GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2025

Raekesha Mcmillian
1232 Kalamazoo Ave SE
Grand Rapids, MI 49507

RE: License #: AS410388538
Investigation #: 2025A0467019
Community Safe Keeping Home

Dear Raekesha Mcmillian:

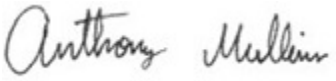
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410388538
Investigation #:	2025A0467019
Complaint Receipt Date:	01/23/2025
Investigation Initiation Date:	01/27/2025
Report Due Date:	03/24/2025
Licensee Name:	Raekesha Mcmillian
Licensee Address:	1232 Kalamazoo Ave SE Grand Rapids, MI 49507
Licensee Telephone #:	(616) 719-3103
Administrator:	Raekesha McMillian
Licensee Designee:	Raekesha McMillian
Name of Facility:	Community Safe Keeping Home
Facility Address:	820 Watkins SE Grand Rapids, MI 49507
Facility Telephone #:	(616) 427-4570
Original Issuance Date:	08/14/2017
License Status:	REGULAR
Effective Date:	02/14/2024
Expiration Date:	02/13/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 1/21/25, Resident A was left outside in the cold after being dropped off at the library.	Yes

III. METHODOLOGY

01/23/2025	Special Investigation Intake 2025A0467019
01/27/2025	Special Investigation Initiated - On Site
01/29/2025	Contact - Face to Face
02/13/2025	Contact – telephone call made to licensee designee, Raekesha McMillian.
02/13/2025	Exit conference with licensee designee, Raekesha McMillian.
03/13/25	APS referral – not necessary based on allegations and no residents being injured as a result of this.

ALLEGATION: On 1/21/25, Resident A was left outside in the cold after being dropped off at the library.

INVESTIGATION: On 1/23/25, I received a LARA-BCHS online complaint stating that Resident A was left outside in the cold/snowstorm after being dropped off at the library, although it was closed. It was approximately 2 degrees Fahrenheit on the day in question. Resident A was left to walk to Sheldon Day Program to get out of the cold, which is nearly a half a mile away from the library.

On 1/27/25, I made an unannounced onsite investigation at the facility. Upon arrival, I knocked on the door several times, and no one answered.

On 1/27/25, I made an unannounced visit to Sheldon House Day Program. Upon arrival, staff informed me that Resident A was not present for the day.

On 1/29/25, I made an unannounced visit to Unlimited Alternatives Day Program. Upon arrival, the Director of the facility answered the door. However, she would not allow entry into the building. Instead, the director called Resident A to the door to be interviewed. Resident A confirmed that AFC staff member, Debbie Long dropped her and Resident B off at the library during the snowstorm. Resident A confirmed that the library was closed, which led to her and Resident B walking to Sheldon House

day program to get out of the cold. Resident A stated that Ms. Long had to go to work and left the library prior to verifying that it was open. Resident A stated that the day program was “not that far” and she had appropriate winter clothing, including a winter jacket.

After speaking to Resident A, the day program director sent Resident B to the front door to be interviewed. Resident B confirmed that she and Resident A were both dropped off at the library on 1/21/25 by AFC staff member, Debbie Long. Resident B stated that the library was closed, and Ms. Long did not confirm this prior to leaving. Due to the library being closed, Resident B walked to Sheldon House day program with Resident A and “sat in the lobby until Debbie picked us up.” Resident B was unsure how long she waited at Sheldon House prior to being picked up to return home. Resident A stated that the other residents in the AFC home were “doing their business” and not at the library with her and Resident A. Aside from having to walk to the day program on the day in question, Resident A denied any other issues or concerns regarding the AFC.

On 2/13/25, I spoke to licensee designee, Raekesha McMillian via phone regarding the allegation. Ms. McMillian confirmed that she was aware of the incident and shared that she spoke to her employee, Debbie Long regarding this matter. Ms. McMillian stated that on the day in question (1/21/25), staff member Debbie Long looked online and the library indicated that it was open during their normal business hours. Due to this, Ms. Long took the residents to the library at their request like she usually does and dropped them off. Ms. McMillian stated that there were other people outside the library when Ms. Long dropped the residents off. After doing so, Ms. Long left the library and went to her other job. While the residents were at the library, it was determined that the library was closed due to the weather and the residents were unable to go inside. The residents eventually walked to Sheldon Day Program before being picked up and returned to the AFC. Ms. McMillian stated that if Ms. Long would have called her and informed her of the library being closed, she would have gone to pick-up the residents to bring them back to the AFC. Ms. McMillian was adamant that Ms. Long didn’t know the library was closed until later in the day. However, she acknowledged that Ms. Long should have waited to make sure the residents were inside of the library prior to leaving.

Ms. McMillian stated that moving forward, Ms. Long is aware that she is not to leave the residents at the library until she confirms that all residents are inside. Ms. McMillian acknowledged that this situation should have been avoided. Ms. McMillian added that residents understand they are not forced to go the library or day program. If a resident decides they want to stay home, Ms. McMillian stated that residents are expected to communicate this to her or Ms. Long so that she can make accommodations to meet their needs.

On 2/13/25, I conducted an exit conference with licensee designee, Raekesha McMillian. She was informed of the investigative findings and aware that a corrective action plan will be due within 15 days of receipt of this report. Fortunately, residents

had proper clothing during the cold weather. However, an incident like this should not occur.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A and Resident B both confirmed that they had to walk nearly a half mile in the cold due to being dropped off at the library while it was closed. Resident A confirmed she had clothing appropriate for the weather and Resident B denied any issues or concerns aside from this incident. Although Ms. Long didn't intentionally leave residents outside in 2 degrees Fahrenheit weather, residents had no choice but to find shelter on their own. Therefore, this is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

Anthony Mullins 03/19/2025

Anthony Mullins Date
Licensing Consultant

Approved By:

Jerry Hendrick 03/19/2025

Jerry Hendrick Date
Area Manager