GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 5, 2026

Satara McMillian
2115 Francis Ave.
Grand Rapids, MI 49507

RE: License #: AS410389803
Investigation #: 2026A0579016
Home Of Hearts

Dear Satara 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) 356-0100.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410389803
Investigation #:	2026A0579016
Complaint Receipt Date:	01/13/2026
Investigation Initiation Date:	01/14/2026
Report Due Date:	03/14/2026
Licensee Name:	Satara McMillian
Licensee Address:	2115 Francis Ave., Grand Rapids, MI 49507
Licensee Telephone #:	(616) 633-3953
Administrator:	Shirley McMillian
Licensee Designee:	Satara McMillian
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:	05/13/2024
Expiration Date:	05/12/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has unreliable access to a phone in the home.	No
Resident A is not receiving required personal development opportunities.	No
Additional Findings	Yes

III. METHODOLOGY

01/13/2026	Special Investigation Intake 2026A0579016
01/14/2026	Special Investigation Initiated - Letter Complainant
01/15/2026	APS Referral
01/15/2026	Contact - Document Received Josh Yonker, network180
02/20/2026	Contact- Face to Face Resident A, Sharon Bruce-Corey, Direct Care Worker, Satara McMillian, Licensee Designee
02/20/2026	Contact- Document Sent Satara McMillian, Licensee Designee
02/20/2026	Contact - Document Received Josh Yonker, Case Manager
02/24/2026	Contact- Telephone call made Called the AFC phone to test service.
03/04/2026	Exit Conference Satara McMillian, Licensee Designee

ALLEGATION: Resident A has unreliable access to a phone in the home.

INVESTIGATION: On 1/15/26, I received this referral which alleged Resident A is unable to make reliable phone calls to her family and friends. She reported the phone only works when connected to Wi-Fi and it is not consistent. It has been challenging for Resident A's supports to contact the home as well.

On 1/15/26, I confirmed receipt of the allegations with the complainant. I was

advised that Josh Yonker from network180 could provide additional information regarding the allegations.

On 1/15/26, I contacted Mr. Yonker who reported Resident A has lived at the home for approximately one month and he believes the concern with the telephone has been occurring since she moved in.

On 2/20/26, I completed an unannounced on-site investigation at the home. Interviews were completed with Resident A, Sharon Bruce-Corey (Direct Care Worker/ “DCW”), and Satara McMillian (Licensee Designee).

Resident A stated her only concern with the phone is that the individuals she calls are long-distance and she worries that she would have to pay to contact them. She denied asking about long-distance calls or being told she could not call her friends or family. She said instead of placing calls, she has friends, family, and caseworkers call her so she does not have worry about fees. She denied any concerns about the reliability of or access to the telephone.

Ms. McMillian stated Resident A makes telephone calls on her tablet which would likely be connected to the home’s Wi-Fi. She stated at times, the Wi-Fi can briefly go out of service, but there is a telephone in the home that Resident A can use to make calls so she always has access to a telephone.

Ms. Bruce-Corey stated Resident A does not request to use the telephone in the home, which is accessible to her. She stated Resident A uses her tablet to communicate with her friends and family.

On 2/20/26, I contacted Mr. Yonker to see if he had ongoing concerns regarding the allegations. He reported he believes the concerns with the telephone were addressed with Ms. McMillian in January 2026.

On 2/24/26, I placed a telephone call to the home. The call was not answered but an option was left to leave a voicemail message. A message was not left at that time.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(e) Have reasonable access to a telephone for private communications, but a licensee may charge a resident for the cost of long-distance telephone calls.**
ANALYSIS:	Resident A denied any concern regarding having reasonable access to a phone in the home.

	Ms. McMillian and Ms. Bruce-Corey reported Resident A utilizes her tablet for telephone calls, but she can utilize the phone that is available in the home as well. There is insufficient evidence that Resident A does not have reasonable access to a telephone in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is not receiving required personal development opportunities.

INVESTIGATION: On 1/15/26, I reviewed the referral which alleged Resident A reported the home manager sits in her office throughout the day and Resident A does not receive the Community Living Support ("CLS") services she is approved for and Ms. McMillian agreed would be provided in the home. Resident A should be receiving 28 hours of CLS services per week to assist with her personal development.

On 1/15/26, Mr. Yonker provided the CLS assessment completed by network180 which broke down Resident A's goals towards personal growth. The CLS assessment specified that Resident A needs 105 minutes of meal preparation, 30 minutes of cleaning, 60 minutes of shopping, 15 minutes of money management, 525 minutes of non-medical care, 630 minutes of socialization and relationship building, 30 minutes of participation in community activities and recreation, 60 minutes of supporting medical appointments, and 210 minutes of medication management support from DCWs in the home each week.

On 2/20/26, Resident A stated she does not know about her CLS goals and does not think she has any goals in this home. She stated DCWs assist her with cooking and cleaning sometimes, she goes on outings, and she makes a shopping list. Resident A requested to show me the kitchen of the home to show the items she has available to cook. While she and I were speaking in the kitchen of the home, Ms. McMillian arrived at the home and Resident A reported she did not want to discuss anything further with me.

Ms. McMillian stated there was an incident at the beginning of January 2026 when it was alleged that Resident A was not getting her CLS services. She stated she was aware of Resident A's CLS requirements at the time she moved in and was providing those services, however, the documentation with Resident A's goals was not sent so they could not document the services that were being provided. She stated Resident A has approximately 10 specific goals and since the forms were received in January 2026, they have been documented appropriately and they were always provided to Resident A.

Ms. Bruce-Corey stated Resident A's CLS goals are met as required and documented appropriately each week.

I reviewed the forms that listed Resident A's CLS goals and had a line for weekly documentation. The forms were filled out where applicable.

On 2/20/26, I contacted Mr. Yonker to inquire if he had any concerns or if the matter was resolved. He stated network180 did not find sufficient evidence to indicate Resident A was not receiving her CLS units as required and there are not any ongoing concerns.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(5) A licensee shall provide the following opportunities for a resident: **(f) Direction and opportunity for growth and development as achieved through activities that foster independent and age-appropriate functioning, such as dressing, grooming, manners, shopping, cooking, money management, and the use of public transportation.**
ANALYSIS:	Resident A denied having goals in this home. She reported DCWs assist her with cooking and cleaning, she makes a shopping list, and she goes on outings. Ms. McMillian and Ms. Bruce-Corey reported Resident A's CLS goals are met and documented weekly. Ms. McMillian reported there was a delay with receiving the necessary paperwork which delayed documentation but goals were met during that time. I observed Resident A's CLS goals forms for February 2026 which appeared appropriately completed and listed tasks that Resident A described completing with DCWs. There is insufficient evidence to support the allegation that Resident A is not given direction and opportunity for growth and development through activities that foster independent and age-appropriate functioning.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

On 2/20/26, I arrived at the home unannounced. I knocked several times and waited four minutes for Ms. Bruce-Corey to answer. I spoke to Resident A in her room for approximately 10 minutes before Resident A requested to show me the kitchen of the home. While standing in the kitchen, approximately 15 minutes after I entered the home, Ms. McMillian arrived at the home with a cardboard box filled with food.

Prior to Ms. McMillian's arrival at the home, I observed limited food items available to Resident A in the kitchen of the home. Resident A reported most of the food in the refrigerator was Ms. Bruce-Corey's, Ms. Bruce-Corey keeps her items on the left side of the refrigerator, and she could not have those items. I observed a half a gallon of milk that Resident A reported is Ms. Bruce-Corey's. I observed two open packages of lunch meat that Resident A reported that neither she nor Ms. Bruce-Corey will eat even though it is on the right side of the refrigerator. I observed a package of American cheese and a partial stick of butter. There were containers of leftovers across the bottom of the refrigerator and pie that Resident A reported were Ms. Bruce-Corey's and not food that she was allowed to eat. I observed a head of lettuce, a bag of carrots, a small container of tomatoes, one apple, and a bag of mandarin oranges pushed to the back of a shelf on the left side of the refrigerator that Resident A reported were Ms. Bruce-Corey's. In the freezer, there were several tied grocery bags of food on the left side of the refrigerator that Resident A reported were Ms. Bruce-Corey's. Resident A reported the food available to her in the freezer was a few frozen pizzas, a frozen bag of sandwich buns, and a bag of breaded chicken breasts.

Resident A showed me the cupboard with dried and canned goods. There were cans of vegetables and fruit cocktail, sloppy joe sauce, chili with beans, pork and beans, packages of Knorr seasoned noodles, and boxes of hamburger helper. Resident A showed me a loaf of bread on the table which she reported she is not sure she can have, she believes it is Ms. Bruce-Corey's, and it has not been served or offered to her. I also observed a bag of ripe apples and an overripe banana on the counter of the home. The protein available for Resident A included half a package of frozen breaded chicken breast, lunch meat she reported she will not eat, and canned meat or beans.

I observed the box Ms. McMillian brought into the home. It included canned goods under packages of broth and noodles, a bottle of juice, and dried beans.

I observed the menu in the home to be a whiteboard with five weeks listed on it. Snacks and alternatives were listed on the side of the whiteboard. The whiteboard appeared to have been smudged off and erased in some areas indicating it had not been changed or updated in some time. Resident A reported the whiteboard has not changed since she arrived at the home approximately two months ago. Resident A reported she had been receiving the meals from week three on the whiteboard. Ms. Bruce-Corey reported the meals this week were from week four. I did not observe food consistent with either week in the kitchen of the home, including the items Ms. McMillian brought into the home when she arrived.

While speaking to Resident A in her room, she stated she does not get enough to eat in this home. I interviewed Resident A at approximately 1:00 p.m. She stated she had breakfast this morning and dinner on 2/19/26 but no other meals that day. She stated there was not enough food for her to have lunch today and she has concerns there will be nothing for her to eat for dinner. She stated currently there are only canned and boxed goods available for her and what is listed on the menu is not available in the home. She stated the boxed goods usually require milk, butter, or meat and there is none available to her in this home so she cannot make those. She stated Ms. McMillian has told her that she needs to prepare a grocery list of all the food she would like for meals for the entire month and Ms. McMillian will purchase those items for March 2026. She stated it is the middle of February and she has concerns she will be without sufficient food for the next two weeks. She stated she monitors her weight with monthly weigh-ins at this home and she does not believe she has lost weight while living at this home.

Ms. McMillian stated part of Resident A's CLS goals are making a monthly list of items. She stated she does not require Resident A to make a grocery list for the home, but rather since she receives so much spending money, Resident A is asked to make a list of snacks and personal care items for Resident A's own use that she needs for the month.

Ms. McMillian stated she does the grocery shopping for the home monthly and follows the posted menu. She stated it is in Resident A's plan of service and CLS notes that she refuses meals so she often will not eat meals during the day. She stated Ms. Bruce-Corey will prepare and offer the meals on the menu but Resident A will not eat them. She stated Ms. Bruce-Corey has awoken to find that Resident A has binge eaten throughout the night and will eat an entire box that has eight burritos or an entire Banquet family sized dinner for herself, which causes the items not to be available for the rest of the month.

I inquired what the meals Resident A consumes when binging are replaced with. Ms. McMillian reported the meals are no longer available for the month and replacements are not provided. She stated she will occasionally bring a box of "staple food items" throughout the month, as she did today, that has options Resident A can eat instead of the posted meals. She denied documenting the alternatives Resident A consumes anywhere. She confirmed Ms. Bruce-Corey's food is kept in the refrigerator as well. She reported Resident A initially reported she is vegan so there were limited proteins in the home but she has learned that Resident A is not vegan and will eat meat products.

Consultation was provided regarding options for limiting the food that is accessible to Resident A without violating her rights, such as having limited amount of nutritionally balanced foods in the area that Resident A has access to and keeping items needed for meals for the month in a separate staff area that Resident A cannot access to ensure meals are available for the entire month. Ms. McMillian stated she also has considered putting an alarm on the refrigerator so that Ms. Bruce-Corey will be

alerted if Resident A opens the refrigerator at night and can redirect her. She stated she will also speak to Guardian A about providing additional funds to purchase food for Resident A since she eats so excessively overnight. She agreed she would discuss options with Resident A's supports.

Ms. Bruce-Corey stated Resident A opened a bottle of syrup this morning and used ¼ of the bottle in one serving. She confirmed that Resident A will get up in the night and eat meals that are supposed to be for the entire month in one sitting. She stated Resident A refuses most of the meals she prepares for her. She stated recently she has learned that if she sets the plate down at the table to Resident A to eat instead of asking Resident A if she would like to eat, Resident A will eat the meal so she has begun doing that. She stated she does keep her food in the refrigerator as well but she will often share her personal items with Resident A.

I reviewed the forms that listed Resident A's CLS goals. It was noted that Resident A frequently refuses meals for fear of gaining weight and concern that others do not have enough to eat. Resident A reported frequent dislike of the menu at her previous placements and reported eating meat is bad for her. The goal for meal preparation was made to address this.

On 2/20/26, I contacted Mr. Yonker to discuss Resident A's concerns regarding food in the home and what I observed while in the home. He stated Resident A has expressed concern about the food in the home to Guardian A as well. He stated he has learned from interacting with Resident A that although she is not intentionally deceitful, she is not always truthful and reports what she believes to be true, without full consideration of the situation. He stated it has been reported to network180 that Resident A is waking up and consuming a full pack of sausage or drinking a gallon of milk in a couple days or less. He stated network180 strongly discourages having locked refrigerators as that is violation to Resident A's rights, although Ms. McMillian did bring the idea up. He stated he encouraged the food be labeled for specific meals or a designated area for snacks. He stated he has not heard any additional concerns since it was first discussed with Ms. McMillian in early January 2026.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents. **(4) Meals must meet the nutritional allowances recommended by the United States Department of Agriculture and the United States Department of Health and Human Services in the Dietary Guidelines for Americans (DGA), 2020-2025. The Dietary Guidelines for Americans 2020-2025 are adopted by reference and available to be viewed or downloaded from the U.S. Department of**

	Agriculture and the U.S. Department of Health and Human Services at https://www.dietaryguidelines.gov at no cost at the time of adoption of these rules. A copy of these guidelines is available for inspection and distribution from the Bureau of Community and Health Services, Department of Licensing and Regulatory Affairs, at 611 West Ottawa Street, P.O. Box 30664, Lansing, Michigan 48909 at a cost of 15 cents per page as of the time of the adoption of these rules.
ANALYSIS:	Resident A denied receiving three meals per day and expressed concern regarding the lack of food in the home. I observed the kitchen and found the items for Resident A to be limited, especially regarding protein, dairy, and fresh food items. Ms. McMillian reported shopping for groceries once per month and occasionally replacing staple food items throughout the month. She reported Resident A refuses meals and will binge eat a month's worth of meals overnight, resulting in the food no longer being available for that month as she will not replace it. Ms. Bruce-Corey reported Resident A refuses meals and then binge eats a month's worth of meals overnight. I observed the menu in the home to be a whiteboard that listed five weeks of meals that was smudged and erased in areas and appeared worn over time. Resident A and Ms. Bruce-Corey reported different weeks of the rotation when discussing the menu when I was in the home. I did not observe food consistent with either week's menu. There is insufficient evidence available to confirm that Resident A receives three meals per day, as noted on the menu, and that the meals meet nutritional guidelines specified in the rule. Therefore, the violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/20/26, I observed the menu in the home to be a whiteboard with five weeks listed on it. Snacks and alternatives were listed on the side of the whiteboard. The whiteboard appeared to have been smudged off and erased in some areas indicating it had not been changed or updated in some time.

Resident A reported the whiteboard has not changed since she arrived at the home

approximately two months ago. Resident A reported she had been inconsistently receiving the meals from week three on the whiteboard.

Ms. Bruce-Corey reported the meals this week were from week four.

I did not observe food consistent with either week in the kitchen of the home, including the items Ms. McMillian brought into the home when she arrived while I was on-site.

Ms. McMillian confirmed the whiteboard is the only menu in the home and alternatives are not documented elsewhere.

On 2/20/26, I contacted Mr. Yonker to discuss Resident A's concerns regarding food in the home and what I observed. He stated Resident A has expressed concern about the menu not being followed to network180.

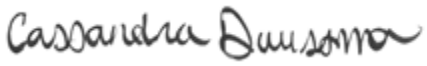
APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented. **(7) A licensee shall keep records of menus, including special diets, for 90 days.**
ANALYSIS:	I observed the menu in the home to be a whiteboard with five weeks written on it that was smudged and erased in areas and appeared worn over time. Resident A and Ms. Bruce-Corey reported different weeks of the rotation when discussing this week's menu. I did not observe food consistent with the menu. Ms. McMillian denied documenting substitutions to the menu. There is insufficient evidence available to confirm that Resident A receives three meals per day, as noted on the menu, and the meals meet nutritional guidelines specified in the rule. Therefore, the violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/4/26, I attempted an exit conference via telephone with Ms. McMillian. The number listed is the same as the number for the home. A voicemail message was not left. A follow-up email was sent discussing the findings of my investigation. A response was requested should any guidance be needed or if Ms. McMillian had any

questions. Ms. McMillian responded with a voicemail message disputing my findings, advising that one to two alternative nutritionally balanced meals are offered to Resident A if she consumes a planned meal while binge eating. However, this was not supported by the menu posted in the home or the food observed in the home.

IV. RECOMMENDATION

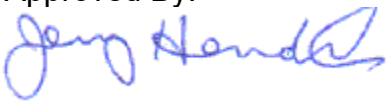
Contingent upon receipt of an acceptable plan of corrective active, I recommend the status of the license remain the same.



03/05/2026

Cassandra Duursma Date
Licensing Consultant

Approved By:



03/05/2026

Jerry Hendrick Date
Area Manager