GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 3, 2023

Satara McMillian
2115 Francis Ave.
Grand Rapids, MI 49507

RE: License #: AS410389803
Investigation #: 2023A0467023
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.

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

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 #:	AS410389803
Investigation #:	2023A0467023
Complaint Receipt Date:	12/19/2022
Investigation Initiation Date:	12/19/2022
Report Due Date:	02/17/2023
Licensee Name:	Satara McMillian
Licensee Address:	2115 Francis Ave. Grand Rapids, MI 49507
Licensee Telephone #:	(616) 633-3953
Administrator:	N/A
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:	05/13/2022
Expiration Date:	05/12/2024
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents were left at the home without staff on 12/4/22 when live-in staff member, Sharon Bruce-Carey had to leave due to a family emergency.	No
Resident's have been locked out of the home on multiple occasions.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/19/2022	Special Investigation Intake 2023A0467023
12/19/2022	Special Investigation Initiated - Telephone
01/12/2023	Inspection Completed On-site
02/02/2023	APS referral sent via email
02/02/2023	Exit conference completed with owner, Satara McMillian.

ALLEGATION: Residents were left at the home without staff on 12/4/22 when live-in staff member, Sharon Bruce-Carey had to leave due to a family emergency.

INVESTIGATION: On 12/19/22, I received a Recipient Rights Complaint stating that residents were left unattended in the home on 12/4/22 when live-in staff member, Mrs. Bruce-Carey had to leave due to a family emergency.

On 12/19/22, I spoke to Kent County Recipient Rights Officer, Melissa Gekeler. Mrs. Gekeler informed me that she went to the AFC home this past Thursday, 12/15/22 and spoke to Mrs. Bruce-Carey. Mrs. Gekeler stated that Mrs. Bruce-Carey denied leaving residents in the home unattended on 12/4/22. Mrs. Gekeler stated that Resident A confirmed that she has never been left inside the home without staff being present.

On 12/29/22, I spoke to live-in staff member, Mrs. Bruce-Carey via phone. Mrs. Bruce-Carey denied residents being left alone at the home on 12/4/22. Ms. Bruce-Carey stated that on the day in question (12/4/22), her adult daughter had a seizure and fell down the stairs, resulting in her daughter being transported to the hospital. Mrs. Bruce-Carey stated that 12/4/22 was a Sunday and all of the residents were away from the home spending time with their family. After the family emergency

occurred, Mrs. Bruce-Carey stated that Resident A informed her that she was heading back to the AFC home with her dad. Due to Mrs. Bruce-Carey being at her daughter's home, she texted Resident A and told her to be dropped off at her daughter's house due to the family emergency. Mrs. Bruce-Carey stated that Resident A was only at her daughter's house for 20 minutes before Ms. McMillian picked her up and took her back to the AFC home. Due to this being an emergency, this was something that Mrs. Bruce-Carey could not prepare for.

After speaking to Mrs. Bruce-Carey, I spoke to the owner, Satara McMillian via phone. Ms. McMillian denied that residents were left home alone/unattended on 12/4/22. Ms. McMillian stated that none of the residents were home due to being away with their family. Ms. McMillian stated, "I guess (Resident A's) dad got lost so I had to go get them." Ms. McMillian stated that she drove to meet Resident A and her dad and then took Resident A to Mrs. Bruce-Carey's daughter's home for a brief period prior to picking up Resident B. Ms. McMillian stated that she wasn't planning to take the residents back to the AFC home as Mrs. Bruce-Carey wasn't planning to be at her daughter's home much longer. Ms. McMillian stated that she was not feeling well during this time.

On 1/12/23, I made an unannounced onsite investigation to the home. Upon arrival, Mrs. Bruce-Carey allowed entry into the home. Resident A and Resident D were not present and therefore, they were not interviewed. However, Resident B and C were home. I made my way to the second floor of the home and knocked on the first door on my right. Introductions were made with Resident B and she agreed to be interviewed from her doorway while she sat on her bed. Resident B denied being left home alone on 12/4/22. She also denied being left alone inside the home without staff on any other day. Resident B was thanked for her time.

After speaking to Resident B, I spoke to Resident C at the dining room table. Resident C insisted that live-in staff member, Mrs. Bruce-Carey was present for the interview. Resident C denied being left at the home on 12/4/22 without staff being present. She also denied being left inside the home without staff present on any day.

On 1/27/23, I left a voicemail for Resident A requesting a call back to discuss case allegations. As of the conclusion of the investigation, Resident A has not returned my call.

On 02/02/2023, I conducted an exit conference with the owner/licensee, Ms. McMillian. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the

	responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Live-in staff member, Mrs. Bruce-Carey and owner/licensee, Ms. McMillian both denied that residents were left alone/unattended in the home on 12/4/22. Resident B and Resident C both denied being left alone/unattended in the home on 12/4/22. Resident A and D were not interviewed due to being away from the home during my onsite investigation. However, Recipient Rights Officer, Melissa Gekeler interviewed Resident A and she also denied being left alone/unattended in the home on 12/4/22. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents have been locked out of the home on multiple occasions.

INVESTIGATION: On 12/19/22, I received a Recipient Rights Complaint stating that residents have been locked out of the home.

On 12/19/22, I spoke to Kent County Recipient Rights Officer, Melissa Gekeler. Mrs. Gekeler stated that Resident A disclosed that she was unable to return to the AFC home on 12/4/22 due live-in staff member, Mrs. Bruce-Carey being away at her daughters for a family emergency. Resident A told Mrs. Gekeler that there have been other times that she has come back to the house, and no one was there, resulting in Resident A waiting outside for staff for approximately 30 minutes.

On 12/29/22, I spoke to Mrs. Bruce-Carey via phone. When asked about residents being locked out of the home, Mrs. Bruce-Carey stated that approximately three weeks ago, she was “a little late” one time due to having car problems and being on the side of the road trying to get help. After getting the help she needed, Mrs. Bruce-Carey was able to make it back to the home, which caused residents to wait outside for approximately 30 minutes. In addition to this, Mrs. Bruce-Carey stated that she has been late “2 or 3 minutes once or so” and that it was “not a lot of time.”

After speaking to Mrs. Bruce-Carey, I spoke to the owner/designee, Ms. McMillian. Ms. McMillian denied residents being locked out of the home for extended periods. Ms. McMillian did acknowledge that Mrs. Bruce-Carey was late to get to the house in the past. Ms. McMillian stated that sometimes, the residents’ bus returns from Day

Program early. Ms. McMillian stated that residents are supposed to notify Mrs. Bruce-Carey when this happens. Ms. McMillian was adamant that she went over this plan with residents a few times. Ms. McMillian stated that residents typically return from Day Program at 4:00 pm or later. To prevent residents getting home before staff, Ms. McMillian stated that approximately two weeks ago, she made changes for Mrs. Bruce-Carey to be at the home by 3:45 pm daily in an attempt to be home before residents return. To Ms. McMillian's knowledge, residents have had to wait approximately 3-5 minutes for Mrs. Bruce-Carey to return to the home in the past.

On 1/12/23, I made an unannounced onsite investigation to the facility. Upon entry into the home, I spoke to Resident B in her doorway while she sat on her bed. Resident B stated that she has been left to wait outside of the home due to staff being away. Resident B stated that the longest she had to wait outside was 30 minutes. Resident B stated that this occurred sometime last year and she has been a resident of the home since September 2022. Resident B stated that she has been left outside waiting for staff to arrive at the home "at least four times."

After speaking to Resident B, I spoke to Resident C at the dining room table. Resident C stated that she was intentionally left outside at Ms. McMillian's request. Resident C was asked to expand on her statement. Resident C stated that sometime in November 2022, she came home past the designated curfew time. When she arrived at home, Resident C stated that Ms. McMillian told Mrs. Bruce-Carey to leave her outside for a little due coming home after curfew. Resident C stated that she was left outside for approximately 15 minutes and "(Mrs. Bruce-Carey) felt bad and let me inside" the house. Resident C stated that she is an adult that pays rent and she believed that Ms. McMillan was being insensitive. Resident C stated that she did not discuss her concerns with Ms. McMillian because she did not want to get upset about this.

After speaking to Resident C, I spoke to Mrs. Bruce-Carey and she confirmed that Ms. McMillian told her to leave Resident C outside when she returned home late past curfew last year. Mrs. Bruce-Carey stated that Resident C was outside for "a few minutes" as opposed to the 15 minutes that Resident C stated she was outside. Mrs. Bruce-Carey stated that she would never leave Resident C or any other Resident outside because "I can't do that."

It should be noted that Resident A and Resident D were not present during my onsite investigation and therefore, were not interviewed.

On 02/02/2023, I conducted an exit conference with the owner/licensee, Ms. McMillian. She was informed of the investigative findings. Ms. McMillian adamantly denied telling Mrs. Bruce-Carey to leave Resident C outside. Ms. McMillian recalled telling Mrs. Bruce-Carey to remind Resident C to return home before everyone in the house was asleep, to prevent her from being left outside. Ms. McMillian plans to discuss this further with her employee. Ms. McMillian agreed to complete a corrective action plan within 15 days of receipt of this report.

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:	Live-in staff member Mrs. Bruce-Carey admitted to being late to return home due to car issues, resulting in resident's waiting outside for 30 minutes. She also admitted to being late by "2 or 3 minutes once or so." Owner/licensee Ms. McMillian acknowledged Mrs. Bruce-Carey being late to the home in the past. Ms. McMillian believes that this is partially due to residents returning home early from Day Program. To prevent this from occurring, Ms. McMillian now has Mrs. Bruce-Carey return to the home by 3:45 pm daily to ensure she is home prior to residents. Resident B disclosed that she's had to wait outside the home for staff to arrive on at least 4 different occasions and 30 minutes being the longest wait time. Resident C disclosed that Ms. McMillian made Mrs. Bruce-Carey keep her locked outside the home for 15 minutes due to returning home past curfew in November 2022. Mrs. Bruce-Carey confirmed this occurred as well, but stated it was only for a few minutes as opposed to 15 minutes. Regardless of the amount of time Resident C was forced to be outside, it is still a violation of her rights. Therefore, a preponderance of evidence does exist to support the allegation. Resident A and D were not present during my onsite investigation and therefore, they were not interviewed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above on 1/12/23, Resident B expressed concerns regarding her medications. Resident B stated that she has concerns for "the ordering of it, how it's prepared, and where it's prepared." Resident B continued as she stated that LTC Pharmacy was supposed to send her medication that she just recently started taking. However, the pharmacy stated that she needed a prescription although the medication was already being provided.

Resident B stated that her concern is with both the pharmacy and the AFC home staff for not getting her medication. Resident B went on to state that she has had issues with medications, "since I've been in the mental health system so I'm very conscious about this". The medication that she was referring to is Prolixin, also known as Fluphenazine. During this onsite investigation I was unable to review Resident B's MAR due to staff having a handyman in the home fixing the med cart.

On 1/24/23, I made an unannounced onsite visit to the home. Mrs. Bruce-Carey allowed entry into the home and showed me Resident B's January 2023 MAR. Mrs. Bruce-Carey stated that she gets Resident B's meds from Janice Pharmacy and sometimes when she has called, the pharmacy has said she needs a refill and will have to call her doctor. Mrs. Bruce-Carey stated that she spoke to Resident B's guardian and the guardian did not like that she relayed this information to Resident B As a result of having issues with Resident B's meds and obtaining them from the pharmacy, Sharon stated that she missed 1 or 2 days of her Prolixin.

While reviewing Resident A's January 2023 MAR, I noticed that on January 14th, there were no initials for Resident A's 8:00 pm Fluphenazine Tab 5MG medication, which is required. I also reviewed Resident A's December 2022 MAR when I noticed that from December 14th through December 28th, there were no initials for Resident A's 8:00 pm Fluphenazine Tab 5MG medication. December 30th and 31st also did not have initials for Resident A's Fluphenazine Tab 5MG medication.

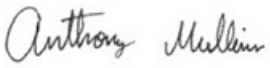
On 02/02/2023, I conducted an exit conference with the owner/licensee, Ms. McMillian. She was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.**

	(iii) Label instructions for use. **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Resident A's MAR was not initialed on January 14th, 2023, for his 8:00 pm Fluphenazine Tab 5MG medication. Resident A's December 2022 MAR was not initialed for his 8:00 pm Fluphenazine Tab 5MG medication from 12/14/22 through 12/28/22, in addition to 12/30/22 and 12/31/22. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

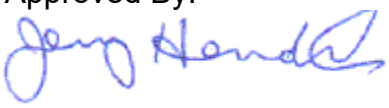
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



02/02/2023

Anthony Mullins Date
Licensing Consultant

Approved By:



02/03/2023

Jerry Hendrick Date
Area Manager