GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 11, 2023

Satara McMillian
2115 Francis Ave.
Grand Rapids, MI 49507

RE: License #: AS410389803
Investigation #: 2023A0583025
Home Of Hearts

Dear Ms. McMillian:

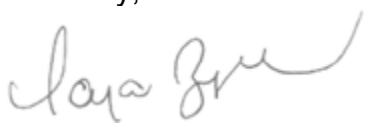
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410389803
Investigation #:	2023A0583025
Complaint Receipt Date:	04/05/2023
Investigation Initiation Date:	04/05/2023
Report Due Date:	05/05/2023
Licensee Name:	Satara McMillian
Licensee Address:	2115 Francis Ave. Grand Rapids, MI 49507
Licensee Telephone #:	(616) 633-3953
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Home Of Hearts
Facility Address:	2115 Francis Grand Rapids, MI 49507
Facility Telephone #:	(616) 633-3953
Original Issuance Date:	11/13/2017
License Status:	REGULAR
Effective Date:	05/13/2022
Expiration Date:	05/12/2024
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff DeNitrice Bruce worked alone at the facility without completing a required background check.	Yes
Licensee Satara McMillian enrolled Resident A in counseling without her guardian's permission.	No
Staff DeNitrice Bruce worked alone at the facility without completing required trainings.	Yes
Staff DeNitrice Bruce worked alone at the facility without completing a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of Ms. Bruce's physical health.	Yes
Staff DeNitrice Bruce worked alone at the facility without completing a test for communicable tuberculosis.	Yes
Resident A is required to leave the facility daily.	No

III. METHODOLOGY

04/05/2023	Special Investigation Intake 2023A0583025
04/05/2023	APS Referral
04/05/2023	Special Investigation Initiated - Letter Recipient Rights Ed Wilson
04/06/2023	Inspection Completed On-site Licensee Satara McMillian, Staff Sharon Bruce-Carey, Staff DeNitrice Bruce
04/07/2023	Contact -Telephone call made Resident A
04/07/2023	Contact – Telephone call made Unlimited Alternatives Executive Director Deanna Arnett
04/11/2023	Exit Conference Licensee Satara McMillian

ALLEGATION: Staff DeNitrice Bruce worked alone at the facility without completing a required background check.

INVESTIGATION: On 04/05/2023 complaint allegations were received from the BCAL online reporting system. The complaint allegations stated that on "March 29

there was an emergency and Sharon, the house manager had to go to the hospital, and of course there was nobody to stay with the ladies, so Sharon's sister, "Neecy" came to stay and it was unknown if “Neecy” was a staff.

On 04/05/2023 I emailed the complaint allegations to Adult Protective Services Centralized Intake and to Ed Wilson of Network 180 Recipient Rights.

On 04/06/2023 I completed an unannounced onsite investigation at the facility and interviewed licensee Satara McMillian, staff Sharon Bruce-Carey, and staff DeNitrice Bruce.

Licensee Satara McMillian stated all residents were currently at “day programs” and therefore could not be interviewed onsite. Ms. McMillian stated that on 03/29/2023 staff Sharon Bruce-Carey required a visit to the Emergency Department and subsequently staff DeNitrice Bruce came to the facility to care for residents. Ms. McMillian stated Ms. Bruce provided care to residents by herself for approximately two hours. Ms. McMillian stated she has not completed a background check via the Michigan Workforce Background Check system for Ms. Bruce.

Staff Sharon Bruce-Carey stated that on 03/29/2023 she left the facility for approximately two hours to visit the Emergency Department and while absent, Ms. Bruce worked alone providing care for residents.

Staff DeNitrice Bruce stated that on 03/29/2023 she worked alone and provided care to residents while Ms. Bruce was at the Emergency Department. Ms. Bruce stated that she has not completed a background check via the Michigan Workforce Background Check system.

On 04/11/2023 I completed an Exit Conference via telephone with licensee Satara McMillian via telephone. Ms. McMillian stated she understood the findings and will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in

	compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Licensee Satara McMillian and staff DeNitrice Bruce each stated Ms. Bruce worked independently at the facility on 03/29/2023 despite not completing a required background check. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates the licensee did not complete a required Workforce Background check on staff DeNitrice Bruce.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Licensee Satara McMillian enrolled Resident A in counseling without her guardian's permission.

INVESTIGATION: On 04/05/2023 complaint allegations were received from the BCAL online reporting system. The allegations stated that licensee Satara McMillian "had a meeting with the Director of the day program at UA and

signed Resident A up for group therapy sessions and one on one without (Resident A's) legal guardian's permission."

On 04/06/2023 I completed an unannounced onsite investigation at the facility and interviewed licensee Satara McMillian. Ms. McMillian stated Resident A's legal guardian is Sheryl Cunningham. Ms. McMillian stated Resident A attends the Unlimited Alternatives day-program which includes an optional peer led group component. Ms. McMillian stated Ms. Cunningham signed Resident A up for the day program months prior. Ms. McMillian stated she did not sign Resident A up for any group or individual counseling at Unlimited Alternatives.

On 04/07/2023 I interviewed Resident A via telephone. Resident A stated she attends the Unlimited Alternatives day-program. Resident A stated she does not receive counseling at the facility but voluntarily attends a peer led group.

On 04/07/2023 I interviewed Unlimited Alternatives Executive Director, Deanna Arnett via telephone. Ms. Arnett stated the facility does not offer any type of counseling programs but does include a peer led support group which is optional to any individual that attends the day program.

On 04/11/2023 I completed an Exit Conference via telephone with licensee Satara McMillian via telephone. Ms. McMillian stated she agreed with the findings.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(11) A licensee, direct care staff, and an administrator shall be willing to cooperate fully with a resident, the resident's family, a designated representative of the resident and the responsible agency.
ANALYSIS:	Licensee Satara McMillian stated Resident A's legal guardian is Sheryl Cunningham and Ms. Cunningham enrolled Resident A in the Unlimited Alternatives day-program. Ms. McMillian stated Resident A attends the Unlimited Alternatives day-program which includes an optional peer led group component. Ms. McMillian stated she did not sign Resident A up for any group or individual counseling at Unlimited Alternatives. Resident A stated she voluntarily participates in a peer led group located within her day program.

	Unlimited Alternatives Executive Director Deanna Arnett stated the facility does not offer any type of counseling service but does include a peer led support group which is optional to any individual that attends the day program. A preponderance of evidence was not discovered during the special investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff DeNitrice Bruce worked alone at the facility without completing required trainings.

INVESTIGATION: On 04/05/2023 complaint allegations were received from the BCAL online reporting system. The complaint allegations stated that on “March 29 there was an emergency and Sharon, the house manager had to go to the hospital, and of course there was nobody to stay with the ladies, so Sharon's sister, "Neecy" came to stay and it is unknown if Neecy was a staff”.

On 04/06/2023 I completed an unannounced onsite investigation at the facility and interviewed licensee Satara McMillian, staff Sharon Bruce-Carey, and staff DeNitrice Bruce.

Licensee Satara McMillian stated that on 03/29/2023 staff Sharon Bruce-Carey required a visit to the Emergency Department and therefore staff DeNitrice Bruce came to the facility to care for residents. Ms. McMillian stated Ms. Bruce independently provided care to residents for approximately two hours. Ms. McMillian stated Ms. Bruce has not completed required trainings.

Staff Sharon Bruce-Carey stated that on 03/29/2023 she left the facility for approximately “two hours” to visit the Emergency Department and while absent, Ms. Bruce independently provided care for residents.

Staff DeNitrice Bruce stated that on 03/29/2023 she provided care independently to residents while Ms. Bruce-Carey was at the Emergency Department. Ms. Bruce stated that she has not completed required trainings.

On 04/11/2023 I completed an Exit Conference via telephone with licensee Satara McMillian via telephone. Ms. McMillian stated she agreed with the findings and will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Licensee Satara McMillian and staff DeNitrice Bruce both stated Ms. Bruce worked independently at the facility on 03/29/2023 despite not completing required trainings. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates staff DeNitrice Bruce worked independently at the facility without completing required trainings.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff DeNitrice Bruce worked alone at the facility without completing a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of Ms. Bruce's physical health.

INVESTIGATION: On 04/05/2023 complaint allegations were received from the BCAL online reporting system. The complaint allegations stated that on "March 29 there was an emergency and Sharon, the house manager had to go to the hospital, and of course there was nobody to stay with the ladies, so Sharon's sister, "Neecy" came to stay and it is unknown if Neecy was a staff".

On 04/06/2023 I completed an unannounced onsite investigation at the facility and interviewed licensee Satara McMillian, staff Sharon Bruce-Carey, and staff DeNitrice Bruce.

Licensee Satara McMillian stated that on 03/29/2023 staff Sharon Bruce-Carey required a visit to the Emergency Department and therefore staff DeNitrice Bruce

came to the facility to care for residents. Ms. McMillian stated Ms. Bruce independently provided care residents for approximately two hours. Ms. McMillian stated Ms. Bruce has not completed a medical examination attesting to her physical health.

Staff Sharon Bruce-Carey stated that on 03/29/2023 she left the facility for approximately two hours to visit the Emergency Department and while absent, Ms. Bruce independently provided care for residents.

Staff DeNitrice Bruce stated that on 03/29/2023 she provided care independently to residents while Ms. Bruce-Carey was the Emergency Department. Ms. Bruce stated that she has not completed a medical examination attesting to her physical health.

On 04/11/2023 I completed an Exit Conference via telephone with licensee Satara McMillian via telephone. Ms. McMillian stated she understood the findings and will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	Licensee Satara McMillian and staff DeNitrice Bruce both stated Ms. Bruce worked independently at the facility on 03/29/2023 despite not completing a medical examination attesting to Ms. Bruce's physical health. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates staff DeNitrice Bruce worked independently at the facility without completing a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of Ms. Bruce's physical health.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff DeNitrice Bruce worked alone at the facility without completing a test for communicable tuberculosis.

INVESTIGATION: On 04/05/2023 complaint allegations were received from the BCAL online reporting system. The complaint allegations stated that on “March 29 there was an emergency and Sharon, the house manager had to go to the hospital, and of course there was nobody to stay with the ladies, so Sharon's sister, "Neecy" came to stay and it is unknown if Neecy was a staff”.

On 04/06/2023 I completed an unannounced onsite investigation at the facility and interviewed Licensee Satara McMillian, staff Sharon Bruce-Carey, and staff DeNitrice Bruce.

Licensee Satara McMillian stated that on 03/29/2023 Ms. Bruce-Carey required a visit to the Emergency Department and therefore Ms. Bruce came to the facility to care for residents. Ms. McMillian stated Ms. Bruce independently provided care to residents for approximately two hours. Mr. McMillian stated Ms. Bruce has not completed a test for communicable tuberculosis.

Staff Sharon Bruce-Carey stated that on 03/29/2023 she left the facility for approximately two hours to visit the Emergency Department and while absent, Ms. Bruce independently provided care for residents.

Staff DeNitrice Bruce stated that on 03/29/2023 she provided care independently to residents while Ms. Bruce was the Emergently Department. Ms. Bruce stated that she has not completed a test for communicable tuberculosis.

On 04/11/2023 I completed an Exit Conference via telephone with licensee Satara McMillian via telephone. Ms. McMillian stated she understood the findings and will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.

ANALYSIS:	Licensee Satara McMillian and staff DeNitrice Bruce both stated Ms. Bruce worked independently at the facility on 03/29/2023 despite not completing a test for communicable tuberculosis. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Evidence discovered through this Special Investigation indicates staff DeNitrice Bruce worked independently at the facility without completing a test for communicable tuberculosis.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is required to leave the facility daily.

INVESTIGATION: On 04/05/2023 complaint allegations were received from the BCAL online reporting system. The complaint allegations stated that “March 6 2023 (Resident A) was kicked out of her day program and licensee Satara McMillian stated (Resident A’s) guardian had to find places for (Resident A) to go during the day and Ms. McMillian went so far as to say to (Resident A) that she will have to pay staff for care”.

On 04/06/2023 I completed an unannounced onsite investigation at the facility and interviewed licensee Satara McMillian and staff Sharon Bruce-Carey. Ms. McMillian stated her “house rules” include a clause indicating that residents must leave the facility during daytime hours. Ms. McMillian stated Resident A was recently “kicked out” of her day-program, Unlimited Alternatives, for approximately thirty days. Ms. McMillian stated Resident A returned to the day-program today after her thirty days of being kicked out. Ms. McMillian stated she had staff at the facility while Resident A was kicked out of her day program and denied telling Resident A she had to pay for staffing. Ms. McMillian stated Resident A was allowed to stay at the facility during the thirty days with adequate staffing.

Staff Sharon Bruce-Carey stated that while Resident A was “kicked out” of her day program for “thirty days” Resident A was permitted to stay at the facility and Ms. Bruce-Carey provided her care.

On 04/07/2023 I interviewed Resident A via telephone. Resident A stated she attends the Unlimited Alternatives day-program during the day. Resident A stated she was previously “kicked out” of the day-program for thirty days but was allowed to spend that time at the facility with adequate staffing.

On 04/11/2023 I completed an Exit Conference via telephone with Licensee Satara McMillian via telephone. Ms. McMillian stated she agreed with the findings.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(p) The right of access to his or her room at his or her own discretion.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A stated she attends the Unlimited Alternatives day-program during the day. Resident A stated she was previously "kicked out" of the day program for thirty days but was allowed to spend that time at the facility with adequate staffing. A preponderance of evidence was not discovered during the special investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

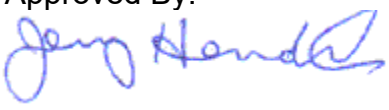
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

04/11/2023

Toya Zylstra, Licensing Consultant Date

Approved By:



04/11/2023

Jerry Hendrick, Area Manager Date