



STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

GRETCHEN WHITMER  
GOVERNOR

MARLON I. BROWN, DPA  
DIRECTOR

May 28, 2026

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

RE: License #:	AS610419070
Investigation #:	2026A0356033
	Brooks

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. If 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 cursive script that reads "Elizabeth Elliott". The signature is written in black ink and is positioned below the word "Sincerely,".

Elizabeth Elliott, Licensing Consultant  
Bureau of Community and Health Systems  
350 Ottawa, N.W.  
Grand Rapids, MI 49503  
(616) 901-0585

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS610419070
<b>Investigation #:</b>	2026A0356033
<b>Complaint Receipt Date:</b>	04/06/2026
<b>Investigation Initiation Date:</b>	04/06/2026
<b>Report Due Date:</b>	06/05/2026
<b>Licensee Name:</b>	MOKA Non-Profit Services Corp
<b>Licensee Address:</b>	Suite 201 715 Terrace St. Muskegon, MI 49440
<b>Licensee Telephone #:</b>	(616) 719-4263
<b>Administrator:</b>	Tracey Hamlet
<b>Licensee Designee:</b>	Tracey Hamlet
<b>Name of Facility:</b>	Brooks
<b>Facility Address:</b>	599 S. Brooks Rd Muskegon, MI 49442
<b>Facility Telephone #:</b>	(231) 830-9376
<b>Original Issuance Date:</b>	07/09/2025
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/08/2026
<b>Expiration Date:</b>	01/07/2028
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Staff Kim Bertoia administered medications to the wrong resident.	Yes
Staff Shannon Lamb failed to administer resident medications.	Yes

## III. METHODOLOGY

04/06/2026	Special Investigation Intake 2026A0356033
04/06/2026	APS Referral APS, denied.
04/06/2026	Special Investigation Initiated - Telephone Casey Olson, Health West ORR
04/08/2026	Contact - Telephone call received Licensing Consultant, R. Piccard.
04/09/2026	Contact - Telephone call made Casey Olson, ORR, HW.
04/13/2026	Contact - Document Received Email from R Piccard, Lic. Consultant with d/c paperwork from Urgent Care.
04/17/2026	Inspection Completed On-site
04/17/2026	Contact - Face to Face Kim Bertoia, DCW, Shannon Lamb, DCW.
04/17/2026	Contact - Document Received Resident MARs. IR (Incident Report) for 03/10/2026.
04/21/2026	Contact - Telephone call made Shannon Lamb re: interview Yakyria Mitchell.
04/27/2026	Contact - Telephone call made Casey Olson, ORR, Yakyria Mitchell, DCW.
05/27/2026	Exit conference- Tracey Hamlet, Licensee Designee

**ALLEGATION: Staff Kim Bertoia administered medications to the wrong resident.**

**INVESTIGATION:** On 04/06/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that in early March 2026, DCW (direct care worker) Kim Bertoia gave Resident A the wrong medication which resulted in Resident A requiring medical attention. Adult Protective Services (APS) denied this complaint for investigation.

On 04/06/2026, I interviewed Casey Olson, Health West, Office of Recipient Rights. Ms. Olson stated she is currently investigating these allegations. We discussed the allegations and will attempt to coordinate interviews.

On 04/08/2026, I interviewed Rebecca Piccard, LARA BCHS Licensing Consultant. Ms. Piccard stated she is awaiting the arrival of a fax from Ms. Olson containing a Trinity Health, Muskegon Emergency Room (ER), after visit summary dated 03/10/2026. Ms. Piccard stated she would forward the fax to me for review.

On 04/13/2026, I reviewed the Trinity health, Muskegon ER after visit summary dated 03/10/2026 for Resident A. The instructions documented Resident A was seen and evaluated in the ER for an 'accidental drug intoxication.' The document showed Resident A was seen and evaluated by 'Dr. W. Deaton, DO and Dr. C. Topp, DO, reason for visit, altered mental status, drug overdose, diagnoses, accidental drug ingestion, initial encounter, bradycardia.'

On 04/17/2026, I conducted an unannounced inspection at the facility and interviewed DCW Kim Bertoia. Ms. Bertoia stated on 03/10/2026 the residents sat in the same chairs at the dining room table that they sit at every meal, Resident A was sitting in her chair and Resident B was sitting in her chair. Both residents had the same color shirt on; the residents were content and so she (Ms. Bertoia) went to get Resident B's medications prepared for administration. Ms. Bertoia came back to the dining room and unbeknownst to her, Resident B had left the table to go to bed and Resident A moved into Resident B's spot at the table. Ms. Bertoia stated she gave Resident A, Resident B's medications in error, thinking she was giving Resident B her medications. Ms. Bertoia stated Resident A took the medications before she realized her mistake and she attempted to stop Resident A from swallowing the pills but was not quick enough to stop her. Ms. Bertoia stated she called poison control and they told her to check Resident A's pulse every two hours and that Resident A would get tired from the medication she took. Ms. Bertoia stated she checked Resident A's pulse every 30 minutes, that Resident A did become tired, but when her heart rate went from 60 to 40, she (Ms. Bertoia) called 9-1-1 and an ambulance responded to the facility. Ms. Bertoia stated EMS (emergency medical services) treated Resident A in the driveway then took her to Trinity ER where she stayed for a few hours for monitoring. Ms. Bertoia stated on March 10, 2026, she administered all Resident B's 8:00a.m. medications to Resident A in error. Ms. Bertoia stated she

is taking a medication class and residents will now be required to go to the office where the medications are stored and get their medications one at a time in the office.

On 04/27/2026, Ms. Olson and I interviewed DCW Yakyria Mitchell via telephone. Ms. Mitchell stated she was working 1<sup>st</sup> shift on 03/10/2026 with Ms. Bertoia and Ms. Bertoia was passing resident medication. Ms. Mitchell stated Resident A & B were sitting in their seats at the dining table when Resident B moved out of her seat and left. Resident A sat down in Resident B's chair at the table and then Ms. Bertoia passed Resident B's medications to Resident A. Ms. Mitchell stated Ms. Bertoia told Resident A that she needed to "throw up" and Ms. Bertoia "was looking for stuff to make her throw up but couldn't find anything." Ms. Mitchell stated that Ms. Bertoia tried to make Resident A throw up by having Resident A put her own finger down her throat to throw up. Ms. Mitchell stated Resident A threw up a little bit but not much. Ms. Mitchell stated Ms. Bertoia called poison control, the Health West nurse and Shannon Lamb, home manager. Ms. Mitchell stated Ms. Bertoia took Resident A's vitals and monitored them closely. Resident A began to get sleepy and when her blood pressure began to fluctuate, Ms. Bertoia called 9-1-1 to get an ambulance. Ms. Mitchell stated Ms. Lamb accompanied Resident A to the hospital.

On 04/27/2026, I reviewed the MAR (medication administration record) for Resident B's 8:00a.m. medications. The medications Ms. Bertoia administered to Resident A that were prescribed to Resident B are as follows:

- Acetaminophen 500mg
- Calcium 500-Vit D3
- Cetirizine Tab 10mg
- Clonazepam Tab 1mg
- Ferrous Sulfate 325mg
- Fish Oil cap 1000mg
- Folic Acid Tab 1mg
- Meloxicam Tab 15mg
- Metoprolol Suc Tab 25mg
- Multivitamin Tab
- Phenobarb Tab 64.8mg
- Pot Chloride Tab 10MEQ ER
- Quetiapine Tab 100MG
- Risperidone Tab 2MG
- Sertraline Tab 25MG

On 04/27/2026, I reviewed an IR (Incident Report) dated 03/10/2026, written by Ms. Bertoia and signed by Ms. Lamb. The IR documented, '(Resident A) was accidentally administered incorrect medication. Called on call nurse but she did not answer. Poison Control was called immediately and gave instructions. On call nurse was called but did not respond. Supervisor was notified. Followed instructions from poison control. (Resident A) did not ingest toxic levels of any medication, do not

administer (Resident A's) morning medications, monitor blood pressure every two hours for 4 to 6 hours, watch for jitteriness and agitation, if either occur, go to emergency room. Notify PCP or pharmacy for further instructions, notified Health West nurse Cassie. After monitoring closely throughout the morning and checking her BP as instructed, (Resident A) seemed good at first. Within 3 to 3.5 hours, (Resident A) became very groggy. Poison Control said the medications would make her sleepy, I was concerned and began checking her BP, Pulse Ox level, and pulse every 10 minutes just to be sure. When (Resident A's) resting heart rate (pulse) dropped below the average (60 to 100bpm), I spoke with my supervisor and called 911. Steps taken to avoid this occurrence in the future, triple check both patient and meds to ensure they are administered correctly, avoid distractions as much as possible in the home, have secondary staff assist.'

On 05/28/2026, I conducted an exit conference with Tracey Hamlet, Licensee Designee via telephone. Ms. Hamlet stated she is aware of this incident and they are taking steps to have more support at this facility to prevent similar incidents from occurring. Ms. Hamlet stated she understands the information, analysis, and conclusion of this applicable rule violation and will submit an acceptable corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
<b>ANALYSIS:</b>	<p>The complainant reported that in early March 2026, DCW Ms. Bertoia gave Resident A another resident's medication which resulted in Resident A requiring medical attention.</p> <p>Based on my investigative findings, it is determined that on 03/10/2026 Ms. Bertoia administered Resident B's 8:00a.m. medications to Resident A erroneously and Resident A required medical attention as a result. A violation of this applicable rule is established.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION: Staff Shannon Lamb failed to administer resident medications**

**INVESTIGATION:** On 04/06/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported the manager of the facility, Shannon Lamb forgot to pass resident medications on 01/15/2026. The complainant reported that Shannon Lamb

and assistant manager Kim Bertoia threw the medication away and charted it as passed.

On 04/06/2026, I interviewed Casey Olson, Health West, Office of Recipient Rights Officer. Ms. Olson stated she is currently investigating these allegations. We discussed the allegations and will attempt to coordinate interviews.

On 04/17/2026, I conducted an unannounced inspection at the facility and interviewed DCW Shannon Lamb. Ms. Lamb stated on 01/15/2026 she was at the facility and left at approximately 3:00p.m. and did not pass residents' 4:00p.m. medications prior to leaving. Ms. Lamb stated Ms. Bertoia was returning to the facility at 4:00p.m. and "thought she (Ms. Bertoia) was going to" pass the 4:00p.m. medications. Ms. Lamb stated Ms. Bertoia thought Ms. Lamb passed the resident medications before she left the facility so all 5 residents' 4:00p.m. medications were not administered on 01/15/2026. Ms. Lamb stated she is not aware that the medications were charted on that day as administered.

On 04/17/2026, I conducted an unannounced inspection at the facility and interviewed DCW Kim Bertoia. Ms. Bertoia stated she "thinks" she charted the medications as passed on 01/15/2026 at 4:00p.m. pass on the electronic MAR system and that she did not pass the 4:00p.m. medications on 01/15/2026 to the residents in the facility.

On 04/27/2026, Ms. Olson and I interviewed DCW Yakyria Mitchell via telephone. Ms. Mitchell stated she started working at this facility in October 2025 and did not begin passing medications until January 2026. Ms. Mitchell stated she worked 2<sup>nd</sup> shift on 01/15/2026 and she clicked on Resident C's MAR chart on the computer and a medication popped up for administration. Ms. Mitchell stated she asked Ms. Bertoia what that meant, Ms. Bertoia called Ms. Lamb to find out what that was all about. Ms. Mitchell stated she did not hear what Ms. Lamb told Ms. Bertoia but she (Ms. Mitchell) stated she observed Ms. Bertoia throw medications in the garbage can, she took the garbage outside to the garbage bin and said that is not something she (Ms. Mitchell) should do. Ms. Mitchell stated the medications that were disposed of were Resident A and B's 4:00p.m. medications (on 01/15/2026). Ms. Mitchell stated Ms. Bertoia reported that Resident B's medications were only vitamins so her medications were "not that big of a deal". Ms. Mitchell stated this all occurred at 8:00p.m. when she noticed on the MAR computer system that Resident A and B's 4:00p.m. medications had not been administered. Ms. Mitchell stated she did not see Ms. Bertoia go into the system and document that the medications had been given to the residents.

On 04/27/2026, I reviewed the MARs for Resident A, B, C, D, and E for the month of January 2026. The MAR documented the following:

- Resident A does not have any medications documented to be administered at 4:00p.m. on 01/15/2026. However, all Resident A's 8:00a.m. medications on

01/15/2026 are documented with a 0-which means, 'not administered.' On the last page of the MAR the explanation as to why the medications were not administered is 'LOA' which means, leave of absence. The medications not administered were as follows, 'Alvesco AER 160MCG, inhale one puff by mouth twice daily for Asthma, Arnuity ELPT INH 200MCG inhale one puff by mouth once daily, Buspirone Tab 15mg, take one tablet by mouth twice daily, Clotrimazole Cre 1%, apply to affected areas on feet every morning, Desitin 1.3% Cream apply to the affected area at bedtime (this was a 8:00p.m. medication not signed as administered), Famotidine Tab 40mg, take one tablet by mouth once daily, Hydrocortisone 1% cream, apply to the affected area in the evening (8:00p.m. medication not signed as administered), L-Methylfolate 15mg take one tablet by mouth once daily, Loratadine tab 10mg, take one tablet by mouth once daily, Fish Oil 2,000mg, take one capsule by mouth once daily, multivitamin tab, take one tablet by mouth every morning, Nystatin Pow 1000000, apply to the affected area twice daily is not signed as administered at 8:00a.m. and 8:00p.m., Oxybutynin tab 5mg ER, take one tablet by mouth every morning, Paroxetine Tab 40mg, take one tablet by mouth once daily, Risperidone Tab 2mg take one tablet by mouth twice daily, Vitamin B complex tab, take one tablet by mouth once daily, Vitamin D3 Cap 50000 unit, cholecalciferol, take one capsule by mouth once daily.'

- Resident B had medications to be administered at 4:00p.m. that are signed as administered by 'KB1,' which is Ms. Bertoia on 01/15/2026. Those medications are as follows, 'Acetaminophen 500mg, take two tablets by mouth three times daily, Blood pressure, check blood pressure and record, Divalproex Tab 250mg, take two tablets by mouth twice daily, Ensure Compl liquid vanilla, drink one can by mouth four times daily, Sertraline Tab 50mg, take one tablet by mouth in the evening.'
- Resident C had medications to be administered at 4:00p.m. on 01/15/2026, that are marked with a 0-which means, 'not administered.' On the last page of the MAR the explanation as to why the medications were not administered is 'LOA' which means, leave of absence. The medications not administered were, 'APAP Codeine Tab 300-30mg, take one tablet by mouth three times daily, Baclofen Tab 10mg, take one tablet by mouth three times daily, Gabapentin Cap 300mg, take two capsules by mouth three times daily, Methsuximide Cap 300mg, take one capsule by mouth three times daily, Quetiapine Tab 400mg ER, take one tablet by mouth every 24 hours.'
- Resident D had no medications to be administered at 4:00p.m. on 01/15/2026.
- Resident E had no medication to be administered at 4:00p.m. on 01/15/2026.

On 05/28/2026, I conducted an exit conference with Tracey Hamlet, Licensee Designee via telephone. Ms. Hamlet stated she is aware of this incident and they are taking steps to have more support at this facility to prevent similar incidents from occurring. Ms. Hamlet stated she understands the information, analysis, and conclusion of this applicable rule violation and will submit an acceptable corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
<b>ANALYSIS:</b>	<p>The complainant reported Ms. Lamb forgot to pass resident medications on 01/15/2026. The complainant reported that Shannon Lamb and assistant manager Kim Bertoia threw the medications away and charted them as passed.</p> <p>Based on my investigative findings, there is a preponderance of evidence to indicate that on 01/15/2026, residents' 4:00p.m. medications were not administered and were not documented correctly as missed administration. A violation of this applicable rule is therefore established.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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



05/28/2026

Elizabeth Elliott  
Licensing Consultant

Date

Approved By:



05/28/2026

Jerry Hendrick  
Area Manager

Date