GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 9, 2022

Hope Lovell
LoveJoy Special Needs Center Corporation
17141 New Jersey Street
Southfield, MI 48075

RE: License #: AS820294204
Investigation #: 2022A0121017
Dolores Residential Care

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 was required. On May 3, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (313) 456-0380.

Sincerely,

K. Robinson

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820294204
Investigation #:	2022A0121017
Complaint Receipt Date:	03/09/2022
Investigation Initiation Date:	03/11/2022
Report Due Date:	05/08/2022
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17141 New Jersey Street Southfield, MI 48075
Licensee Telephone #:	(517) 574-4693
Administrator:	Hope Lovell, Designee
Name of Facility:	Dolores Residential Care
Facility Address:	17101 Dolores St. Livonia, MI 48152
Facility Telephone #:	(734) 469-4019
Original Issuance Date:	04/07/2008
License **Status:**	REGULAR
Effective Date:	08/14/2021
Expiration Date:	08/13/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Per incident report, female resident was highly agitated that direct care worker, Lucinda Thompkins hurt her neck.	Yes

III. METHODOLOGY

03/09/2022	Special Investigation Intake 2022A0121017
03/11/2022	Special Investigation Initiated - Telephone Left message for Hope Lovell, licensee designee
03/11/2022	Contact - Telephone call received Message from Hilda Morton, licensee designee
03/14/2022	Contact - Telephone call made Call to Hilda Morton
03/29/2022	Contact - Telephone call made Left message for Carol Jackson with ORR
04/08/2022	APR referral made
04/06/2022	Contact - Telephone call received Return call from Carol Jackson
04/22/2022	Contact - Telephone call made Attempted call to Lucinda Thompkins; received outgoing message that caller cannot accept calls now.
04/22/2022	Exit Conference Hilda Morton
05/02/2022	Contact - Telephone call made Follow up call to Ms. Morton regarding CAP
05/03/2022	Corrective Action Plan Received via fax
05/03/2022	Corrective Action Plan Approved

05/04/2022	Inspection Completed On-site Interviewed Resident A and Direct Care Workers, Jasmine Smith and LaTonya Wilson.
05/04/2022	Contact - Telephone call made Attempted call to Lucinda Thompkins; received outgoing message that caller cannot accept calls right now.

ALLEGATION: Per incident report, female resident was highly agitated that direct care worker, Lucinda Thompkins hurt her neck.

INVESTIGATION: Upon reviewing the bureau of information tracking system, I determined there are 2 licensee designees attached to this facility. Hope Lovell and Hilda Morton (also known as "Heidi") are the licensee designees. I initiated the complaint with a call to Hope Lovell. On 3/11/22, I received a return call from Hilda Morton. Ms. Morton indicated Resident A informed her direct care worker, Lucinda Thompkins grabbed her by the neck and forced the resident into her bedroom. Ms. Morton reported Resident A is assigned to a private room, so there are no witnesses to the alleged abuse. Ms. Morton stated Ms. Thompkins has worked at the home for 2 years. According to Ms. Morton, the Office of Recipient Rights recently substantiated Ms. Thompkins verbally abused Resident A. Carol Knight-Jackson was the investigating officer. Once, Mrs. Knight-Jackson was made aware of the physical abuse allegation, she recommended Ms. Morton fire her. Per Ms. Morton, Ms. Thompkins was terminated from employment on 3/7/22. The choking incident occurred on 3/6/22. Resident A was taken to St. Mary's Hospital for treatment and evaluation.

On 4/6/22, I interviewed Mrs. Knight-Jackson regarding the current allegation. Mrs. Knight-Jackson indicated she was leaning toward substantiating the abuse case considering Ms. Thompkins abusive history.

I attempted to reach Ms. Thompkins on 4/22/22 and 5/4/22 to no avail. I received an outgoing message that the "caller cannot accept calls right now" both times I dialed her number.

On 5/4/22, I made an unannounced onsite inspection at the facility. Resident A was not engaged in the interview. Resident A was slow to speak; she uttered very few words. However, Resident A did say Ms. Thompkins did not choke her and that she likes Ms. Thompkins. Direct care workers, Jasmine Smith and Latonya Wilson both reported Resident A informed them Ms. Thompkins choked her. Ms. Smith and Ms. Wilson reported seeing bruising around Resident A's neck. Ms. Wilson showed me a picture of the injury. Ms. Wilson indicated Resident A is known to recant her story out of fear of "getting Staff in trouble."

I completed an exit conference with Ms. Morton based on my conversation with Mrs. Knight-Jackson. Ms. Morton submitted an acceptable corrective action plan to the department on 5/3/22.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	- Resident A reported Lucinda Thompkins choked her causing bruising around the neck. - Direct care workers, Jasmine Smith and Latonya Wilson observed bruising to Resident A's neck shortly after the incident occurred. - Lucinda Thompkins was recently involved in a separate abuse case with the Office of Recipient Rights for verbally abusing Resident A. Therefore, it is reasonable to conclude, Ms. Thompkins is responsible for injuring the resident as reported.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

05/04/22

Kara Robinson Date
Licensing Consultant

Approved By:

5/09/22

Ardra Hunter Date
Area Manager