GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 17, 2026

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

RE: License #: AS780413489
Investigation #: 2026A1033011
Matthew Home

Dear Ms. Lovell:

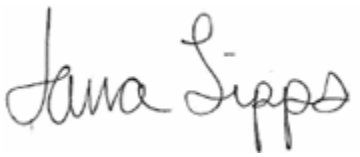
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Jana Lipps, 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 #:** | 2026A1033011 |
| | |
| **Complaint Receipt Date:** | 12/26/2025 |
| | |
| **Investigation Initiation Date:** | 12/26/2025 |
| | |
| **Report Due Date:** | 02/24/2026 |
| | |
| **Licensee Name:** | LoveJoy Special Needs Center Corporation |
| | |
| **Licensee Address:** | 17101 Dolores St<br>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<br>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<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A is not being provided with adequate supervision by direct care staff as she has unexplained bruises on her left knee and right breast. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 12/26/2025 | Special Investigation Intake<br>2026A1033011 |
| 12/26/2025 | APS Referral<br>Assigned to adult services worker, Rebecca Schalow. |
| 12/26/2025 | Special Investigation Initiated - Telephone<br>Interview conducted with adult services worker, Cheryl Hunt, with Adult Protective Services. |
| 12/26/2025 | Contact - Document Sent<br>Email correspondence sent to APS, Rebecca Schalow. |
| 12/30/2025 | Inspection Completed On-site<br>Interviews conducted with direct care staff, Jolie Porubsky, Hayley Rainey, & Bradley Gibbs. Observations made of residents. Review of documentation initiated. |
| 12/30/2025 | Contact - Document Sent<br>Email correspondence sent to licensee designee, Hope Lovell. |
| 01/27/2026 | Contact - Telephone call received<br>Telephone conversation with APS, Rebecca Schalow. |
| 01/28/2026 | Contact - Document Received<br>Email correspondence received from Keagan Sarkar, recipient rights advisor with Central Michigan Community Mental Health. |
| 02/17/2026 | Exit Conference<br>Conducted via email with licensee designee, Hope Lovell. |

**ALLEGATION: Resident A is not being provided with adequate supervision by direct care staff as she has unexplained bruises on her left knee and right breast.**

**INVESTIGATION:**

On 12/26/25 I received an online complaint regarding the Matthew Home adult foster care facility (the facility). The complaint alleged that Resident A was not receiving adequate supervision and protection at the facility as she was discovered to have unexplained bruises on her left knee and right breast. The complaint reported that these bruises were discovered by a direct care staff member and then reported to adult protective services (APS) for investigation. On 12/26/25 I interviewed adult services worker, Cheryl Hunt, with APS, via telephone. Ms. Hunt reported that this case is currently assigned to APS, adult services worker, Rebecca Schalow, for investigation. Ms. Hunt reported that APS, adult services worker, Gregg Showalter, made a face-to-face visit to Resident A at the facility on 12/23/25. Ms. Hunt reported that Resident A stated that Resident B hit her. The direct care staff working on 12/23/25 had no knowledge of this incident. It was reported to Mr. Showalter that Resident A has tendencies to self-harm and the direct care staff noted she will drop to the ground and begin hitting herself when she becomes upset.

On 12/30/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/program manager, Julie Porubsky, regarding the allegations. Ms. Porubsky reported that on 12/22/25 direct care staff, Hayley Rainey, was assisting Resident A with her shower and observed a bruise on her right breast toward her armpit and another bruise on her left knee. Ms. Porubsky reported that there was no witnessed event that indicated where these bruises originated. She reported that Resident A requires one-on-one supervision for eight hours each day. She reported that the facility is staffed with two to three direct care staff on first shift and two direct care staff on second and third shift. She reported that Resident A does not require line of sight supervision when she is using the restroom, showering, or in her bedroom. She reported that when Resident A is in these areas, she requires hourly checks from direct care staff members. Ms. Porubsky reported that the eight hours of one-on-one supervision is not specific to which hours of the day, so the direct care staff attempt to provide this between 8am – 4pm each day as this is an active time when Resident A benefits from additional supervision. She reported that increasing Resident A's one-on-one supervision has been discussed and is in process of being approved through Community Mental Health (CMH). She reported that the plan is to increase the level of supervision from eight hours per day to 16 hours per day.

Ms. Porubsky reported that Resident A exhibits self-injurious behaviors at least five days per week. She reported that these behaviors can happen multiple times in one day. Ms. Porubsky reported that Resident A will hit, punch, and throw herself onto the floor. She reported that direct care staff can usually redirect her from these behaviors by offering to take her on an outing. She reported that Resident A is calmed by outings. Ms. Porubsky reported that Resident A has been engaged in altercations with Resident

B. She reported that the direct care staff are aware of Resident A and Resident B's confrontations with one another and do look to de-escalate these situations as quickly as possible. She reported that Resident A can take 10-15 verbal prompts to disengage from a negative interaction.

Ms. Porubsky reported that Resident A appears to be adjusting well to the facility, the direct care staff, and the other residents. She reported that Resident A currently works with Guardian A1, Central Michigan Community Mental Health, case manager, Keith Anderson, and Psychologist, Chelsey McGillis, for her behavior treatment plan. Ms. Porubsky reported that Resident A was not receiving proper behavior tracking at her previous adult foster care placement. She reported direct care staff are working to provide effective feedback regarding Resident A's needs to ensure the best care moving forward. She reported no reason to suspect that a direct care staff member had caused Resident A's injuries. She reported that Resident A does not receive visits from family or friends and that she only interacts with the current residents, direct care staff, Guardian A1, and her Community Mental Health care team.

During the unannounced, on-site investigation on 12/30/25 I interviewed direct care staff, Hayley Rainey, regarding the allegation. Ms. Rainey reported that she has worked at the facility for over one year. She reported that she first observed the bruises on Resident A when she was showering her on 12/22/25. Ms. Rainey reported that she entered the restroom to assist Resident A with changing her clothing and noticed a yellowish/purple bruise the size of a quarter on her right breast near her armpit. She reported that she also observed a bruise on her left knee that appeared red in color. Ms. Rainey reported that she informed Ms. Porubsky of the bruises and wrote an incident report regarding what she observed. She reported that she did not take any photographs of the bruises. She reported that as of today's date the bruise on her breast was almost completed resolved and the bruise on her knee was no longer visible. Ms. Rainey reported that she asked Resident A about the bruises and Resident A did not have an answer about what occurred. She reported that she has no reason to suspect a direct care staff member caused the bruises. Ms. Rainey reported that Resident A requires one-on-one supervision for at least eight hours per day. She reported that this supervision is provided during first shift from 8am to 4pm each day, as this is when Resident A presents most frequently with behavioral issues. She reported that there are three direct care staff scheduled on first shift, and two on second and third shifts. Ms. Rainey reported that Resident A only requires hourly checks when she is in her bedroom or in the bathroom.

Ms. Rainey reported that Resident B has hit Resident A in the past. She reported that Resident A and Resident B get into physical/verbal altercations once or twice per week. She reported that Resident A seeks out Resident B and this upsets Resident B. Ms. Rainey reported that Resident A will sneak into Resident B's bedroom and try to hit him while he is in bed. She reported that Resident B will respond by hitting Resident A. Ms. Rainey could not be certain that the bruises were not caused by Resident B.

During the unannounced, on-site investigation on 12/30/25, I interviewed direct care staff, Bradley Gibbs. Mr. Gibbs reported that he has worked at the facility for 6-7 years. He reported that he normally works third shift but was filling in today on the day shift. Mr. Gibbs reported that Resident A has self-injurious behaviors and will hit herself and throw herself on the ground when she is upset. Mr. Gibbs reported that he was told about Resident A's bruises, but he did not visualize the bruises. Mr. Gibbs reported that Resident A can shower herself and dress herself. He reported that she needs assistance picking out appropriate clothing. Mr. Gibbs reported he has never observed a direct care staff member being rough with Resident A. He reported he has no reason to believe a direct care staff member caused her bruises. Mr. Gibbs reported that he has observed Resident A and Resident B in physical altercations. He reported that just the sound of Resident B's voice aggravates Resident A. He reported that these altercations between Resident A and Resident B occur about five times per week. He reported that direct care staff attempt to keep them separated to stop these occurrences. He reported that Resident A likes to have one-on-one attention and the direct care staff attempt to meet this need as often as possible. He reported that Resident A appears to be getting along with the other residents and direct care staff at the facility.

During the unannounced, on-site investigation on 12/30/25, I observed Resident A and Resident B at the facility. Resident B propels himself through the facility in a manual wheelchair. Resident A is ambulatory and was up walking around the facility. There were three direct care staff members on duty on this date. The direct care staff appeared to be conscious of keeping Resident A and Resident B at a distance from one another. The direct care staff were providing line of sight supervision to Resident A and actively enforcing redirection and distraction techniques with Resident A.

During the unannounced, on-site investigation on 12/30/25 I reviewed the following documentation:

- *Assessment Plan for AFC Residents*, document for Resident B. This document was not dated or signed by any parties. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *I. Controls Aggressive Behavior*, it reads, "Will attempt to hit peers and staff."
- *Community Mental Health for Central Michigan, PCP,* document for Resident B, dated 4/1/25. On page two, under section, *Indicate The Need For Supports in Any Of The Following Safety Domains*, the subsection, *Aggressive behavior*, is marked with the narrative, "Hitting, pushing peers and staff and running his walker into people." On page four, paragraph two notes that Resident B requires "2 to 1 support in the community and during transport." Also, on page four, paragraph three reads, "[Resident B] has a history of aggressive behavior. He has punched, pushed other residents with his walker or wheelchair, and pulled staff's hair. Home has been offered to have intervention by behavior treatment team. Home manager does not feel that this would be beneficial and states that they have been able to manage the behavior by distracting and redirecting. Home manager stated that she will call 911 if behavior becomes unmanageable. He does tend to be more verbally aggressive especially when he is struggling

with his memory. Home manager and CM are working on nursing home placement for him due to these memory issues as well as his difficulty ambulating."

- *Community Mental Health for Central Michigan, Behavior Treatment Plan,* for Resident A, dated 12/9/24. One page one, under section, *Reason For Referral*, it reads, "[Resident A] has had *Behavior Treatment Plan* (BTP) with limiting and intrusive interventions since December of 2022. She has historically engaged in physical aggression toward herself and others. In the last year staff have verbally noted increases in her agitation and engagement in unsafe behaviors. This revision increases staffing supports and outlines environmental limits to assist [Resident A] in remaining safe."
    - On page eight, section*, Intrusive Strategies*, subsection, *Enhanced Supervision*, reads, "[Resident A] has a history of agitation and physical aggression toward herself and others. [Resident A] is also legally blind and unable to navigate unknown locations without staff support to ensure her safety. Due to these behavioral and safety needs, [Resident A] requires enhanced staffing. The level of staffing varies based on the circumstances below." Under the section, *Home*, it reads, "[Resident A] requires 1:1 line of sight supervision for 8 hours per day while at home to ensure the safety and wellbeing of herself and others. Suggested times for enhanced staffing include just after she wakes up in the morning and later at night when she is struggling to sleep. This aligns with the times of day [Resident A] is most likely to engage in target behaviors. Her 1:1 staff should be within eyesight of [Resident A] at all times and able to respond to her quickly if she engages in self-injurious or aggressive actions. Staff should monitor her level of agitation and position themselves accordingly (e.g., standing between her and the kitchen stairs). At any given time, [Resident A] should have a designated staff member monitoring her throughout the home. This staff person can and should rotate with other staff on shift, as long as all staff in the home are aware of who is providing her with 1:1 support at any given moment. Her staff should be communicating with one another to coordinate supports, including expressing when they need to step away or take a break."
    - Under the section, *Bedroom*, it reads, "While in the bedroom, staff should complete periodic monitoring hourly (every 60 minutes). If [Resident A] is in her room and appears agitated or aggressive staff should continue to monitor her visually, but do not need to enter her room to intervene unless she engages in behaviors that place herself or others at serious risk of harm. Instead, staff should position themselves just outside of her bedroom so that they are able to react and move with her once she elects to leave her bedroom. Staff should return to 1:1 line of sight supervision when [Resident A] leaves her bedroom during scheduled staffing hours or if she has recently engaged in self-harm behaviors (as described below)."
    - Under the section, *Bathroom*, it reads, "Although [Resident A] will likely require personal care assistance, line of sight supervision is not required to maintain [Resident A's] or others' safety when she is in the bathroom."

    - On page nine, under the section, *After Self-Injury*, it reads, "[Resident A] also requires line of sight supervision after self-harm (e.g., hitting self, dropping self, etc.). Staff should be able to see [Resident A] within their field of vision at all times except when she is using the restroom. This means that staff and [Resident A] should be in the same room or area. Enhanced supervision in the home should continue until [Resident A] has discontinued threatening or engaging in self-harm for 30 minutes and has resumed participation in other appropriate goal-directed behaviors."
- *Community Mental Health for Central Michigan, PCP Addendum*, for Resident A, dated 1/26/25. On page one, under the section, *Indicate The Need For Supports In Any Of The Following Safety Domains*, subsection, *Aggressive Behavior*, is marked with the narrative, "[Resident A] continues to be aggressive towards staff and other residents." Subsection, *Self-injurious behavior*, is also marked, with the narrative, "Hitting herself, throwing herself on the ground." This document references the BTP and advises direct care staff to follow the restrictive measures set forth in the BTP document.
- *Assessment Plan for AFC Residents* document for Resident A. This document was not dated or signed by any parties. On page one, under the section, *I. Social/Behavioral Assessment*, subsection, *I. Controls Aggressive Behavior*, is marked "no", with the narrative, "Requires full staff assistance to monitor for health and safety." Subsection, *K. Gets Along with Others*, is marked, "no", with the narrative, "Will hit others often. Staff prompting and redirection needed." Subsection, *L. Exhibits Self Injurious Behavior*, is marked, "Yes", with the narrative, "Staff prompting and redirection to discontinue behaviors." On page two, under section, *III. Health Care Assessment*, subsection, *C. Physical Limitations*, is marked "Yes", with the narrative, "Visually impaired guiding and verbal prompting from staff." Subsection, *E. Other Difficulties (Vision, Weight, Allergies, etc.)*, has the narrative, "Visually impaired requires full staff assistance."
- *Assessment Plan for AFC Residents,* for Resident A, dated 4/3/24 was also provided. Ms. Porubsky reported that the assessment plans provided for Resident A and Resident B that did not contain signatures or dates were updated plans and she needed to obtain signatures.
- *Assessment Plan for AFC Resident* document for Resident B. This document was also noted dated and did not include signatures. Ms. Porubsky reported that she was not sure why this document did not include signatures or dates. She reported that this was Resident B's prior assessment plan. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *I. Controls Aggressive Behavior*, the document is marked, "Yes", with the narrative, "very friendly, pleasant no behaviors."
- Direct care staff schedule for the month of December was reviewed. The schedule demonstrates consistently two direct care staff members scheduled per shift. Occasionally there are three direct care staff scheduled between the hours of 8am and 4pm. This is not consistently seen in this document. On 12/21/25 I observed two direct care staff scheduled from 12am to 12pm and two direct care staff scheduled from 12pm to 12am.

- *AFC Licensing Division – Incident/Accident Report* for Resident A, dated 12/22/25. This document is completed by Ms. Rainey. Under the section, *Explain What Happened/Describe Injury (if any)*, it reads, “Staff was assisting [Resident A] get dressed when staff noticed a bruise on [Resident A’s] left knee, and a bruise on her right breast. Staff is unsure how [Resident A] got the bruises.” Under the section, *Action taken by staff/Treatment Given*, it reads, “Manager notified, other shifts will also be notified.”
- *AFC Licensing Division – Incident/Accident Report* documents were reviewed for Resident A and Resident B from July 2025 through December 2025. I observed the following information:
    - There were 16 documented incidents of Resident A acting in a physically aggressive manner toward direct care staff, residents, and/or herself.
    - There were 3 documented incidents of Resident B being the subject of Resident A’s physical aggression.
    - Thirteen of the 16 incidents involving Resident A acting in a physically aggressive manner toward direct care staff, residents, and/or herself, occurred between the hours of 8am – 4pm. This is the current hours the direct care staff attempt to provide Resident A’s 8 hours of line-of-sight supervision, as stated due to her higher levels of behaviors during this time period.
- *Resident Register* for the facility. The *Resident Register* identified that Resident A moved into the facility on 5/14/25 and Resident B moved into the facility on 12/6/22.

On 1/27/26 I received a telephone call from Ms. Schalow regarding the allegations. Ms. Schalow reported that Central Michigan Community Mental Health, recipient rights advisor, Keagon Sarkar, interviewed all direct care staff members, including Ms. Porubsky, on 1/8/26, at the facility. She reported that Ms. Sarkar was told by all direct care staff that Resident A requires one-on-one supervision from direct care staff for eight hours per day. She reported that the direct care staff stated that Resident A does demonstrate self-injurious behaviors and will throw herself on the floor when she is upset. Ms. Sarkar reported to Ms. Schalow that Resident A stated she enjoys residing at the home and has no concerns about the direct care staff members. Resident A responded to Ms. Sarkar’s questions with simple “yes” and “no” responses. Ms. Schalow reported that she completed an on-site visit at the facility on 1/21/26 and attempted to interview Resident A. She reported that Resident A would not participate in an interview on this date. Ms. Schalow reported that there is current consideration for increasing Resident A’s line of sight supervision due to her continued behaviors.

On 1/27/26 I received email correspondence from Ms. Sarkar. She reported that she interviewed all direct care staff members at the facility. She reported that the direct care staff members appeared to have a good understanding of Resident A’s supervision requirements, with the first shift staff understanding the supervision required better than the second and third shift direct care staff. She reported that the direct care staff (names not mentioned) who worked on 12/21/25 stated that Resident A did exhibit self-injurious behaviors on this date and had thrown herself to the ground. Ms. Sarkar reported that

these behaviors were reported to last for about one hour. Ms. Sarkar reported that other direct care staff members noted that Resident A does tend to walk into furniture and will knock her knees against the side of her bed when getting into bed. Ms. Sarkar further reported that direct care staff members also noted a negative relationship between Resident A and Resident B with a history of physical altercations.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.671** | **Resident care.** |
| | **(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.** |
| **ANALYSIS:** | Based upon interviews conducted, documents reviewed, and observations made during the unannounced on-site investigation, there is not adequate evidence that direct care staff are not providing for Resident A's supervision and protection at the facility. The direct care staff interviewed were well versed in Resident A's enhanced supervision protocol and behavior patterns. They reported that Resident A will frequently be the aggressor in the facility and targets behaviors of physical aggression toward herself, direct care staff, and her peers. The incident reports reviewed identified that direct care staff were responsive to Resident A's behaviors, providing the required line of sight supervision, and providing necessary redirection and distraction techniques for Resident A. The direct care staff schedule identified that there are always at least two direct care staff members per shift to provide for the care of the six current residents. Observations made during the unannounced on-site investigation demonstrated direct care staff providing line of sight supervision to Resident A and actively providing redirection and distraction techniques. Based upon Resident A's documented history of self-injurious behaviors and physical aggression toward her peers and direct care staff the bruises identified on her breast and knee could have been caused by these behaviors. As a result, there is a lack of evidence to identify that the direct care staff were not providing for Resident A's protection and safety. A violation will not be established at this time. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

During the unannounced, on-site investigation on 12/30/25 I reviewed the following documentation:

- *Assessment Plan for AFC Residents*, document for Resident B. This document was not dated or signed by any parties. Ms. Porubsky reported that this was the current assessment plan for Resident B but she had yet to obtain signatures or date the document.
- *Assessment Plan for AFC Residents* document for Resident A. This document was not dated or signed by any parties. Ms. Porubsky reported that this was the current assessment plan for Resident A but she had yet to obtain signatures or date the document.
- *Assessment Plan for AFC Residents,* for Resident A, dated 4/3/24 was also provided. Ms. Porubsky reported this was the assessment plan for Resident A upon her admission to the facility.
- *Assessment Plan for AFC Resident* document for Resident B. This document was also noted dated and did not include signatures. Ms. Porubsky reported that she was not sure why this document did not include signatures or dates. She reported that this was Resident B's prior assessment plan.
- *Resident Register* for the facility. The *Resident Register* identified that Resident A moved into the facility on 5/14/25 and Resident B moved into the facility on 12/6/22.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.685** | **Resident admission; resident assessment plan; resident care agreement; health care appraisal.** |
| | **(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.** |

| | |
|---|---|
| **ANALYSIS:** | Based upon the interview conducted with Ms. Porubsky and the *Assessment Plan for AFC Residents* documents reviewed during the on-site investigation on 12/30/25, the assessment plans have not been completed as required for Resident A and Resident B. Ms. Porubsky reported that Resident A's assessment plan dated 4/3/24 was the assessment plan utilized upon her admission to the facility. The *Resident Register* identified that Resident A was admitted to the facility on 5/14/25, which was over a year after this document was dated and signed. The two assessment plans for Resident B did not contain any signatures or dates to verify accuracy. These documents were incomplete. Based on these findings a violation has been established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

2/12/26

_____

Jana Lipps Date
Licensing Consultant

Approved By:

02/12/2026

_____

Dawn N. Timm Date
Area Manager