GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 06, 2023

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

RE: License #: AS330297845
Investigation #: 2023A0466052
Michigan Ave. Residential Care

Dear Ms. Lovell:

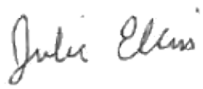
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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

I. IDENTIFYING INFORMATION

License #:	AS330297845
Investigation #:	2023A0466052
Complaint Receipt Date:	07/10/2023
Investigation Initiation Date:	07/11/2023
Report Due Date:	09/08/2023
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:	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:	02/23/2022
Expiration Date:	02/22/2024
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS:

	Violation Established?
The direct care workers (DCW)s are having sex with each other and smoking marijuana in the facility.	No
Residents are being physically abused.	No
Facility lacks food for residents.	No
Direct carer workers (DCW)s administer Ativan to residents when they want them to go to sleep even though it is not prescribed to them.	No
Direct care workers (DCW)s do not take residents on outings and they refuse to help residents with activities of daily living (ADL)'s.	No
Additional Findings	Yes

III. METHODOLOGY

07/10/2023	Special Investigation Intake- 2023A0466052.
07/10/2023	APS Referral Robert Lindley assigned.
07/10/2023	Contact - Telephone call made to APS Robert Lindley, message left.
07/11/2023	Special Investigation Initiated – Telephone APS Robert Lindley interviewed.
07/17/2023	Inspection Completed On-site.
07/17/2023	Contact – Email received from Ariana Heringhausen.
08/21/2023	Contact – Email sent/received to/from APS Robert Lindley.
08/29/2023	Contact – Email sent to Ariana Heringhausen.
08/30/2023	Contact – Email received from Ariana Heringhausen.
08/31/2023	Exit Conference with licensee designee Hope Lovell.

ALLEGATION: The direct care workers (DCW)s are having sex with each other and smoking marijuana in the facility.

INVESTIGATION:
On 07/10/2023 I received a written complaint via centralized intake from Complainant who reported that at Michigan Avenue Residential Care (Marc) house residents suffer from physical disabilities, mental health disorders, cognitive disorders are medical fragile and require assistance with activities of daily living (ADL's). Complainant reported direct care workers (DCW) at the facility are not properly caring for the for residents. Complainant reported DCWs are having sex with one another, smoking marijuana and inviting other people over to smoke and have sex within the home. Complainant reported DCWs often yell and send the residents to their rooms.

On 07/10/2023, I interviewed adult protective service (APS) specialist Robert Lindley who reported that when he was at the facility on 07/08/2023, he did not observe any DCWs having sex with each other, nor did he witness any DCWs smoking marijuana. APS specialist Lindley reported that he did not smell any marijuana, nor did he see any signs of marijuana use while ate the facility.

On 07/17/2023, I conducted an unannounced investigation with APS specialist Lindley and we interviewed Resident A and Resident B separately. Resident A and Resident B both denied observing any DCWs are having sex with each other and Resident A and Resident B both denied any DCW smokes marijuana while at the facility. Resident A and Resident B both reported that they have never seen any evidence that anyone has/had been smoking marijuana in the facility nor have they ever smelled marijuana in the facility.

At the time of the unannounced investigation Resident C and Resident D were not at the facility and therefore was unable to be interviewed.

APS specialist Lindley and I interviewed DCW Ariana Heringhausen who reported that she works as a house manager and a direct care worker. DCW Heringhausen denied that any resident nor any DCW has ever reported to her DCWs were having sex with each other and/or smoking marijuana while at the facility. DCW Heringhausen reported she has never observed any DCW having sex while at work nor has she observed any DCW smoking marijuana while at work. DCW Heringhausen reported she has never observed any evidence that anyone had been smoking marijuana in the facility nor has she ever smelled marijuana in the facility.

APS specialist Lindley and I did not observe any DCWs having sex with each other, nor did we witness any DCWs smoking marijuana while at the facility on 07/17/2023. APS specialist Lindley and I did not smell any marijuana odor nor did we see any signs of marijuana use while at the facility.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Although complainant reported direct care workers are smoking marijuana in the facility, this was denied by Resident A, Resident B, and DCW Heringhausen and there was no evidence of this behavior during either of APS Specialist's Lindley's two onsite investigation or my investigation. Therefore, there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	Although complainant reported that direct care workers are having sex with each other in the facility this allegation was denied by Resident A, Resident B, and DCW Heringhausen.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are being physically abused.

INVESTIGATION:
On 07/10/2023, Complainant reported residents are being physically abused. Complainant reported that on an unknown date and time, a female DCW kicked and scratched a resident on their chest until they drew blood.

On 07/10/2023, I interviewed APS specialist Lindley who reported that when he was at the facility on 07/08/2023 and he did not observe any resident to have any signs of being physically abused nor did any resident or staff member report that residents were being physically abused. APS specialist Lindley reported that he did not observe any resident to have any scratch marks.

On 07/17/2023, I conducted an unannounced investigation with APS specialist Lindley and we interviewed Resident A and Resident B separately. Resident A and Resident B both denied that residents are being physically abused by anyone. Resident A and Resident B both denied that a female DCW kicked and scratched a resident on their chest until they drew blood. Resident A reported that Resident D will kick and scratch other residents and DCWs but none of the DCWs put their hands on any resident. Resident A and Resident B both denied having scratch marks on them. APS specialist Lindley and I did not observe any visible scratch marks on Resident A or Resident B while interviewing them.

At the time of the unannounced investigation Resident C and Resident D were not at the facility and therefore was unable to be interviewed.

On 07/17/2023, APS specialist Lindley and I interviewed DCW Heringhausen who denied that a female DCW kicked and scratched a resident on their chest until blood was drawn. DCW Heringhausen stated Resident A, Resident B, Resident C or Resident D never reported to her that they were kicked and scratched by a DCW on their chest until they drew blood. DCW Heringhausen reported that no DCW reported to her that any resident was kicked and scratched by a DCW on their chest until they drew blood. DCW Heringhausen reported that she has never observed any scratch marks on any of the residents.

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:	Although complainant reported a resident was kicked and scratched by a DCW on their chest until they drew blood, this allegation was denied by Resident A, Resident B, APS specialist Lindley and DCW Heringhausen. There was no evidence any resident had been involved in any altercation with a direct care worker or that a direct care worker purposefully or accidentally injured a resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Facility lacks food for residents.

INVESTIGATION:
On 07/10/2023, Complainant reported during the first week of July 2023, the only food available in the facility was bread, eggs, grapes and milk. Complainant reported that DCWs refused to go to the grocery store to get more food until the following Monday.

On 07/11/2023, APS worker Robert Lindley reported he had been to the facility on 07/08/2023 and he observed two to three days' worth of food in the home.

On 07/17/2023, I conducted an unannounced investigation with APS specialist Lindley and I observed the facility to have bread, left over prepared meals, oranges, grapes, condiments, cheese, two large bags of frozen chicken breast, frozen burritos, hotdogs, hamburger, bacon, frozen vegetables, peanut butter, dressings and sauces. The facility also had a pantry with non-perishable items such as pasta, rice, potatoes, chips and cookies.

APS specialist Lindley and I interviewed Resident A and Resident B separately. Resident A and Resident B both reported the facility has food and that they were provided with three meals and snacks daily. Resident A stated being provide with candy, pizza, coffee and tea which she likes. Resident B stated that they did run out of milk, bread and eggs last week. Resident B stated that they had multiple meals where hot dogs were served and that they also had tacos, pancakes, waffles and pizza. Resident B stated that when they were out of bread, he used hot dog buns to make peanut butter and jelly sandwiches.

At the time of the unannounced investigation Resident C and Resident D were not at the facility and therefore were unable to be interviewed.

On 07/17/2023, APS specialist Lindley and I interviewed DCW Heringhausen who denied that the facility ran out of food. DCW Heringhausen reported that a DCW did refuse to go to the store last Monday (07/10/2023) when asked and she reported that she could not pick up groceries because she was sick. DCW Heringhausen reported that the facility did have groceries and enough food to cook meals/snacks

however there were some grocery items that they were low/ran out of. DCW Heringhausen could not remember exactly which items those were.

On 08/21/2023, APS specialist Lindley reported that he substantiated DCW Arianna Heringhausen for neglect due to her being responsible for the facility not having enough food for the residents.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Although complainant reported the facility did not have enough food, this allegation was denied by Resident A, Resident B and DCW Heringhausen. At the time of the unannounced onsite investigation there was enough food to feed the four residents living at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct carer workers (DCW)s administer Ativan to residents when they want them to go to sleep even though it is not prescribed.

INVESTIGATION:
On 07/10/2023, Complainant reported DCWs administer residents Ativan when they want them to go to sleep even though it is not prescribed.

On 07/17/2023, I conducted an unannounced investigation with APS specialist Lindley and we interviewed Resident A and Resident B separately. Resident A and Resident B both reported that they are not prescribed Ativan and both denied being administered Ativan. Resident A and Resident B both reported being knowledgeable about the medications they are prescribed and stated they would notice if a DCW tried to give them a pill that they were not prescribed. Resident A and Resident B both reported that they would not ingest a medication that they did not believe was prescribed to them.

At the time of the unannounced investigation Resident C and Resident D were not at the facility and therefore was unable to be interviewed.

APS specialist Lindley and I interviewed DCW Heringhausen who denied that there was any Ativan in the facility. DCW Heringhausen reported that none of the residents are prescribed that medication.

I inspected the medication in the pharmacy prescribed containers and Resident C and Resident D were both prescribed Ativan.

- Resident C was prescribed “Ativan .5 MG Tab, take 1 tablet by mouth twice daily as needed for increased agitation with OCD. Wait four hours before giving second dose.” This prescription was filled on 06/05/2023 and the prescription documented that 60 pills were dispensed. The medication was packaged in two separate cards which contained 30 pills per card. 14 pills were dispensed from package one and 30 pills were in package two. At the time of the unannounced investigation there was a *Controlled Drug Receipt/Record/Disposition Form* which documented that Resident C was administered 1 pill of Ativan on 06/8/2023 at 1pm and on 06/10/2023 at 9 am, 1 pill. At the time of the unannounced investigation there was no written documentation available for the reason for each medication administration.

- Resident C’s June 2023 MAR documented that he was prescribed “Ativan .5 MG Tab, take 1 tablet by mouth twice daily as needed for increased agitation with OCD. Wait four hours before giving second dose.” This prescription was written 03/21/2023. The June 2023 MAR documented Resident C was administered this medication on 6/10/2023 and 6/17/2023. The MAR did not contain a reason the as needed medication was administered. Resident C’s June MAR was not consistent with the *Controlled Drug Receipt/Record/Disposition Form* which documented that Resident C was administered Ativan on 06/8/2023 at 1pm, 1 pill and on 06/10/2023 at 9 am, 1 pill.

- Resident C’s July 2023 MAR documented that Resident C had not been administered any Ativan in July. Given this information, Resident C should have at least 57 pills available however at the time of investigation there were 46 pills available therefore 11 pills unaccounted.

- Resident D was prescribed “Ativan 1 MG Tab, take 1 tablet by mouth twice daily as needed for agitation.” This prescription was filled on 06/05/2023 and the prescription contained 60 pills. The medication came in two separate cards with 30 pills per card. 21 pills were administered from package one and at the time of the unannounced investigation DCW Heringhausen could not locate the second package of 30 pills. At the time of the unannounced investigation a there was a *Controlled Drug Receipt/Record/Disposition Form* with Resident D’s name on it, but it was blank. There was no written documentation available for the reason for each administration of medication was administered. Additionally based on the documentation provided, Resident D should have 60 pills available however at the time of the unannounced investigation there were only 9 pills available which left 51 pills unaccounted.

- Resident D’s June 2023 MAR documented that she was prescribed “Ativan 1 MG Tab, take 1 tablet by mouth twice daily as needed for agitation.” This

prescription was originally written on 01/24/2023 and rewritten on 06/14/2023. Resident D's June 2023 MAR documented that she had not been administered any Ativan that month. Resident D's June MAR is consistent with the *Controlled Drug Receipt/Record/Disposition Form* which was blank. Based on both of these documents, Resident D should have 60 pills available however at the time of inspection there were 9 pills available which left 51 pills unaccounted for.

- Resident C's July 2023 MAR documented that Resident C had not been administered any Ativan in July. Resident C should have 60 pills available however at the time of inspection there were 9 pills available therefore 51 pills unaccounted for.

On 08/21/2023, APS specialist Lindley reported that DCW Arianna Heringhausen was substantiated for neglect due Ativan being given to residents without proper documentation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my review of Resident C and Resident D's medications and the facility's documentation, Resident C and Resident D received Ativan medication at various times but the reason for the administration is unknown as it is not documented in the record. Neither resident was available for interview and there was no further information to verify any other resident was given Ativan to assist with sleeping. There is not enough information to establish this part of the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions. **(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:** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**

	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my review of Resident C and Resident D's medications and the facility's documentation, Resident C had 11 Ativan pills unaccounted and Resident D had 51 Ativan pills unaccounted at the time of the unannounced onsite investigation. There was no explanation if either resident was administered these pills per the label instruction. Additionally due to the number of pills that are unaccounted for, there is evidence to support that reasonable precautions were not taken to ensure that prescription medication was not used by a person other than for whom the medication was prescribed. At the time of the unannounced investigation, Resident C's and Resident D's June 2023 MAR/ *Controlled Drug Receipt/Record/Disposition Form* did not contain written documentation for the reason for medication administration of an as needed medication as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care workers (DCW)s do not take residents on outings and they refuse to help residents with activities of daily living (ADL)'s.

INVESTIGATION:
On 07/10/2023, Complainant reported DCWs do not take residents on outings and they refuse to help residents with their ADL's. Complainant reported DCWs do not like to do laundry, so they only change the residents soiled under garments at shift change only. Complainant reported residents sit in their soiled linen for hours until the next shift.

On 07/17/2023, I conducted an unannounced investigation with APS specialist Lindley and we interviewed Resident A and Resident B separately. Resident A and Resident B both reported that residents are taken out on outings and they reported Resident C and Resident D were both out on an outing at the time of the interview. Resident A and Resident B both reported DCWs regularly assist them with ADL's. Resident A and Resident B both reported DCWs do laundry. Resident A and Resident B both reported that they have never been left in soiled linen nor have they witnessed any other resident left in soiled in linen. APS specialist Lindley and I went into each bedroom and we did not observe any soiled lined. Additionally, there was no foul odor or any smell to indicate soiled linens were in the bedrooms/facility. APS specialist Lindley and I observed clean linen in the facility and available for resident use. I went to the basement where the dirty laundry was kept and I found a load or

two of laundry that needed to be done. The basement did not have a foul or urine odor.

While APS specialist Lindley and I interviewed Resident A she experienced urinary incontinence. Resident A apologized for doing this but reported that she could not hold it any longer. Resident A reported that she does not wear a brief. After APS specialist Lindley and I completed the interview I informed DCW Heringhausen of what had occurred. DCW Heringhausen approached Resident A and asked her to come into the facility to change and shower. Resident A told DCW Heringhausen that she had to make a telephone call before she would come in. According to both DCW Heringhausen and Resident A, Resident A is fully ambulatory and able to toilet herself. Resident A reported that this was the first accident that she has had at the facility.

APS specialist Lindley and I interviewed DCW Heringhausen who reported that residents are taken out on outings and reported that Resident C and Resident D were out on an outing now with staff.

I reviewed Resident B and Resident D's *Assessment Plan for AFC Residents* which documented that Resident D requires assistance with ADL's. Resident A and Resident C's *Assessment Plan for AFC Residents* were not available for review at the time investigation.

At the time of the unannounced investigation Resident C and Resident D were not at the facility and therefore was unable to be interviewed.

APPLICABLE RULE	
R 400.14317	**Resident recreation.**
	Rule 317. (1) A licensee shall make reasonable provision for a varied supply of leisure and recreational equipment and activities that are appropriate to the number, care, needs, age, and interests of the residents.
ANALYSIS:	At the time of the unannounced onsite investigation, two residents were on an outing with direct care staff and per interviews, residents reported going on regular outings.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each

	bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	At the time of inspection clean bedding was available for resident use and resident bedding was clean.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 07/17/2023, I conducted an unannounced investigation with APS specialist Lindley and the facility did not have a menu posted or available for review. DCW Heringhausen reported that the facility does not do a menu because they cook what residents request.

APS specialist Lindley and I interviewed Resident A and Resident B who reported that they have never seen a menu posted at least 1 week in advance.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	At the time of the unannounced investigation the facility did not have a menu posted nor was one available for review. DCW Heringhausen stated the facility does write/post a menu but Resident A and Resident B reported that they have never seen a menu posted.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

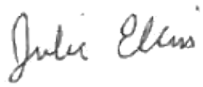
On 07/17/2023, I reviewed Resident A and Resident C's records and an *Assessment Plan for AFC Residents* was not available for review at the time investigation. According to Resident A's *AFC Resident Care Agreement*, Resident A was admitted to the facility on 07/12/2023. There was no documentation in Resident A's record that she was an emergency admission. According to Resident C's *AFC-Resident Information and Identification Record*, Resident C was admitted to the facility on 01/20/2019.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	At the time of the unannounced investigation Resident A and Resident C's records did not contain a completed resident assessment plan as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/31/2023 and on 09/05/2023, I conducted an exit conference with licensee designee Hope Lovell. During the exit conference licensee designee Hope Lovell reported that the facility did report the missing medications to the Lansing Police Department. Licensee designee Hope Lovell reported that the direct care worker suspected of stealing the medication is no longer employed at the facility. Licensee designee Hope Lovell reported that she understood the findings of the investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in license status.



09/05/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

09/06/2023

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Dawn N. Timm Date
Area Manager