
Additional Findings	Yes

III. METHODOLOGY

01/29/2026	Special Investigation Intake 2026A0579019
01/29/2026	Special Investigation Initiated - Letter Complainant
01/29/2026	APS Referral Kevin Souser, APS
02/06/2026	Contact- Face to Face Kennedy Kailiti, Direct Care Worker
02/24/26	Contact- Document Sent Kevin Souser, APS
03/09/2026	Contact- Face to Face Resident B Kennedy Kailiti, Direct Care Worker
03/09/2026	Contact- Document Sent Kevin Souser, APS
03/12/2026	Exit Conference Tracey Hamlet, Licensee Designee

ALLEGATION: Resident A's nutritional needs were not met.

INVESTIGATION: On 1/29/26, I received this referral which alleged Resident A's meal plan has not been followed. This has led to him losing 10 pounds and being hospitalized for failure to thrive.

On 1/29/26, I contacted the complainant to confirm receipt of the allegations. It was reported Adult Protective Services (APS) worker Kevin Souser was investigating as well. On 1/29/26, I contacted Mr. Souser to confirm my involvement.

On 2/6/26, I completed an unannounced on-site investigation at the home. It was

reported Resident A was still hospitalized and it is uncertain if or when he will be returning to the home. I completed an interview with direct care worker (DCW) Kennedy Kailiti.

Mr. Kailiti stated this home uses an electronic menu program called My25 to plan nutritionally balanced menus that reflect each resident's individual preferences and nutritional needs. He stated initially Resident A expressed dislike of the general menu for the home and used his personal funds to go to a local convenience store and purchase high calorie snacks. He stated Resident A's nutritionist eventually cleared him to be added to and follow the My25 menu used in the home.

Mr. Kailiti stated Resident A was initially compliant with the new menu but then began refusing meals and requesting alternatives such as peanut butter and jelly sandwiches. He stated if DCWs encouraged him to follow the menu, he would state, "I know my rights. I'll call (Office of Recipient) Rights on you." He stated that while Resident A did lose weight during January, his weight has fluctuated since he moved into the home in September 2025. He stated Resident A is not at a lower weight than he was when he moved into this home, so he does not understand how Resident A has been diagnosed with failure to thrive.

Mr. Kailiti stated he is the DCW who brought Resident A to his team meeting/ medical appointment on 1/23/26. He stated Resident A walked into the appointment independently and it was even discussed how Resident A was gaining strength and doing well at the meeting. He stated at the meeting, Resident A reported he had not felt well, even though he had not previously reported any concerns and appeared well. He stated Resident A requested an ambulance take him to the hospital and stated he could not breathe. He stated Resident A has been hospitalized since. Mr. Kailiti expressed concern that Resident A can be manipulative and has reported being unhappy at this placement.

I reviewed the home's menu for January and the My25 system which is a menu program that creates a nutritionally balanced menu tailored toward each resident and their nutritional needs. Resident A's preferences/substitutions were listed on the daily menu. The menu appeared nutritionally balanced and included three meals per day and a snack.

I reviewed Resident A's weight log. Resident A weighed an average of 170.7 in September 2025, 162 in October 2025, 177 in November 2025, and 180 in December 2025. Mr. Kailiti stated Resident A weighed 170 pounds at his appointment on 1/23/26.

Resident A's Medication Administration Record (MAR) reported Resident A was weighed weekly in January 2026. However, the weekly weights were not listed on the MAR and were averaged in the e-MAR system I observed.

On 2/24/26, I contacted Mr. Souser inquiring if he had any concerns during his

investigation. He advised Resident A did express concerns about having limited food in the home and showed him a photo of a limited breakfast menu, lacking protein, when Resident A was hospitalized. He reported he would be visiting Resident A at the home as it was reported he was discharged from the hospital back to the home.

On 3/9/26, I completed an unannounced on-site contact at the home with the assistance of licensing consultant Natasha Grew. Resident B and Mr. Kailiti were spoken to.

Resident B greeted Ms. Grew and I when staff led us into the home. He expressed willingness to be interviewed. He reported he receives adequate food at this home including breakfast, lunch, dinner and snacks. He stated his meals are balanced and he gets enough to eat.

Mr. Kailiti reported Resident A discharged from the home on 3/6/26 and was not present at the home. He reported he believes APS interviewed Resident A the home the week prior.

On 3/9/26, I exchanged emails with Mr. Souser who reported he was able to see Resident A at this home and he did not have any concerns following his contact with Resident A.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	<p>Resident A could not be interviewed due to being hospitalized and then discharging from the home. APS worker Kevin Souser interviewed Resident A twice and reported he did not have concerns after concluding his interviews with Resident A.</p> <p>Resident B reported receiving breakfast, lunch, dinner, and snacks. He reported the meals are sufficient and nutritious. He denied concerns about the food in the home.</p> <p>Mr. Kailiti stated a My25 menu tailored for each resident's preferences and nutritional needs is utilized in the home. He stated Resident A was included on the My25 menu in the home, but he preferred not to follow the menu.</p> <p>I observed the My25 menu from January 2026 and the My25 system. The My25 menu listed three nutritious meals and a snack daily.</p>

	<p>I observed Resident A's weight log, which was an average of monthly weigh-ins. His weight fluctuated monthly during his time in this home.</p> <p>Based on the interviews completed and documentation reviewed, there is insufficient evidence that Resident A was not provided three nutritious meals daily.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A does not receive his diabetes medication correctly.

INVESTIGATION: On 1/29/26, I received this referral which alleged Resident A does not receive his diabetes medication correctly.

On 2/6/26, Mr. Kailiti stated it is impossible that Resident A would not be receiving his diabetes medication correctly. He stated Resident A complies with his diabetes treatment and the only medical assistance he typically refuses is his pulmonary machine. He stated Resident A wears a glucose monitor which is connected to an alert system on a tablet in the home which alerts staff when his blood glucose is too low or too high. He stated there is a very simple chart that DCWs follow to determine how much insulin needs to be given when his glucose is too high or how many carbs he needs to consume when it is too low. He stated DCWs document the treatment given on a log. He stated Resident A's diabetes is well managed in this home and he has no concern that his medication is not given correctly.

I observed a document where DCWs noted how much insulin or carbohydrates were given to Resident A which was not a part of the MAR. This confirmed Resident A was receiving diabetes management in the home.

Resident A's MAR noted Resident A's glucose monitor was replaced appropriately by Mr. Kailiti on 1/14/26. It was documented that Resident A occasionally refused medications.

On 2/24/26, Mr. Souser denied having any immediate concerns.

On 3/9/26, Resident B reported he receives medication daily and denied concerns for not receiving his medication correctly.

On 3/9/26, Mr. Souser denied concerns after interviewing Resident A at the home and observing the home.

On 3/11/26, I reviewed the case file for this home and found SIR#2025A0357056 from 9/9/25, which addressed allegations that Resident A did not receive his insulin correctly. Evidence was not found to support the allegations at that time.

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:	<p>Resident A's MAR noted Resident A would refuse medications.</p> <p>Mr. Kailiti denied it was possible that Resident A did not receive his necessary diabetes medication due to Resident A having a glucose monitor and alert system in the home.</p> <p>I observed documentation, outside of the MAR, noting diabetes interventions DCWs were providing to Resident A.</p> <p>Resident A's MAR noted Mr. Kailiti following replacing Resident A's glucose monitor appropriately.</p> <p>Based on the interviews completed and documentation observed, there is insufficient evidence that the instructions and recommendations of Resident A's physician were not followed with Resident A's cooperation.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 2/6/26, I while reviewing Resident A's MAR. I noticed DCW initials were missing, leaving the box confirming the medication had been passed blank, for the following medications on the following dates:

Antifungal POW 2% at 8:00 a.m.- 1/2/26 and 1/10/26
 Antifungal POW 2% at 8:00 p.m.- 1/5/26
 Benefiber POW at 8:00 a.m.- 1/2/26, 1/10/26, and 1/16/26
 Ciprofloxacin TAB 750 MG at 8:00 p.m.- 1/21/26
 Dekas Plus CAP at 8:00 a.m.- 1/2/26 and 1/10/26
 Dekas Plus CAP at 8:00 p.m.- 1/5/26
 Eplerenone TAB 50 MG at 8:00 a.m.- 1/2/26 and 1/10/26
 Eplerenone TAB 50 MG at 12:00 p.m.- 1/1/26, 1/3/26-1/5/26, 1/8/26, 1/10/26
 Erythromycin OIN at 8:00 PM- 1/5/26
 Fluoxetine CAP 20 MG at 8:00 a.m.- 1/2/26 and 1/10/26
 Furosemide TAB 80 MG at 8:00 a.m.- 1/2/26 and 1/10/26
 Lantus Solos INJ 100/ML at 8:00 a.m.- 1/2/26 and 1/10/26
 Levalbuterol NEB 0.63MG at 5:00 p.m.- 1/4/26 and 1/5/26
 Levetiracetam TAB 500 MG at 8:00 a.m.- 1/2/26 and 1/10/26

Levetiraceta TAB 500 MG at 8:00 p.m.- 1/5/26
 Loratadine TAB 10 MG at 8:00 a.m.- 1/2/26 and 1/10/26
 Megestrol AC SUS 40MG/ML at 8:00 a.m.- 1/2/26 and 1/10/26
 Montelukast TAB 10MG at 8:00 p.m.- 1/5/26
 Mucinex-Mucus Relief ER 1200 MG at 8:00 a.m.- 1/2/26 and 1/10/26
 Mucinex-Mucus Relief ER 1200 MG at 8:00 p.m.- 1/5/26
 Pantoprazole TAB 40 MG at 8:00 a.m.- 1/2/26 and 1/10/26
 Pantoprazole TAB 40 MG at 5:00 p.m.- 1/4/26 and 1/5/26
 Polyeth Glyc Pow 3350 NF at 8:00 a.m.- 1/2/26 and 1/10/26
 Polyeth Glyc Pow 3350 NF at 8:00 p.m.- 1/5/26
 Pregabalin CAP 50 MG at 8:00 a.m.- 1/2/26 and 1/10/26
 Pregabalin CAP 50 MG at 8:00 p.m.- 1/5/26
 Pulmozyme SOL 1MG/ML at 5:00 p.m.- 1/4/26 and 1/5/26
 Quetiapine TAB 100 MG at 8:00 p.m.- 1/5/26
 Ropinirole TAB 0.5 MG at 8:00 p.m.- 1/5/26
 Ursodiol CAP 300 MG at 8:00 a.m.- 1/2/26 and 1/10/26
 Ursodiol CAP 300 MG at 4:00 p.m.- 1/4/26 and 1/5/26
 Ursodiol CAP 300 MG at 8:00 p.m.- 1/5/26
 Zinc Sulfate TAB 220MG at 8:00 a.m.- 1/2/26 ad 1/10/26

Resident A's PRN medications, including medications for diabetes aside from Creon CAP 36000UNT, were primarily left blank on the MAR.

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(b) Complete an individual medication log that contains all of the following:</p> <p>(v) Initials of the individual who administered the medication at the time given.</p>
ANALYSIS:	<p>Resident A's MAR was found to be incomplete with boxes missing initials indicating the medication was passed on 1/1/26, 1/2/26, 1/3/26, 1/4/26, 1/5/26, 1/8/26, 1/10/26, 1/16/26, and 1/21/26.</p> <p>Based on the documentation reviewed there is sufficient evidence direct care workers did not comply with documenting the initials of the individual who administered the medication at the time given.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 3/12/26, I completed an exit conference with licensee designee Tracey Hamlet 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 remains the same.

Cassandra Duursma

03/12/2026

Cassandra Duursma
Licensing Consultant

Date

Approved By:

Jerry Hendrick

03/12/2026

Jerry Hendrick
Area Manager

Date