GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 20, 2025

Carlos Hamilton
Miracle Manor Enterprise LLC
927 East Grand Blvd
Detroit, MI 48207

RE: License #: AS820269490
Investigation #: 2026A0901003
Miracle Manor #3

Dear Carlos Hamilton:

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 feel free to 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 (313) 456-0439.

Sincerely,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820269490
Investigation #:	2026A0901003
Complaint Receipt Date:	10/23/2025
Investigation Initiation Date:	10/24/2025
Report Due Date:	12/22/2025
Licensee Name:	Miracle Manor Enterprise LLC
LicenseeAddress:	927 East Grand Blvd Detroit, MI 48207
Licensee Telephone #:	(248) 571-3444
Administrator:	Carlos Hamilton
Licensee Designee:	Carlos Hamilton
Name of Facility:	Miracle Manor #3
Facility Address:	929 E. Grand Blvd Detroit, MI 48207
Facility Telephone #:	(313) 922-8338
Original Issuance Date:	11/05/2004
License Status:	REGULAR
Effective Date:	06/30/2024
Expiration Date:	06/29/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed.	Yes
There are gates on the windows.	Yes
The residents are fed the same food.	No
Resident B went into Resident A's room and may have touched him inappropriately.	No
Resident C fell while going down the stairs and sustained a head injury and abrasion on his arm. He did not get medical care.	No
The residents are locked upstairs for bed at 7:00 p.m.	No

III. METHODOLOGY

10/23/2025	Special Investigation Intake 2026A0901003
10/23/2025	Adult Protective Services (APS) Referral
10/24/2025	Special Investigation Initiated - Telephone APS
10/29/2025	Referral - Recipient Rights
10/29/2025	Inspection Completed On-site
10/31/2025	Contact - Telephone call made Staff, Talicia Walker
11/05/2025	Inspection Completed On-site
11/07/2025	Inspection Completed On-site
11/10/2025	Exit Conference Licensee Designee, Carlos Hamilton
11/12/2025	Contact - Telephone call made Guardian A1

11/12/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

On 10/24/2025 I left a voice message and sent an email to Shantel Johnson, from APS, for additional information.

On 10/29/2025, I conducted an onsite inspection at the facility. Staff, Shavelle Matthewes, contacted the home manager, Alexandria Hamilton, and I spoke with her by phone. She stated there are always three or four staff on duty each shift and that there are currently four residents residing at the facility. Alexandria also reported Resident A requires 1:1 staffing and Resident D requires 2:1 staffing. The facility is part of a duplex and both sides are owned by the licensee designee, Carlos Hamilton, and both are licensed AFC facilities. She stated the fourth staff person goes back and forth between the two sides to assist.

During the onsite inspection on 10/29/2025, I only observed two staff on duty, Shavelle and Trayne Williams. I interviewed them separately and they each reported there are always three or four staff on duty and when there is four, one person goes back and forth and assists with the other facility as well. During this onsite inspection, I needed to check the food supply, which was in the basement of the facility next door. Although I offered to go next door alone, since there were only two staff on duty, and have the staff next door show me the food supply, Shavelle accompanied me, which left one staff on duty with four residents.

On 11/05/2025, I conducted an unannounced onsite inspection at the facility. Staff, Angela May, was present. She stated she was the only staff working at the time and all four residents were there.

On 11/05/2025, I later received a test message from Alexandria explaining she was short staff this day due to having a staff person leave because of an emergency and that another staff was a “no call no show”. She stated she was enroute to the facility to fill in.

On 11/07/2025, licensing consultant, Lakeitha Stevens, who is the assigned consultant for both sides of the duplex, was onsite for a renewal inspection and observed four residents present and three staff on duty.

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:	Based on the information I obtained during this investigation and my observation, the facility does not always have sufficient staff on duty for the supervision, personal care, and protection of the residents. Due to there being a total of four residents and Resident A requiring 1:1 staffing and Resident D requiring 2:1 staffing, there should always be at least four staff on duty. During each onsite inspection conducted, there were less than four staff. Also, the home manager and staff reported that when there are four staff working, one staff person rotates back and forth between the two facilities as needed, which also takes the facility under staffing capacity.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are gates on the windows.

INVESTIGATION:

On 10/29/2025, I conducted an onsite inspection at the facility. I observed some of the windows to have a metal barrier affixed to them, preventing direct access. This included the bathroom and dining and office area, as well as the front window.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on my observation the allegation is confirmed. The metal barrier affixed to the windows impairs the safety and wellbeing of the residents because it impacts egress in the event of an emergency and affects fire safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The residents are fed the same food.

INVESTIGATION:

On 10/29/2025, I conducted an onsite inspection at the facility. Staff, Shavelle Matthews, contacted the home manager, Alexandria Hamilton, and I spoke with her by phone. She stated there was plenty of food at the facility and that the menu was posted on the refrigerator. She encouraged me to take a look.

On 10/29/2025, I interviewed Shavell. She stated there is never a shortage of food and that the menu never stays the same. She stated the majority of the food is locked in the basement and Alexandria or the licensee designee, Carlos Hamilton, take out everything they need for the week. I observed the refrigerator in the kitchen, which had an ample food supply, and I also observed some dry and canned goods in the kitchen. Multiple freezers were observed in the basement with food as well. Dry goods and canned goods were also stored in the basement. Shavell reported that the residents had grits, sausage and toast for breakfast today, and oatmeal yesterday. She said they were having sandwiches for lunch today. The items she reported were consistent with the menu.

On 10/29/2025, I interviewed Residents E and F separately. They both reported getting three meals a day. They stated they had grits and sausages for breakfast today and had oatmeal yesterday. They could not remember what they had for dinner last night.

During the onsite inspection on 10/29/2025, Resident A and D were not interviewed due to being nonverbal.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. Residents E and F reported receiving three meals day and the meals they reported to me were consistent with the menu. The menu was observed to be appropriate and plenty of food was observed in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B went into Resident A's room and may have touched him inappropriately.

INVESTIGATION:

On 10/29/2025, I conducted an onsite inspection at the facility. Staff, Shavelle Matthews, contacted the home manager, Alexandria Hamilton, and I spoke with her by phone. She stated the allegations were bogus. She explained that Resident A was in his room with his 1:1 staff person, Talicia Walker. Resident B, from the facility next door, came over to visit. She indicated that the residents from the two facilities tend to go back and forth for socialization. Resident B went upstairs to go to the bathroom and made the wrong turn and opened the wrong door. Alexandria said he was never alone with Resident A because Talicia was present and redirected him.

On 10/29/2025, I interviewed staff, Shavelle and Trayne Williams, separately. Both described Resident B as having a childlike mind and as being very friendly. They said he has an issue with boundaries and must be redirected a lot, but that he means no harm. They also stated they were not aware of him ever being inappropriate with any of the residents.

On 10/29/2025, I interviewed Resident B. He said he came over to visit and wanted to see his friend, Resident A. He indicated he went to his room to say hi, and when he opened the door, Resident A was changing. Resident B reported there was a

staff person in the room with Resident A and as soon as he opened the door, she told him to get out. He said he immediately closed the door and left.

On 10/31/2025 I made a telephone call to Talicia. She confirmed she was Resident A's 1:1 staff person the day of the incident. She stated she was in the room with Resident A and he was changing into his pajamas, when Resident B opened the door. She asked him what he was doing, and he said he was looking for the bathroom. Talicia told him to go the other way, and he closed the door. She said the incident happened very quicky and that as soon as Resident B opened the door, he closed it. She stated there was never any inappropriate touching because Resident B never entered the room and she was present the whole time. Talicia further said Resident B requires a lot of attention and redirection, but they have never had an issue with him being inappropriate with other residents.

On 11/12/2025, I made a telephone call to Resident A's guardian, Guardian A1. She stated she had no issues with the facility. She indicated she was initially concerned when she first heard of the allegations, but staff conveyed to her the same information that was reported to me. She said he was relieved to know that Resident B was not alone with Resident A.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. There is no indication that Resident A's protection and safety was not attended to. Resident A's 1:1, Talicia, confirmed she was with Resident A when Resident B opened his room door and stated he never entered the room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C fell while going down the stairs and sustained a head injury and abrasion on his arm. He did not get medical care.

INVESTIGATION:

On 11/05/2025, I conducted an onsite inspection at the facility. Staff, Angela May was present, and contacted the home manager, Alexandria Hamilton by phone.

Alexandria indicated Resident C never fell and hit his head. She explained that on 10/01/2025 he was going down the stairs outside and lost balance. He grabbed the ledge to balance himself, which is how he scraped his arm. Since he was able to balance himself by grabbing the ledge, he did not fall. She said the scar on his head is old and is from Melanoma. Alexandria indicated that Resident C no longer resides at the facility. She said he was aged and getting weaker. They noticed he was having balance issues and was often tripping over his own feet, which was contributing to falls. She stated the decline in his mobility started rapidly. On 10/05/2025, there was another incident in which he attempted to sit down and missed the bench and fell on the ground. He broke his hip because of this. Alexandria said when he went to the hospital, Detroit Receiving, informed the social worker that they would not be able to accept him back because all the bedrooms at the facility were on the second floor. Therefore, when he was discharged from the hospital, he was sent to The River's of Grosse Pointe for rehabilitation. She further said Resident C did not have a guardian or case manager.

On 11/07/2025, licensing consultant, LaKeitha Stevens, met with Resident C face to face at The Rivers of Grosse Pointe. He stated he did not recall ever falling and hitting his head but said he did scrape his arm. He said the scars on his head and on other areas of his body were from Melanoma. Resident C spoke very well of the facility. He stated he really liked it there and that staff took very good care of him. He indicated he was there a very long time and would like to go back but cannot, because they can no longer care for him.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm that staff failed to get needed medical care for Resident C immediately. The home manager indicated Resident C never fell and hit his head but only scraped his arm. This was confirmed by Resident C.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The residents are locked upstairs for bed at 7:00 p.m.

INVESTIGATION:

On 10/29/2025, I conducted an onsite inspection at the facility and observed the residents' bedrooms and doors leading to their rooms to all be equipped with nonlocking against egress hardware.

During the onsite inspection on 10/29/2025, I interviewed staff, Shavelle Matthews and Trayne Williams, separately. They denied the residents being locked upstairs. Trayne explained that staff clean the facility every day at 7:00 p.m. and they start with the downstairs area. If residents are down there during that time, they ask them to go upstairs while they clean.

During the onsite inspection on 10/29/2025, I interviewed Residents E and F separately. They both denied being locked upstairs.

On 11/10/2025, I made a telephone call to the licensee designee, Carlos Hamilton, for an exit conference. There was no answer so I left a voice message informing him of my investigative finding and welcoming him to call me if he had questions.

APPLICABLE RULE	
R 400.657	**Bedrooms.**
	(4) Interior doorways of a resident bedroom must be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. I observed all the resident bedroom to be equipped with positive-latching, non-locking-against-egress hardware. In addition to this, the staff and residents interviewed denied the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend the status of the license remains unchanged.

_____ 11/14/2025
Regina Buchanan Date
Licensing Consultant

Approved By:

11/20/2025
_____
Ardra Hunter Date
Area Manager