GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 18, 2023

Hope Lovell
LoveJoy Special Needs Center Corporation
17101 Dolores St
Livonia, MI 48152

RE: License #: AS780413489
Investigation #: 2024A0584003
Matthew Home

Dear Ms. Lovell:

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 (517) 284-9727.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780413489
Investigation #:	2024A0584003
Complaint Receipt Date:	10/24/2023
Investigation Initiation Date:	10/25/2023
Report Due Date:	12/23/2023
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17101 Dolores St Livonia, MI 48152
Licensee Telephone #:	(517) 574-4693
Administrator:	Hope Lovell
Licensee Designee:	Hope Lovell
Name of Facility:	Matthew Home
Facility Address:	1016 Wood Court Owosso, MI 48867
Facility Telephone #:	(517) 574-4693
Original Issuance Date:	10/01/2022
License Status:	REGULAR
Effective Date:	03/31/2023
Expiration Date:	03/30/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 10/21/2023, staff refused to allow Resident A into the home after being discharged from the Memorial Hospital Emergency Room.	Yes
The facility did not ensure hospital staff members had all of Resident A's medications when he was away from the facility.	Yes

III. METHODOLOGY

10/24/2023	Special Investigation Intake 2024A0584003.
10/25/2023	Special Investigation Initiated – Email to Andrea Andrykovich, Shiawassee Health and Wellness Recipient Rights Office.
10/26/2023	Contact - Telephone call made to complainant.
10/26/2023	Contact – Telephone call to Allison Kadlek, Memorial Hospital.
10/26/2023	Contact - Telephone call made to Hope Lovell, licensee designee.
10/27/2023	Contact - Face to Face onsite investigation, interview with Jolie Porubsky and house manager Erika Heringhausen.
11/27/2023	Contact - Telephone interviews with Emily Shadden and Alena Bothof.
12/05/2023	Contact – Email sent to Erika Heringhausen for more information on new allegation.
12/08/2023	Contact - Face to Face interview with house manager Erika Heringhausen at the facility.
12/08/2023	Contact - Telephone call conducted and voicemail message for Owosso PD, Detective Sargent to return a call regarding their investigation.
12/14/2023	Contact – Email sent to Rebecca Schalow, Adult protective services worker with Shiawassee County Department of Health and Human Services.

12/15/2023	Exit Conference via email to Hope Lovell, licensee designee, with findings from new allegation.

ALLEGATION:

On 10/21/2023, staff refused to allow Resident A into the home after being discharged from the Memorial Hospital Emergency Room.

INVESTIGATION:

On 10/24/2023, the Bureau of Community and Health Systems received the above allegation via the online complaint system.

On 10/26/2023, I conducted a telephone interview with Complainant who confirmed the allegation.

I conducted a telephone interview with emergency room nurse Allison Kadlek of Memorial Hospital who stated that Resident A is admitted at Memorial hospital as of 10/22/2023.

On 10/27/2023, I conducted an unannounced investigation onsite, and interviewed direct care staff member Jolie Porubsky and house manager Erika Heringhausen.

Ms. Porubsky stated she was working at the home on 10/20/2023 when Resident A started to hit and bite her. Ms. Porubsky stated she contacted Ms. Heringhausen for assistance because Resident A continued his physical attacks. Ms. Porubsky stated the police were called and Resident A was transferred to Memorial Hospital's emergency room (ER) for evaluation.

Ms. Heringhausen stated that after being contacted by Ms. Porubsky, she arrived at the facility on 10/20/2023, and observed Resident A hitting, biting, and attacking Ms. Porubsky. Ms. Heringhausen stated she called regional manager Christina Worthington who instructed her to complete a written 24-hour emergency discharge notice, which she did. According to Ms. Heringhausen, she provided Resident A's responsible agency and legally appointed guardian with a copy of the discharge letter. Ms. Heringhausen confirmed Resident A was transported to the ER for evaluation. Ms. Heringhausen stated, per instruction from Executive Director Heidi Morton, she also completed a petition to order a psychiatric hospitalization for Resident A, due to his violent behaviors. Ms. Heringhausen stated a hospital staff member contacted a facility staff member, via telephone on 10/22/2023, and stated the hospital was discharging Resident A back to the facility as they determined he had reached a "baseline of nonviolent behavior". According to Ms. Heringhausen, she was instructed by management staff to not allow Resident A back into the home and she informed Memorial Hospital staff members of this decision. Ms. Heringhausen stated that later that day, direct care staff members Emily Shadden and Alena Bothof called her when she was not at the home, to report Memorial

Hospital staff members had transported Resident A back to the home anyway, and they were standing outside the front door. Ms. Heringhausen stated she advised both staff members to refuse Resident A access into the facility Ms. Heringhausen stated Memorial Hospital staff members transported Resident A back to the hospital and admitted him.

While on-site, I observed all residents in the home to be well groomed and in good health. I observed the facility to be neat and in good repair.

On 11/27/2023, I conducted separate telephone interviews with Ms. Shadden and Ms. Bothof, whose statements were consistent with the statements Ms. Heringhausen provided to me.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff members, the Complainant, and a Memorial Hospital staff member, it has been established that on 10/20/2023, Resident A was issued a 24-hour discharge notice due to violent physical behavior. Subsequently, Resident A was admitted to the hospital on 10/20/2023 for a psychiatric evaluation. Upon his discharge from the hospital on 10/22/2023,

	facility staff members refused to allow Resident A to return to the facility, even though an appropriate setting that meets his immediate needs had not yet been located.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not ensure hospital staff had all of Resident A's medications when he was away from the facility.

INVESTIGATION:

On 11/17/2023, the Bureau of Community and Health Systems received the above additional allegation via the online complaint system.

On 12/8/2023, I conducted a face-to-face interview with Ms. Heringhausen at the facility, regarding the missing medications. Ms. Heringhausen stated that when Memorial Hospital came to pick up Resident A's medications, they were placed in a bag by staff members. According to Ms. Heringhausen, she handed Memorial Hospital staff members the bag to take with them. Ms. Heringhausen stated she assumed all of Resident A's medications were in the bag and was unaware that three bubble packs of Resident A's medications were still locked in the narcotics section of the medication cabinet. According to Ms. Heringhausen, she was later contacted by staff members employed at Resident A's new placement, who inquired about the missing medication. Ms. Heringhausen stated she checked Resident A's medication log and valuables sheet and discovered some medications had not been given to Memorial Hospital Staff members when they came to the facility to collect his medications. Ms. Heringhausen stated Resident A's "missing" medication is currently at the facility. According to Ms. Heringhausen, Detective Sargent of the Owosso Police Department instructed her to keep the medication locked up until they provide her with further instructions.

While on-site, I confirmed there were three unopened bubble packs of Ativan prescribed to Resident A still at the facility.

I attempted to conduct a telephone interviewed with Detective Sargent but was unable to reach him. I left Detective Sargent a voice mail message. I have not received a return telephone call from Detective Sargent as of 12/15/2023.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the

	alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based upon my investigation, which consisted of an interview of house manager Erika Heringhausen, and an observation of Resident A's medication still at the facility, it has been established that the facility neglected to provide Memorial Hospital Staff Members all of Resident A's prescription medications while he was out of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/26/2023 and 12/15/2023, I conducted an exit conference, via telephone, with licensee designee Hope Lovell and informed her of the findings of this investigation.

IV. RECOMMENDATION

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

12/18/2023

_____

Candace Coburn Date
Licensing Consultant

Approved By:

12/19/2023

_____

Michele Streeter Date
Area Manager