GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2026

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

RE: License #: AS780413489
Investigation #: 2026A0577045
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) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	2026A0577045
Complaint Receipt Date:	05/27/2026
Investigation Initiation Date:	05/28/2026
Report Due Date:	07/26/2026
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17101 Dolores St Livonia, MI 48152
Licensee Telephone #:	(517) 574-4693
Administrator/Licensee Designee:	Hope Lovell
Name of Facility:	Matthew Home
Facility Address:	1016 Wood Court Owosso, MI 48867
Facility Telephone #:	(989) 723-3554
Original Issuance Date:	10/01/2022
License **Status:**	REGULAR
Effective Date:	03/31/2025
Expiration Date:	03/30/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is constantly harassing and beating up Resident B causing injury.	Yes
There is insufficient number of staff members needed to implement Resident A's care plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/27/2026	Special Investigation Intake, 2026A0577045
05/28/2026	APS Referral
05/28/2026	Special Investigation Initiated - Face to Face Onsite Investigation
05/28/2026	Inspection Completed On-site
05/28/2026	Contact - Document Received Keegan Sarker, ORR-CMH, sends copy of updated BTP.
05/28/2026	Contact - Document Received, HC IR's.
05/28/2026	Referral - Recipient Rights Keegan Sarkar, ORR-CMHCM.
05/28/2026	Contact - Telephone call received Keegan Sarker, ORR-CMHCM.
06/04/2026	Contact- Document received Katie Hohner, ORR-CMHCM Supervisor via email sends IR from 5/30/26 with concerns.
06/04/2026	Contact- Telephone call made, Katie Hohner, ORR-CMHCM Supervisor.
06/04/2026	Contact-Telephone call made, Interviews with DCS.
07/01/2026	Exit Conference with licensee designee Hope Lovell.

ALLEGATION: Resident A is constantly harassing and beating up Resident B causing injuries.

INVESTIGATION:

*Prior to this complaint, Resident A was hospitalized due to aggressive behavior. On April 23, 2026, a safety plan meeting was held with the following individuals present: me, Hope Lovell-Licensee Designee (LD), Kathleen Redmer-Operations Director (OD), Jolie Porubsky- direct care staff (DCS), Emma Lentz-CMHCM Case Manager, Dr. Chelsey "Katie" McGillis-Psychologist CMHCM, and Katie Horner ORR Supervisor CMHCM. This meeting determined that a safety plan requiring Resident A be provided with 2:1 direct care staff enhanced supervision will be implemented upon Resident A's return to facility.

On May 27, 2026, a complaint was received alleging that Resident A continues to harass and assault Resident B leading to Resident B suffering multiple injuries.

On May 28, 2026, I interviewed Keegan Sarkar, Office of Recipient Rights (ORR) with Community Mental Health of Central Michigan (CMHCM) who reported upon reviewing *AFC Licensing Division-Incident/Accident Report* (IR) dated May 20, 2026, she determined that direct care staff were not following Resident A's *Behavior Treatment Plan* (BTP). Ms. Sarkar emailed me a copy of the IR which documented that at 5:30pm on May 20, 2026, direct care staff (DCS) Haley Rainey and Valerie Schiller were cooking dinner and assisting other residents and could not get to Resident A before she got into Resident B's bedroom and scratched Resident B. The IR documented direct care staff verbally redirected Resident A out of Resident B's bedroom. In the 'Action taken' section of the IR it documented that "staff made sure that [Resident A] got back into bathtub instead of returning to [Resident B's] bedroom. Correction measure is to continue to monitor for health and safety, follow BTP and PCP."

On May 28, 2026, I completed an unannounced onsite investigation and interviewed DCS Jolie Porubsky, whose role is home manager, who reported Resident A remains fixated on Resident B even after being discharged from the hospital on April 30,2026. Ms. Porubsky reported there have been 32 IRs completed regarding Resident A's aggressive behaviors since Resident A's return from the hospital. Ms. Porubsky emailed me copies of Resident A's IRs since April 30, 2026. After reviewing the 32 IRs involving Resident A, I focused on those specifically involving Resident A and Resident B and noted a significant pattern of escalating physical aggression, targeted assaults toward Resident B, aggression toward other residents, self-injurious behaviors, and assaults on staff during May 9, 2026, through May 27, 2026. The incidents occurred throughout all times of day, including overnight hours, and frequently involved Resident A entering Resident B's bedroom despite staff attempts to intervene. The following is a summary of the IR's reviewed.

- On May 9, 2026, Resident A entered Resident B's bedroom and struck Resident B on the back. Staff verbally redirected Resident A.

- On May 10, 2026, Resident A stood from the dining table, located Resident B, and began hitting him.
- On May 13, 2026, multiple incidents occurred: • Resident A yelled “murder,” searched for Resident B, and slapped another resident across the face. • Resident A threatened to kill Resident B but was unable to locate him, so began hitting herself in the face and throwing herself to the ground. • Resident A entered Resident B’s bedroom before staff could intervene and hit Resident B. • Staff documented that Resident A verbally threatened to kill Resident B for approximately 11 hours.
- On May 14, 2026, Resident A pulled down another resident’s pants and spanked them, then repeated the behavior with a second resident while searching for Resident B. Later the same day, Resident A ran naked from the bathtub into Resident B’s bedroom and struck Resident B while staff attempted to redirect her.
- On May 16, 2026, beginning at midnight, Resident A repeatedly ran from the bathtub to Resident B’s bedroom while screaming. After returning to the bathtub and dressing, Resident A forced her way into Resident B’s room and struck him multiple times with stuffed animals and her fists. Resident A also punched a staff member in the back of the head during this shift.
- On May 17, 2026, Resident A entered Resident B’s bedroom while both staff were assisting other residents and struck Resident B, then bit him when staff attempted to intervene. Later the same day, Resident A punched another resident in the back of the head in the kitchen.
- On May 21, 2026, Resident A left the bathroom naked and entered Resident B’s bedroom, hitting him until staff redirected her.
- On May 22, 2026, Resident A attempted to enter Resident B’s room stating she intended to “beat him up.” When staff blocked the doorway, Resident A punched a staff member in the face, causing the staff to fall against the door. Another staff member redirected Resident A before she could reach Resident B.
- On May 23, 2026, Resident A left the dining table, located Resident B, and began hitting him. Resident B pushed Resident A in response, causing her to fall and hit her head on a chair; no injuries were noted. Later the same day, Resident A attempted twice to kick Resident B while kicking his wheelchair.
- On May 24, 2026, Resident A engaged in self-injurious behavior by screaming and hitting herself in the face. Later that morning, Resident A again attempted to reach Resident B, hitting him, hitting staff, throwing herself to the ground, and remaining awake and aggressive from 2:00am to 10:00am. Staff provided continuous verbal redirection and administered PRN medication.
- On May 27, 2026, while staff were preparing dinner, Resident A struck another resident four to five times on the back and shoulder before being redirected to her bedroom.

During the onsite investigation on May 28, 2026, I observed Resident B who had a bruise on his shin, a bite mark-bruise on his right arm, and scratch marks on his left arm. Resident B reported that Residet A continues to attack and hurt him.

On June 04, 2026, I received an IR via email from Katie Hohrner, ORR-CMHCM Supervisor. The IR dated May 30, 2026, reported that at 1:00am Resident A left her room, walked down the hallway to Resident B's bedroom and started knocking on the door. Staff attempted to verbally redirect Resident A to another area of the house when Resident A broke Resident B's doorhandle, went into Resident B's bedroom and hit Resident B six times until direct care staff were able to verbally redirect Resident A out of the bedroom. The IR documented direct care staff used verbal prompts to redirect Resident A. The IR documented the corrective measures taken were to continue to follow PCP and BTP, by monitoring for health and safety.

On June 4, 2026, Katie Hohner, ORR-CMHCM Supervisor, reported that she and Supervisor Dr. Chelsey McGillis, Psychologist CMHCM, completed a TEAMS training for direct care staff covering Resident A's BTP. The training reviewed the full crisis-intervention continuum, including verbal prompting, redirection, environmental adjustments, de-escalation techniques, and physical intervention, along with guidance on when each intervention style is appropriate for use.

On June 04, 2026, I interviewed DCS Arianna Haringhausen regarding the IR dated May 30, 2026, and Ms. Haringhausen reported on May 30, 2026, it was herself and DCS Courtney Hall working first shift. Ms. Haringhausen reported that herself and DCS Hall were the only direct care staff working at the time. Ms. Haringhausen reported that she was in the hallway while Resident A was in her bedroom and DCS Hall was providing care to another resident when Resident A ran out of her bedroom to Resident B door, started pounding on the door and twisting the handle to get into Resident B's bedroom. Ms. Haringhausen reported she attempted to verbally redirect Resident A but Resident A refused to follow the prompts. Ms. Haringhausen reported that Resident A broke the door handle, entered Resident B's bedroom, and started punching Resident B. Ms. Haringhausen reported she continued to verbally prompt Resident A to leave the bedroom and also attempted to place herself between Resident A and Resident B to stop Resident A from hitting Resident B. Ms. Haringhausen stated she finally called DCS Hall for assistance after the third time Resident A hit Resident B. Ms. Haringhausen reported she received training on crisis intervention at hire. Ms. Haringhausen reported that she did not attempt to use physical interventions to removed Resident A from Resident B's bedroom and stated this was, "because physical interventions do not work with [Resident A]." Ms. Haringhausen reported that she attended the training provided by Ms. Hohner and Ms. McGillis on June 4, 2026, about when it is appropriate to use physical intervention with Resident A.

On June 04, 2026, I interviewed DCS Hailey Rainey who reported that on May 20, 2026, she worked with DCS Valarie Schiller and confirmed they were the only two direct care staff scheduled. Ms. Rainey reported that she was in the kitchen making dinner while DCS Schiller was assisting another resident with care. Ms. Rainey reported DCS Schiller heard Resident B call for help so DCS Schiller ran into Resident B's room and found that Resident A had already scratched Resident B's bottom left shin before leaving Resident B's bedroom. During my onsite investigation on May 27, 2026, I took a photo of Resident B's shin showing a cut mark on the front of his left shin.

Ms. Rainey also reported on May 17, 2026, she was working with DCS Schiller and only two direct care staff were scheduled. Ms. Rainey reported herself and DCS Schiller were assisting another resident with care, while Resident A was in her bedroom. DCS Ms. Rainey reported she heard Resident B yelling, went into Resident B's bedroom and observed Resident A hitting Resident B. Ms. Rainey reported Resident A hit Resident B about six times while Ms. Rainey verbally prompted Resident A to stop hitting Resident B by going to do a calming activity. Ms. Rainey reported Resident A leaned over the bed and bit Resident B on the toe, when Resident B said he was hurt, Resident A laughed and walked out of Resident B's bedroom. Ms. Rainey reported that no physical intervention was used. Ms. Rainey reported that she attended the training provided by Ms. Hohner and Ms. McGillis regarding when it is proper to use physical intervention.

On June 05, 2026, I contacted Dr. Chelsey McGillis Psychologist CMHCM regarding the list of attendees at the training provided on May 20, 2026, and the attendees were the following DCS Jolie Porubsky, Ariana Heringhausen, Hayley Rainey, Courtney Hall, Breanna Worthington, Bradley Gibbs, Christina Worthington, and Valerie Schiller Dr. McGillis reported the training consisted of reviewing Resident A's BTP, training on behavior crisis interventions and supporting the use of physical interventions when necessary.

On June 05, 2026, I contacted DCS Jolie Porubsky who confirmed Operations Director Kathleen Redmer was aware of the training conducted by Dr. Chelsey McGillis but did not attend. Ms. Porubsky stated licensee designee Hope Lovell did not attend this training either.

*SIR 2026A0577035, cited rule R 400.681 (1) after it was determined that licensee designee Hope Lovell and direct care staff did not keep Resident B safe from Resident A attacking him causing injury. The Corrective Action Plan documented that direct care staff will be supported by senior leadership when implementing safety protocols in Resident A's *Behavior Treatment Plan* such as the use of Safety-Care/ CPI Interventions when Resident A is attacking Resident B.

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:	A review of incident reports dated **May 9–27, 2026**, documented that direct care staff along with the licensee designee were not capable of ensuring the welfare and safety of residents, particularly Resident B and other peers repeatedly targeted by Resident A. Throughout this period, Resident A engaged in ongoing physical aggression, including hitting, slapping, biting, punching, pulling down residents' clothing, entering other residents' bedrooms without permission, and making repeated verbal threats to kill Resident B. Resident A also engaged in self-injurious behaviors and assaulted staff on multiple occasions. Despite these repeated and escalating behaviors, direct care staff were frequently unable to intervene in time to prevent Resident A from entering Resident B's bedroom or assaulting residents. Several incidents occurred while staff were occupied with other duties or assisting other residents, resulting in Resident A gaining access to Resident B and causing harm. In multiple cases, direct care staff relied solely on verbal redirection/prompting, which was ineffective in preventing or stopping the aggression. The frequency, severity, and duration of these incidents, combined with documented staffing shortages and the inability of staff to consistently prevent harm, demonstrate that the licensee and staff were not capable of ensuring the welfare of residents, as required. Residents were repeatedly placed at risk of physical harm, emotional distress, and unsafe living conditions due to their inability to provide adequate supervision, timely intervention, and effective behavioral support.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2026A0577035, DATED 05/20/2026 AND CAP DATED 06/04/2026.]**

ALLEGATION: There is insufficient number of staff members needed to implement Resident A's care plan.

INVESTIGATION:

During the April 23, 2026, safety plan meeting for Resident A CMHCM recommended that upon Resident A's discharge, that Resident A be provided with enhanced 2:1 direct care staff supervision from 12:00 PM to 12:00 AM. During the meeting, I specifically asked LD Hope Lovell and OD Ms. Redmer if this staffing demand could be met by the

licensee and both confirmed having the staffing numbers to meet Resident A's enhanced 2:1 direct care staff supervision requirement.

On May 28, 2026, I received a telephone call from Keegan Sarkar, ORR-CMH reporting upon Resident A being discharged from the hospital, Resident A's Behavior Treatment Plan (BTP) was updated, documenting Resident A requiring 2:1 supervision from 12:00pm-12:00am. Ms. Sarkar reported recently that Resident A's BTP was amended to include an additional three hours of 2:1 direct care staff supervision from midnight until 3:00am. Ms. Sarkar reported that there is concern that Resident A is not being provided with this additional 2:1 supervision requirement.

On May 28, 2026, via email, Ms. Sarkar, ORR-CMH I received copies of Resident A's updated BTP's documenting approval of enhanced supervision from 1:1 staffing to 2:1 staffing. The BTP addendums document the following information:

- The initial BTP addendum went into effect on May 01, 2026, due to Resident A engaging in seriously aggressive behavior, threats of killing another resident, displaying self-injurious behaviors, and physically breaking bedroom doorknobs. With Resident A's behaviors placing herself and others at risk, the approved addendum to Resident A's BTP documented an increase in enhanced staffing supports and more intensive periodic monitoring. Specifically, approving 2:1 staffing supports from 1200pm to 12:00am daily, with the remainder of the day being 1:1 (from 12 am to 12 pm). The addendum also requires when Resident A is in her bedroom, that she is frequently monitored at least every 15 minutes.
- On May 18, 2026, Resident A's BTP was updated and approved to increase 2:1 enhanced supervision by adding three additional hours from 12:00pm-3:00am due to Resident A's continuing aggressive behaviors, making threats to kill residents, seeking out knives, and finding a bat with a plan to hurt Resident B. Staff are reporting these behaviors are continuing until 3:00am.

On May 28, 2026, during the unannounced onsite investigation, I observed four direct care staff working, with two direct care staff providing 2:1 enhanced supervision to Resident A.

Ms. Porubsky provided copies of the direct care staff schedules for May 1–28, 2026. The schedules were reviewed and summarized by the number of staff assigned to each enhanced-supervision shift—First Shift (12:00pm–4:00pm), Second Shift (4:00pm–12:00am), and Third Shift (12:00am–3:00am beginning May 18, 2026). Per Resident A's BTP, there should be at minimum three direct care staff from 12:00pm until 4:00pm (1st shift), three direct care staff from 4:00pm-midnight, and two direct care staff from midnight until noon. Beginning on May 18, 2026, there should be three direct care staff from midnight until 3:00am, per Resident A's updated BTP. The table below reflects the number of staff scheduled per shift for each date within this period and deficiencies noted.

Staffing Summary Table

Date	1st Shift (12PM-4PM)	2nd Shift (4PM-midnight)	3rd Shift (midnight-3AM)	Insufficient Staffing
5/1	2	2	2	Insufficient staff 1st & 2nd shift
5/2	2	2	2	Insufficient staff 1st & 2nd shift
5/3	2	2	3	Insufficient staff 1st & 2nd shift
5/4	1	3	2	Insufficient staff 1st Shift
5/5	2	2	2	Insufficient staff 1st & 2nd shift
5/6	3	2	2	Insufficient staff 2nd shift
5/7	3	3	2	Insufficient staff 2nd shift from 8pm–12am
5/8	3	3	2	In Compliance
5/9	2	1	2	Insufficient staff 2nd shift from 8pm–12am
5/10	2	2	2	Insufficient staff 1st & 2nd shift
5/11	3	2	2	Insufficient staff 2nd shift
5/12	3	2	2	Insufficient staff 2nd shift
5/13	3	3	2	Insufficient staff 2nd shift from 6:30pm–12am
5/14	3	2	2	Insufficient staff 2nd shift
5/15	2	2	2	Insufficient staff 1st, & 2nd shift
5/16	2	1	2	Insufficient staff 1st & 2nd shift
5/17	2	1	2	Insufficient staff 1st & 2nd shift
5/18	3	2	2	Insufficient staff 2nd & 3rd shift (2:1 required until 3am)
5/19	3	2	2	Insufficient staff 2nd & 3rd shift
5/20	4	2	2	Insufficient staff 2nd & 3rd shift
5/21	3	3	2	Insufficient staff on 3rd shift
5/22	2	2	2	Insufficient staff 1st , 2nd & 3rd shift

5/23	2	2	2	Insufficient staff 1st , 2nd, & 3rd shift
5/24	2	2	2	Insufficient staff 1st, 2nd , and 3rd shift
5/25	2	2	2	Insufficient staff 1st, 2nd , and 3rd shift
5/26	2	2	2	Insufficient staff 1st, 2nd , and 3rd shift
5/27	3	2	2	Insufficient staff 1st, 2nd , and 3rd shift
5/28	4	4 (4–8pm), 2 (8–12am)	2	Insufficient staff 2nd shift from 8pm–12am & 3rd shift

On June 04, 2026, I interviewed DCS Arianna Haringhausen who reported that on May 30, 2026, only she and DCS Courtney Hall worked first shift. Ms. Haringhausen reported knowing Resident A requires 2:1 supervision from noon until 3AM and stated, “we are doing the best we can with staffing.”

On June 04, 2026, I interviewed DCS Hailey Rainey who reported that on May 17 and 20, 2026, Ms. Rainey and DCS Valerie Schiller were the only staff members scheduled for their shift.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Based on my review of the staff schedule for May 1, 2026 through May 28, 2026, there was only one day during that time frame (May 8, 2026) when there was sufficient staff to meet all resident needs, including Resident A’s enhanced supervision needs. Otherwise, on all the dates during that time frame, Resident A was not provided with the required 2:1 direct care staff supervision per her BTP.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

On June 8, 2026, a 1st provisional license was issued. I recommend that the status of the license continue upon receipt of an acceptable corrective action plan.

Bridget Vermeesch

07/01/2026

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 07/01/2026

_____

Dawn N. Timm Date
Area Manager