



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2026

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

RE: License #: AS610419069
Investigation #: 2026A0340060
Horton

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,

A handwritten signature in blue ink that reads "Rebecca Piccard". The signature is fluid and cursive, with the first name "Rebecca" and last name "Piccard" clearly distinguishable.

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610419069
Investigation #:	2026A0340060
Complaint Receipt Date:	09/08/2026
Investigation Initiation Date:	09/08/2026
Report Due Date:	11/07/2026
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(616) 719-4263
Administrator:	Ann Meldrum
Licensee Designee:	Tracey Hamlet
Name of Facility:	Horton
Facility Address:	1231 Horton Road Muskegon, MI 49445
Facility Telephone #:	(231) 830-9376
Original Issuance Date:	03/24/2025
License Status:	REGULAR
Effective Date:	09/24/2025
Expiration Date:	09/23/2027
Capacity:	3
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents were left without staff present in the home for approximately 30 minutes when 3 rd shift staff left the home before another staff arrived.	Yes

III. METHODOLOGY

09/08/2026	Special Investigation Intake 2026A0340060
09/08/2026	APS Referral Rejected for investigation by APS
09/08/2026	Special Investigation Initiated - Letter Kim Thelen-home manager
09/09/2026	Inspection Completed On-site
09/09/2026	Inspection Completed-BCAL Sub. Compliance
09/10/2026	Exit Conference Tracey Hamlet

ALLEGATION: Residents were left without staff present in the home for approximately 30 minutes when 3rd shift staff left the home before another staff arrived.

INVESTIGATION: On September 8, 2026, a complaint was filed with the BCHS Online Complaints. It stated that residents at the Horton AFC home were left without any staff for about 30 minutes until relief staff arrived around 3:00AM. All the residents were asleep in bed and appeared safe when relief staff arrived.

On September 8, 2026, I spoke with home manager, Kim Thelen. I asked Ms. Thelen to explain what happened that staff left the home in the middle of the night. She stated 3rd shift staff Katie Highland, became very ill and needed to go to the ER. As a result there were approximately 30 minutes when no staff were at the home. Ms. Thelen arrived and immediately checked all the residents. They were all asleep in their beds with no concerns noted. None of them even knew what happened.

I asked Ms. Thelen about MOKA's policy for calling off of work and getting fill in/relief. She stated there is a hierarchy phone list. Since Ms. Thelen is the home manager she was called and was able to go to the home asap. I asked why Ms. Highland was unable to stay until she arrived. Ms. Thelen stated she had become

violently ill and was afraid she was going to pass out. Her husband came to the home and took her to the ER immediately.

I requested the Incident Report (IR) for Ms. Highland leaving, which she sent. I reviewed the IR completed by Ms. Thelen and signed on 9/4/26. It stated “while cleaning the bathroom that had been coated with tile sealant earlier in the day, staff became dizzy and started vomiting. Due to the severity, staff left the home to go to the emergency room. Residents were left in the home without staff for 30 minutes before supervisor arrived to Horton.”

On September 9, 2026, I conducted an unannounced home inspection. Ms. Thelen was present at the time of my inspection. We again discussed the issue which occurred. There are three residents in the home, none of whom were awake or aware that they had been left unsupervised.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities. (b) 12 residents for small group and family homes.
ANALYSIS:	A complaint was filed stating Ms. Highland left the home unexpectedly and residents were left unsupervised. It was 30 minutes before relief staff arrived. Residents were home with no staff present. Ms. Thelen stated Ms. Highland had become violently ill and was taken to the ER by her husband. She arrived approximately 30 minutes after Ms. Highland left. No residents were awake, harmed, or knew what had happened. There is a preponderance of evidence to support the allegation that residents were left unsupervised.
CONCLUSION:	VIOLATION ESTABLISHED

On September 10, 2026, I conducted an exit conference with Designee Tracey Hamlet. We discussed the situation and rule violation found. I requested a Corrective Action Plan which she agreed to send. She had no further questions.

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the current license status.

 September 29, 2026

Rebecca Piccard
Licensing Consultant

Date

Approved By:

 September 29, 2026

Jerry Hendrick
Area Manager

Date