GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2025

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

RE: License #: AS330297845
Investigation #: 2025A0466024
Michigan Ave. Residential Care

Dear Ms. Lovell:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report and the recommendation of revocation of the license from Special Investigation Report #2025A1033024. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 335-5985.

Sincerely,

Julie Elkins

Julie Elkins, 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

To maintain coding consistency of residents across Special Investigation Reports, the resident in this Special Investigation is not identified in sequential order.

I. IDENTIFYING INFORMATION

License #:	AS330297845
Investigation #:	2025A0466024
Complaint Receipt Date:	03/14/2025
Investigation Initiation Date:	03/17/2025
Report Due Date:	05/13/2025
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:	Michigan Ave. Residential Care
Facility Address:	1204 W. Michigan Ave. Lansing, MI 48915
Facility Telephone #:	(517) 367-8172
Original Issuance Date:	12/11/2009
License Status:	REGULAR
Effective Date:	02/23/2024
Expiration Date:	02/22/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION:

	Violation Established?
Resident C was absent without permission from 03/07/2025 through 03/12/2025 and the police were not contacted.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/14/2025	Special Investigation Intake 2025A0466024.
03/14/2025	APS Referral, APS Gene Mellen assigned.
03/17/2025	Special Investigation Initiated - On Site.
03/17/2025	Contact - Telephone call made to APS Gene Mellen.
03/18/2025	Contact - Document Received from Melissa Misner, LPD Social Worker.
03/18/2025	Contact - Telephone call made Melissa Misner, LPD Social Worker interviewed.
05/02/2025	Contact- Document Sent to APS Gene Mellen.
05/05/2025	Contact- Exit Conference with licensee designee Hope Lovell, message left.
05/07/2025	Contact- Exit Conference with licensee designee Hope Lovell.

*****To maintain coding consistency of residents across Special Investigation Reports, the resident in this Special Investigation is not identified in sequential order.***

ALLEGATION: Resident C was absent without permission from 03/07/2025 through 03/12/2025 and the police were not contacted.

INVESTIGATION:
On 03/14/2025, Complainant reported that Resident C was absent without permission from the adult foster care (AFC) home on or about 03/07/2025 until 03/12/2025.

On 03/17/2025, Complainant reported facility direct care staff members did not contact the police while Resident C was missing for several days.

On 03/17/2025, I contacted adult protective services (APS) Gene Mellen who reported facility direct care staff never contacted the Lansing Police Department (LPD) when Resident C was missing. APS Mellen reported that he contacted the LPD about Resident C leaving the facility without permission and remaining missing. APS Mellen reported that the first interaction facility direct care staff members had with LPD was after Resident C returned to the facility on 03/12/2025 and the direct care worker was concerned that Resident C was under the influence of drugs and that Resident C had drugs on her person. APS Mellen stated that is when LPD was contacted by a facility direct care staff member.

On 03/17/2025, I conducted an unannounced investigation and direct care worker (DCW) Keyonna Stewart was on duty and she was training Breshay Wilder. DCW Stewart was aware that Resident C had left the facility, but she was not sure of the dates, the circumstances or if law enforcement was contacted.

I reviewed Resident C's *Assessment Plan for AFC Residents* which documented that Resident C does not move in the community independently. There was a signature documented in the licensee designee section of the report but the signature for the resident or the resident's designated representative was blank.

I reviewed Resident C's record which contained a *AFC- Resident Information and Identification Record* which documented that Resident C's date of admission was 03/03/2025. Resident C's record contained a *Calendar of Activity* that documented a leave of absence (LOA) on March 7, 8,9,10,11,12,13,14,15,16 and 17, 2025.

I reviewed another document labeled as *[Resident C] LOA Log* which documented the following:

- 3/5/2025-left premises 5:50pm, said she was at the store and returned on 3/6 at 2pm.
- 3/6/2025 left at 3:10pm to go to the store to cash check, returned 10:15pm.
- 3/7/2025 left 5:45pm, going to walk to the store.
- 3/11/2025 returned around 8:45pm "seemed to be on a substance drug related was yelling and belligerent."
- 3/12/2025 Woke up about 8am, took medication, ate breakfast and took sugar levels. Police were called as Resident C reported that she was "touched/raped."
- 3/12/2025 [Resident C] returned from hospital very lethargic and belligerent. She threw a bowl at a resident and kicked him so the police were called. [Resident C] was unresponsive to Lansing Police officer so emergency medical services (EMS) was contacted and her blood sugar was so high she was transported to the hospital.
- 3/13/2025 Resident C left to go to the store at 8:53 am.
- 3/14/2025 Resident C not at home.
- 3/15/2025 Resident C not at home.
- 3/16/2025 Resident C not at home.
- 3/17/2025 Resident C not at home.

I interviewed Kathleen Delmerico, LoveJoy Operations Director, who reported that Resident C leaves when she wants to and there is no support from Guardian C1. Ms. Delmerico reported that Resident C was hospitalized on 03/05/2025. Ms. Delmerico reported that on 03/07/2025 Sparrow Hospital released Resident C without notifying facility direct care staff members and when she was driving into work she saw Resident C walking away from the facility unsupervised. Ms. Delmerico reported that she did not talk to Resident C nor did she try to redirect her back to the facility. Ms. Delmerico reported that a missing person report was filed on 03/14/2025 however she did not have a report number or any documentation to support that. Ms. Delmerico had no explanation for why LPD was not contacted prior to 03/14/2025 as Resident C was initially missing overnight on 03/05/2025-03/06/2025, on 03/06/2025 for 7 hours and over several nights from 3/07/2025-3/11/2025. Ms. Delmerico reported that Resident C was hospitalized a second time on 03/12/2025 and then had been missing since 03/13/2025.

I attempted to interview Resident C but observed Resident C to be very distraught about not being allowed entry into the facility, afraid of having no place to live, needing to use the bathroom and being in a police car so she was not very responsive to the questions that I asked her. Resident C reported that she was unaware of the discharge notice until arriving at the facility (03/17/2025). Resident C admitted leaving the facility without supervision.

On 03/18/2025, Melissa Misner, LPD Social Worker verified that APS Mellen on 3/14/2025 was the only one that had filed a missing person report regarding Resident C. Social Worker Misner reported that a dispatch call had been made from the facility on different dates about a medical concern involving Resident C and she was transported to the hospital for medical treatment by EMS. Additionally Social Worker Misner reported that on 03/16/2025, dispatch was contracted by someone working at the facility reporting Resident C was observed to be panhandling by the Plasma center. Social Worker Misner reported that although facility direct care staff had located Resident C's whereabouts, facility direct care staff did not approach her nor attempt any intervention or offer her a ride back to the facility.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident C's *Assessment Plan for AFC Residents* documented that Resident C does not move in the community independently. Resident C's record contained a *Calendar of Activity* that documented leaves of absences (LOA) without permission on March 7, 8,9,10,11,12,13,14,15,16 and 17, 2025. A violation has been established as the amount of supervision and protection that Resident C required was not available and Resident C frequently left the facility without direct care staff supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.** **(b)Contact the local police authority.**
ANALYSIS:	Based on Resident C's record, additional documentation that DCW Stewart and Ms. Delmerico provided along with interviews, there is no evidence to support that each time Resident C left the facility without permission that any facility direct care staff notified the LPD or Guardian C1 as required. The facility had a *Calendar of Activity and a LOA Log* for documenting Resident C's patten of leaving the facility however neither document recorded that either Guardian C or the LPD were contacted as required. Social Worker Misner and APS Mellen both reported that APS Mellen was the only one that notified LPD about Resident C leaving without permission on 03/14/2025 therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 03/13/2025, I conducted an unannounced investigation and when I arrived at the facility Resident C was sitting out in front of the facility in a police car. DCW Stewart reported that Resident C was provided with a discharge notice and therefore she was no longer authorized to allow her entry into the facility. DCW Stewart also reported that Resident C had been absent without permission for several days. DCW Stewart reported that the discharge notice was sent to Guardian C1 but there

was not any documentation available for review to verify this. All Resident C's belongings had been gathered by facility direct care staff and were in garbage bags by the police vehicle. I observed that Resident C was not allowed entry into the home to ensure that all of her belongings had been gathered. Lansing Police Officer Haydn Havard contacted EMS and Resident C was medically cleared as DCW Stewart was concerned about Resident C being under the influence of illegal drugs and/or alcohol. Durning this time Resident C needed to use the restroom and DCW Stewart denied Resident C entry into the facility to use the restroom. DCW Stewart denied Resident C access to the bathroom even if escorted into the facility by Officer Havard. Consequently, Officer Havard had to take Resident C to another location to allow her to use the bathroom while Social Worker Misner was working to find Resident C another living arrangement.

Resident C's record documented that a *Discharge Notice* dated 3/12/2025 had been signed by Ms. Delmerico with a proposed date of discharge as 3/13/2025. According to the documentation provided Resident C was absent without permission when the *Discharge Notice* was issued and there was no documentation available for review that either Resident C, Guardian C1 and/or Resident C's responsible agency was notified of the discharge as required.

On 5/19/2024, Special Investigation Report #2024A1033042, cited a rule violation of Rule R 400.14304 (1)(o)(2), after a direct care worker had not been treating residents with dignity and respect, by directing profanity at residents. The corrective action plan which was approved on 7/09/2024 documented that the direct care worker had been terminated and all direct care staff members were in-serviced/trained on supervision, protection and personal care as well as dignity and respect of residents.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	A violation has been established as Resident C was not treated with consideration, respect and dignity when DCW Stewart would not allow Resident C entry into the facility for her to use the bathroom and to ensure that all her personal belongings had been gathered.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Reference Special Investigation Report # 2024A1033042 dated 5/19/2024, CAP 7/9/2024.]**

INVESTIGATION:
Resident C's record documented that a *Discharge Notice* dated 3/12/2025 had been signed by Ms. Delmerico with a proposed date of discharge as 3/13/2025.

The Discharge Notice stated:
"Upon my arrival at the MARC, I observed [Resident C] who had been reported missing since March 7, 2025. I sat at the kitchen table with her and asked about her whereabouts and activities during her absence. [Resident C] spoke for approximately 10 minutes, exhibiting slurred speech, closing her eyes, and leaning over.
From what I could discern, she stated she had been staying with individuals she met at a store near the AFC home, who supplied her with drugs, including crack cocaine. She also mentioned spending a night at a warming facility but could not recall its name or location. [Resident C] attempted to return to the AFC home by bus but was unable to navigate the route.
She then disclosed to me and two other staff members that she had been raped by four men but could not provide details on the time or location of the incident. I asked if she wanted to file a police report or seek medical care. She declined to report the incident but requested medical attention.
When asked if she had drugs in her possession, [Resident C] admitted to having "some rocks and pipes" in her room. I accompanied her upstairs to remove them from the premises. Once the drugs and paraphernalia were secured, I immediately contacted the Lansing Police Department to file a report and surrender the items. Officers arrived, took statements from the two DCs and me, and arranged for [Resident C] to be transported to Sparrow Hospital by ambulance.
Due to repeated violations of home policies, including bringing drugs onto the premises, and posing a risk to herself and others, [Resident C] was issued a 24-hour discharge notice immediately following her departure."

Resident C's record did not contain any evidence that Resident C, Guardian C1 and Resident C's case manager had received the *Discharge Notice*. On 03/17/2025 at the time of the unannounced investigation there was not another appropriate setting available to meet the needs of Resident C at that time. According to the documentation provided, Resident C was absent without permission when the *Discharge Notice* was issued and there was no documentation available for review that Guardian C1 and Resident C's responsible agency were notified of the

discharge. Resident C expressed concern that she is not from this area and that she needed a place to live. According to Resident C's records she was placed in the facility by Saginaw County Community Mental Health.

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: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(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:	Resident C's record documented that a *Discharge Notice* dated 3/12/2025 had been signed by Ms. Delmerico with a proposed date of discharge as 3/13/2025. There was no documentation or verification in Resident C's record that this discharge notice was provided to Resident C, Guardian C1 and Resident C's responsible agency. Additionally the discharge notice did not provide alternatives to discharge that have been attempted by the licensee which could have included consultation with Resident C's case manager or physician. Therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/07/2025, I conducted an exit conference with licensee designee Hope Lovell who understood the violations.

IV. RECOMMENDATION

Based upon the number and severity of quality care violations cited in investigation#2025A1033024 and this investigation, a recommendation for revocation of the license continues at this time.

Julie Elkins 05/05/2025

Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm 05/05/2025

Dawn N. Timm Date
Area Manager