GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2026

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

RE: License #: AS780413489
Investigation #: 2026A0577035
Matthew Home

Dear Ms. Lovell:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality of care 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 #:	2026A0577035
Complaint Receipt Date:	04/07/2026
Investigation Initiation Date:	04/08/2026
Report Due Date:	06/06/2026
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17101 Dolores St Livonia, MI 48152
Licensee Telephone #:	(517) 574-4693
Licensee Designee:	Hope Lovell
Administrator:	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 leading to Resident B suffering injuries requiring medical attention.	Yes
Licensee designee and direct care staff cannot meet Resident A's supervision needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/07/2026	Special Investigation Intake-2026A0577035
04/08/2026	APS Referral- Via Telephone, due to referral being on the whole facility.
04/08/2026	Special Investigation Initiated – Telephone call from Ardis Bates, ORR-SBH.
04/08/2026	Referral - Recipient Rights, Shiawassee Co Behavioral Health.
04/08/2026	Contact - Document Received- IR received via email from Jolie Porubsky, HM.
04/09/2026	Inspection Completed On-site
04/13/2026	Contact - Telephone call made, Interviews with DCS.
04/13/2026	Referral - Recipient Rights, CMHCM-ORR
04/13/2026	Contact - Document Received, Discharge Notice for Resident B.
04/15/2026	Contact - Telephone call made, Interview with DCS.
04/15/2026	Contact - Document Received- Resident Assessment Plans, PCP and BTP.
04/16/2026	Contact - Document Sent- Email to Guardian A1, request interview.
04/16/2026	Contact - Document Received, CPI Training records for DCS.
04/16/2026	Contact - Telephone call made to Emma Lentz, Case Manager with CMHCM.

04/20/2026	Contact - Telephone call made, Hope Lovell, LD.
04/22/2026	Contact - Telephone call made- Interview with Kathleen Redmer, Operations Director.
04/22/2026	Contact - Telephone call received from Emma Lentz, Case Manager, CMHCM.
04/22/2026	Contact - Telephone call made, Jolie Porubsky, HM
04/22/2026	Contact - Document Received, Discharge for Resident B.
04/22/2026	Contact - Document Received, Resident A's Behavior Data Sheets.
04/30/2026	Contact - Document Received; Katie Horner, ORR-CMHCM.
05/05/2026	Contact-Document Sent, via email Kathleen Redmer, OD.
05/04/2026	Inspection Completed-BCAL Sub. Non-Compliance
05/14/2026	Contact-Document Sent, Hope Lovell, LD., via email requesting documents
05/21/2026	Exit Conference, Hope Lovell, LD.

ALLEGATION:

- **Resident A is constantly harassing and beating up Resident B leading to Resident B suffering injuries requiring medical attention.**
- **Licensee designee and direct care staff cannot meet Resident A's supervision needs.**

INVESTIGATION:

On April 07, 2026, a complaint was received alleging that Resident A was constantly harassing and assaulting Resident B leading to Resident B suffering multiple injuries. The complaint reported direct care staff attempt to keep the residents separated, with little assistance from licensee designee Hope Lovell.

On April 8, 2026, I contacted Adris Bates from the Office of Recipient Rights (ORR) at Shiawassee County Behavioral Health (SCBH). Ms. Bates reported that she completed the facility's site recipient rights assessment in March 2026 and noted no concerns. She stated that the current six residents exhibit behavioral needs, which is why three direct care workers are scheduled during waking hours. Ms. Bates denied receiving any concerning incident reports from licensee designee Hope Lovell nor

has she observed an increase in critical incident reports related to aggressive behaviors between residents. She further reported that their office has not been contacted by direct care staff regarding concerns about residents arguing or fighting, or staff being unable to intervene or de-escalate situations. Ms. Bates noted a few of the residents are highly behavioral and were placed at the home by Community Mental Health of Central Michigan ORR (CMHCM-ORR); therefore, SCBH would not receive incident reports for those individuals.

On April 13, 2026, I contacted Keegan Sarkar, from CMHCM-ORR who reported she currently has an open investigation alleging that direct care staff cannot meet Resident A's needs.

On April 08, 2026, I received an email from Jolie Porubsky, whose role is both as direct care staff (DCS) and home manager (HM), which reported an incident that happened at the home involving Resident A and Resident B. I was provided with a copy of an *AFC Licensing Division-Incident/Accident Report* (IR) which documented an incident from April 08, 2026, at 7:00pm involving Resident A, Resident B, DCS 1 and DCS 2. The IR reported Resident A was targeting Resident B throughout the 12-hour shift, starting at 8:00am. Resident A was continuously redirected to choose a different activity such as games, outing, and movie. Resident A declined stating "I need to kill peer." The IR documented that "At approximately 7:00pm, [Resident A] chose to get into the bathtub for a sensory bath, after about 15 minutes, [Resident A] proceeded to exit the bathtub and ran into [Resident B's] bedroom naked. [Resident A] declined verbal prompt, saying "no". [Resident A] continued to hit [Resident B] for 10 minutes with staff continuing to verbally prompt [Resident A] to put her pajamas on or return to the tub." The IR further documented, "[Resident B] put his finger into [Resident A] genital, staff were able to place their person between [Resident A] and [Resident B] without touching either resident, just verbal prompt [Resident A] to move into the living room away from [Resident B]."

On April 09, 2026, I completed an unannounced onsite investigation and during my investigation I reviewed and received a copy of the *Resident Register* which documented that Resident A moved into the facility on May 14, 2025, and Resident B moved into the facility on December 06, 2022. During the onsite investigation, I observed Resident A persistently trying to swat at Resident B while I was attempting to interview Resident B at the dining room table. As Resident B was attempting to return to his bedroom, I observed Resident A attempting to grab and hit Resident B as he passed by Resident A in the dining room and while trying to get into his room. Once Resident B returned to his bedroom, he closed the door and locked it, as I observed Resident A trying to open Resident B's bedroom door to access Resident B. During my observation, I noted Resident A had one-on-one direct care staff supervision while in the common areas and this DCS was continuously trying to verbally redirect Resident A from going near Resident B. At times, I observed that both direct care staff on duty were required to verbally redirect Resident A from approaching Resident B. I also observed staff positioning themselves in front of Resident A to block Resident A from getting close to Resident B. During my

investigation, I attempted to interview both residents. Resident A declined to be interviewed, and Resident B was unable to provide specific information.

During the onsite investigation I reviewed and received a copy of Resident A's *Assessment Plan for AFC Residents*, *Behavior Treatment Plan* (BTP), and *Person Centered Plan* (PCP) which documented the following information, in part:

- *Assessment Plan for AFC Residents*:
    - Completed on 12/29/2025 and signed by Jolie Porubsky, Under the subtitle *Social/Behavioral Assessment*: *H- Follows Instructions*, it documented "no- needs verbal prompting from staff;" Under the subtitle *I-Controls Aggressive Behaviors*, it documented "no-requires full staff assistance to monitor for health and safety"; and lastly it documented under subsection *K-Gets Along With Others*, "no-will hit others often, staff prompting and redirection needed."

I reviewed Resident A's current Behavioral Treatment Plan (BTP) along with Resident A's previous BTPs. According to Resident A's resident record, Resident A had a BTP since December 2022 due to a history of physical aggression toward herself and others. I noted that Resident A's BTP was revised in December 2023 to increase Resident A's need for line of sight supervision while in the community. Another revision occurred in December 2025 which included increased staffing support to assist Resident A in remaining safe due to exhibiting lengthy episodes of aggressive or self-injurious behavior that can occur without warning. The December 2025 BTP noted that after a functional assessment was completed, it was determined that Resident A's physically aggressive and self-injurious behaviors were primarily related to poor emotional regulation and low functional communication skills. Resident A's final BTP revision dated December 9, 2025 listed the following:

- Increased 1:1 direct care staffing supervision for 16 hours per day. Suggested times for the 16 hours of 1:1 staffing were after waking up for the day and when Resident A is struggling to sleep during the night.
- Periodic monitoring of Resident A when she is in her bedroom or in the bathroom, but does not require the enhanced 1:1 line of sight supervision in these spaces.
- Use of psychotropic medication to decrease inappropriate behaviors or sequences of behaviors.
- Strategies to be used by direct care staff to decrease self-injury and physical aggression included direct care staff interacting with Resident A at least every 15 minutes, giving verbal prompts and narrate actions to Resident A due to vision challenges, keep a consistent schedule, provide warnings of changes in environment, increase Resident A's functional communication skills by using short phrases to express her wants, needs, and preferences, and staff should help Resident A recognize signs when she is getting upset by using short phrases to verbally prompt Resident A to use coping skills.

- Lastly, Resident A's BTP documented that, "If all other less restrictive measures have failed and there is imminent risk of severe physical harm, staff should implement the least restrictive techniques necessary according to the provider's approve physical intervention policy to maintain safety and avoid injury."

I also reviewed Resident A's *Person Centered Plan* dated October 21, 2025, which listed Resident A's target behaviors as self-injurious behavior described as hitting, punching, headbanging or biting herself and physical aggression toward others including hitting, punching, biting, or throwing objects at others. Resident A's *Person Centered Plan* documented that, "Staff will use a culture of gentleness and prompt and redirect [Resident A] from hitting herself, biting herself, or banging her head. Staff will use a calm voice and tell [Resident A] they are here for her and she is safe and ask [Resident A] if she would like to listen to music, or go to a different room, or choose a new activity to do, if they see or are aware that [Resident A] is starting to get agitated or upset. Staff will encourage [Resident A] several times daily to choose an activity she would like to do, such as puzzles or games or listening to TV or music. Staff report that [Resident A] takes sensory showers daily or sometimes multiple times a day. Staff will collect ongoing behavioral data regarding frequency and patterns of target behaviors on behavior data collection sheets to further inform behavior interventions." Resident A's PCP also stated that, "if all other less restrictive measures have failed and there is imminent risk of severe physical harm, staff should implement the least restrictive techniques necessary according to the provider's approve physical intervention policy to maintain safety and avoid injury."

Resident A also has a *Behavior Plan* which is separate from Resident A's BTP and PCP and was approved by the Behavior Treatment Committee. Resident A's *Behavior Plan* documented a long history of Resident A's personal care needs and behavior noting Resident A has a long history of hurting herself and others along with complex physical health and psychiatric needs. The *Behavior Plan* noted sometimes Resident A shows signs that she is struggling to be calm by saying, "I'm going to do it" or asking for specific movies that she only wants to watch when she is upset, but most times Resident A hurts other people with no warning when she is upset. According to the *Behavior Plan* Resident A has been on psychotropic medications for many years to address agitation and requires regular monitoring to adjust medications to meet her needs. Resident A is blind and needs help walking in new or unfamiliar places, or when in the community. She also has significant dental decay, which is believed to cause her pain and increased agitation. Resident A's ability to tell staff what she feels and what she needs is limited according to the *Behavior Plan*. The *Behavior Plan* documented that Resident A has experienced events considered traumatic but she cannot tell others how these experiences continue to affect her. These events include the death of her mother, sudden change in placement, history of hospitalization for agitation, and sexual abuse. Per the *Behavior Plan*, it is believed that these past traumatic events continue to affect Resident A as behavioral data suggests that Resident A has been more agitated and aggressive since she was sexually assaulted in March 2025.

The *Behavior Plan* listed Resident A's diagnoses as autism spectrum disorder, mild intellectual disability, intermittent explosive disorder, and unspecified anxiety. Per the *Behavior Plan*, these conditions mean that "[Resident A] struggles to show safe behaviors, especially when she is upset. [Resident A] can be impulsive and do things that place her or others at risk of harm. Once very upset, her caregivers can struggle to redirect her. When she cannot calm down, she has hurt her housemate and staff in the past." Examples documented in the Behavior Plan included incidents that occurred on 7/30/2025 and 8/11/2025, when she continually targeted and attacked Resident B which led to Resident B needing medical attention. Lastly, Resident A's *Behavior Plan* noted that, "because of these complex behavioral, physical, and psychiatric needs, [Resident A] requires limitations to promote safety. Limitations are needed because she has hurt herself, her housemates, and her staff before without these supports. [Resident A] needs help to remind her of safety and encourage healthy alternatives to her behaviors. Due to these safety concerns, [Resident A] needs extra supervision and an as-needed medication for behavior control."

I also received and reviewed *AFC Incident/Accident Reports* (IR) for Resident A from the March1- March 31. During this timeframe, there were 22 separate IRs involving Resident A having aggressive behaviors towards herself, Resident B, and/or direct care staff in the facility; 13 of the 22 IR's documented assaultive behaviors towards Resident B specifically. Some of the IR's documented behaviors lasting from minutes to hours or for the entire day or work shift. The IR's documented direct care staff interventions included verbal prompting and redirecting Resident A to do an activity, go on an outing, go for a walk, and attempting to get in between Resident A and Resident B while Resident A was attacking Resident B. Upon reviewing the IRs no physical management was used by direct care staff at any time during Resident A's physically aggressive behaviors toward Resident B.

After reviewing the 22 IRs involving Resident A assaulting Resident B, the following IRs required police involvement and/or required that Resident B receive medical treatment due to injuries from Resident A's assaults. The IRs are summarized below:

- IR dated April 08, 2026, documented that Resident A targeted Resident B throughout the 12 hour shift which started at 8:00am. Direct care staff used verbal redirection to assist Resident A away from Resident B and suggested that Resident A choose different activities like games, outings, and/or movies. The IR documented that Resident A declined these options and continually stated, "I need to kill peer" in reference to Resident B. After choosing to do a sensory bath, Resident A exited the bathroom and ran naked into Resident B's bedroom without permission. Resident A did not respond to any verbal redirection from direct care staff and continued to hit Resident B for 10 minutes while direct care staff responded by giving only verbal prompts. The IR did not document that direct care staff physically intervened to keep Resident B safe. The IR documented Resident B responded to this assault by, "[Resident B] put his finger into [Resident A's] genital, staff were able to place their person between [Resident A] and [Resident B] without touching either resident, just verbal prompt or get [Resident A] to move into the living room away from

[Resident B]." Owosso Police Department was called at 8:02pm on April 08, 2026, to report the alleged sexual assault of Resident A by Resident B. DCS 1 and DCS 2 reported that Resident A had been harassing and punching Resident B repeatedly throughout the day. There is no documentation describing how this behavior was addressed throughout the day.

- IR dated March 10, 2026, IR documented that at 4:00pm while DCS 1 and DCS 4 were assisting another resident they heard Resident B call out for assistance. Staff then observed Resident A leave the bathroom and upon entering the bathroom, staff found Resident B on the floor with a small cut near his eye. While staff were assisting Resident B, Resident A attempted to strike Resident B again. Staff verbally redirected Resident A out of the area. Resident B reported Resident A had pushed him. Resident B reported pain in his back and was yelling out in plan and did not want to be moved. Staff assisted Resident B out of the bathroom, Resident B reporting pain in his back and was yelling in pain. Staff called an ambulance and Resident B was transported to the hospital and diagnosed with cracked ribs. Owosso Police Department was called at 5:30pm on March 10, 2026, to report the assault and injuries to Resident B by Resident A.
- IR dated August 11, 2025, documented that at 2:30pm Resident B was in his bedroom lying down when Resident A began to hit and pull on Resident B's door. Resident B got up to open the door but was hit by the door as Resident A pushed it when Resident B began to open it. Resident B fell and hit his head which began to bleed. Staff removed Resident B from the area, started first aid and called 911. Resident B was transported to hospital by ambulance with a diagnosis of laceration of occipital region of scalp.
- IR dated July 30, 2025, documented that at 11:15am, Resident B was in the hallway when Resident A came up to Resident B and attempted to push Resident B. Staff could not successfully redirect Resident A away from Resident B and Resident B was pushed to the ground by Resident A. Resident B reported pain and an ambulance was called transporting Resident B to the hospital. Resident B was diagnosed with a fractured of T11 and L1 Vertebrae.

On April 15, 2026, I interviewed DCS 1 who reported that Resident A requires enhanced 1:1 supervision which was described by DCS 1 as direct care staff being next to Resident A at all times providing supervision while Resident A is in the common areas of the home, during transportation, and while in the community. DCS 1 reported Resident A can be in her bedroom and the bathroom without 1:1 supervision by direct care staff. DCS 1 reported that when Resident A is in her bedroom or the bathroom, direct care staff stand in the vicinity of the bedroom or bathroom, so direct care staff are immediately available to supervise Resident A upon her exit and to assure Resident A does not go into Resident B's bedroom or attacks Resident B. DCS 1 reported Resident A requires verbal prompting from direct care staff when attempting to harm herself or

others (residents or direct care staff). DCS 1 reported being advised by “management” that physical behavior management is not to be used. DCS 1 could not provide the name of the person who provided this direction. DCS 1 confirmed completing CPI Crisis Intervention training but denied ever using the physical interventions techniques demonstrated in the training while working at the facility. DCS 1 stating believing that Resident A is not a good fit in the home due to Resident A’s aggressive behaviors and inability to be redirected. DCS 1 reported verbal prompts do not divert Resident A from acting out or becoming physically aggressive toward herself, residents and/or direct care staff. DCS 1 confirmed the events of the incident as described in the IRs above and added that although hands on physical intervention were not used, DCS 1 and DCS 2 were eventually able to get in between Resident A and Resident B to stop the assault that occurred on April 08, 2026. DCS 1 confirmed that Resident A hit Resident B on the head for approximately 10 minutes while DCS 1 and DCS 2 verbally prompted her to stop. DCS 1 stated Resident B attempted to protect himself by grabbing toward Resident A’s vaginal area to get her away from him.

On April 15, 2026, I interviewed DCS 2, who reported that over the past several months direct care staff have been unable to keep Resident B or the other residents safe from Resident A’s physically aggressive behaviors. DCS 2 stated that, according to LoveJoy Special Needs Center Corporation policy, physical crisis intervention is not permitted and staff are limited to verbal prompting techniques only. DCS 2 confirmed successfully completing CPI Crisis Intervention training and Recipient Rights Crisis Prevention; however, reiterated that Resident A cannot currently be verbally prompted or redirected when upset. According to DCS 2, Resident A’s behaviors can last from several minutes to an entire eight-hour shift and may include continuous redirection from DCS, attacking staff or Resident B, hitting herself, throwing herself on the ground, biting, kicking, spitting, and throwing objects. DCS 2 reported that Resident B’s bedroom door has been replaced four times because Resident A broke the door handle attempting to enter the room to attack Resident B. DCS 2 further reported that Resident B has been hospitalized three times since Resident A moved into the facility in May 2025, with diagnoses including fractured vertebrae, cracked ribs, and a head laceration. DSC 2 stated there are currently six residents residing in the facility and all six residents exhibit aggressive behaviors, and that Resident A is the only resident requiring enhanced 1:1 supervision while in common areas per the PCPs and BTPs. DCS 2 stated the other five residents require hands-on assistance with bathing and toileting, and Resident B sometimes requires assistance with transfers. DCS 2 reported that concerns regarding the inability to meet Resident A’s needs and adequately protect Resident B have been communicated to management and community mental health, with no additional supports implemented or guidance provided to date.

On April 15, 2026, I interviewed DCS 3 who stated that all direct care staff have successfully completed CPI Crisis Intervention training. DCS 3 reported that LoveJoy Special Needs Center Corporation prefers a “no hands-on” crisis intervention approach, relying solely on verbal prompting and de-escalation techniques due to concerns about potential investigations. DCS 3 indicated there is limited support from upper management regarding staff concerns about their inability to meet Resident A’s needs.

According to DCS 3, Resident A targets Resident B with physical aggression and has verbally threatened Resident B by stating, “die, you die.” DCS 3 reported that several direct care staff previously assigned as Resident A’s 1:1 staff have recently quit due to the abusive environment created by Resident A’s behaviors. DCS 3 further stated that it often requires two direct care staff to calm Resident A, a process that can take up to an hour, leaving the remaining residents unsupervised or without adequate care during those periods.

On April 15, 2026, I emailed direct care staff member and home manager Jolie Porbusky and requested copies of CPI training certifications for all direct care staff, which she provided. As of that date, all nine direct care staff have been trained and certified in CPI Crisis Intervention Training and Recipient Rights Crisis Prevention Training. Ms. Porbusky reported that direct care staff are instructed by licensee designee Hope Lovell and other upper management personnel that physical management interventions cannot be used during behavioral crises unless specified in the resident’s BTP. Ms. Porbusky stated direct care staff are directed to use verbal prompting only. Ms. Porbusky stated that verbal prompting is not effective as a behavioral intervention for Resident A.

I also requested and received a copy of the staff schedule, which confirmed that two direct care staff are scheduled per shift. Ms. Porbusky reported that over the past few months Resident A’s behaviors have increased in both frequency and duration, often requiring both DCSs to intervene for the safety of Resident A and other residents. Ms. Porbusky stated that when both staff are engaged in managing Resident A’s behaviors, the remaining residents do not receive the care or supervision they may need during that time.

On April 16, 2026, I left a message with Guardian A1 requesting a return call, however no return call has been received at the time of the submission of this report.

On April 16, 2026, I interviewed DCS 4, who reported successfully completing CPI Crisis Intervention training, which included instruction on appropriate physical hold techniques and verbal de-escalation. DCS 4 stated, “we do not use the holds or physical interventions at the facility. I am not sure why it is not used, but at times it would be beneficial for the safety of [Resident B] when [Resident B] is being attacked by [Resident A].” DCS 4 reported that verbal prompting is no longer effective for Resident A during behavioral episodes and stated that Resident A’s behaviors have become dangerous to herself and others, adding, “it is not fair to anyone how these behaviors have disrupted the home,” including Resident A’s ability to receive needed support. DCS 4 also reported that the medication intended to help manage Resident A’s behaviors is no longer effective.

DCS 4 stated that the facility previously scheduled three direct care staff during first and second shifts, including one DCS dedicated to providing 1:1 enhanced supervision for Resident A. However, several staff have recently quit due to the environment in the

facility, leaving only two staff scheduled per shift. The remaining staff now split the 1:1 supervision responsibility. According to DCS 4, the increase in Resident A's behaviors often results in no staff being immediately available to meet the needs of the other residents.

DCS 4 reported that there are currently six residents living in the facility, all of whom exhibit behaviors such as hitting, pinching, spitting, and throwing items. DCS 4 stated these behaviors have increased for all residents since Resident A moved into the facility in May 2025. DCS 4 stated "Resident A repeatedly walks around the facility saying, "kill him, [Resident B] die," and requires consistent verbal redirection to keep her away from Resident B." DCS 4 added that "if [Resident A] cannot get to [Resident B] then she will go after staff, punching staff in the head, face, ribs, kicking staff, and attempting to bite." DCS 4 reported there has been times when DCS 4 has had to call additional staff to the home for assistance when Resident A is being aggressive towards direct care staff and residents. DCS 4 reported that police assistance has been required on two occasions, though exact dates were not recalled.

DCS 4 denied being explicitly told by anyone that physical management cannot be used when Resident A is physically aggressive, but said, "no one does, so I am not comfortable using it if no one else does." DCS 4 reported there is no support from upper management when concerns about Resident A's aggressive and assaultive behaviors are raised. According to DCS 4, requests to upper management for Resident A to be taken to the hospital for evaluation have been denied because the facility cannot bill if Resident A is admitted to the hospital. DCS 4 also reported that on April 16, 2026, Resident A broke the newly replaced door handle to Resident B's bedroom while trying to enter his room without permission and broke the entrance door handle while attempting to exit the facility.

Ms. Lentz reported per Resident A's BTP, Resident A is prescribed a medication to be administered when needed to assist with calming Resident A. Ms. Lentz reported that per Resident A's BTP, if Resident A grabs hair or the clothing of other residents or staff in an aggressive manner, staff should verbally state "Stop. Please let go. Walk away." Ms. Lentz reported staff should wait approximately three seconds to see if Resident A follows this direction and these directions should be provided in a neutral but firm tone. Ms. Lentz reported Resident A's BTP also encourages the use of environmental manipulations to keep residents and/or staff safe. Ms. Lentz stated, "for example, if [Resident A] begins to engage in physical aggression, staff should increase their distance from [Resident A] and encourage other residents to leave the area to maintain their safety. If other residents are unable to leave the area, staff should stand between [Resident A] and other residents if she engages in physical aggression or its precursors. Other strategies may be to remove certain objects from the environment or strategically place objects between [Resident A] and others. Staff should encourage [Resident A] toward safe spaces in the home (e.g., her bedroom, the living room, etc.) rather than areas with potential hazards (e.g., kitchen, stairs)." Ms. Lentz reported if all other less

restrictive measures have failed and there is imminent risk of severe physical harm to another resident or DCS, direct care staff should implement the least restrictive physical intervention techniques necessary. according to the provider's approved physical intervention policy to maintain safety and avoid injury. Ms. Lentz reported that Resident A is prescribed Haloperidol, 10mg to be used as needed for challenging behaviors, such as when Resident A engages in ongoing behaviors to indicate she is experiencing agitation such as engaging in physical aggression towards herself or others without response to staff support) for an extended length of time and does not respond to attempted positive support strategies that have previously been successful with her. The PRN medication may be administered as prescribed.

On April 20, 2026, I interviewed Emma Lentz, Case Manager with CMHCM, who reported that Resident A is seen monthly by another Community Mental Health agency because Resident A resides outside CMHCM's six-county service area. Ms. Lentz stated that Resident A was last seen by a case manager on February 4, 2026, and was evaluated by a Behavioral Psychologist on December 8, 2025, for a Functional Behavior Assessment. She reported that the recent increase in Resident A's behaviors prompted the completion of the assessment and the scheduling of a treatment team meeting to address these concerns.

Ms. Lentz reported that Resident A's BTP authorizes the PRN medication Haloperidol 10 mg, to be used as needed for challenging behaviors when Resident A exhibits ongoing agitation, engages in physical aggression toward herself or others, and does not respond to staff support or previously effective positive strategies. She stated Resident A's BTP also instructs staff that if Resident A grabs the hair or clothing of other residents or staff in an aggressive manner, staff are to direct her by stating, "Stop. Please let go. Walk away," in a neutral but firm tone, then wait approximately three seconds to determine if she complies. Ms. Lentz further explained that the BTP encourages the use of environmental manipulation strategies to maintain safety. She stated, "for example, if [Resident A] begins to engage in physical aggression, staff should increase their distance from [Resident A] and encourage other residents to leave the area. If other residents are unable to leave, staff should stand between [Resident A] and other residents. Other strategies may include removing certain objects or strategically placing objects between [Resident A] and others. Staff should encourage [Resident A] toward safe spaces in the home, such as her bedroom or the living room, rather than areas with potential hazards like the kitchen or stairs." Ms. Lentz reported that if all less restrictive measures fail and there is an imminent risk of severe physical harm to another resident or DCS, staff should implement the least restrictive physical intervention techniques necessary consistent with training received.

On April 20, 2026, I interviewed Hope Lovell, Licensee Designee, who reported she is very familiar with Resident A, as Resident A was previously placed at another LoveJoy Special Needs Center Corporation AFC facility. Ms. Lovell stated that Resident A exhibited similar behaviors at the prior placement, including episodes of aggression, but

these were not constant or consistent. Ms. Lovell reported she was not aware that Resident A had broken five bedroom door handles while attempting to reach Resident B to harm him. She stated that Resident A's behaviors can be indiscriminate, though they are often directed toward males.

Ms. Lovell reported she believed Resident A was compatible with the other residents because they all have intellectual and developmental disabilities, share similar social components, and the facility specializes in residents with behavioral needs. She explained that the corporation's position is that physical intervention may not be used unless it is specifically authorized in a resident's Person-Centered Plan or Behavior Treatment Plan. She stated direct care staff are directed to use verbal prompts and redirection during behavioral incidents and to administer prescribed medication as needed to assist with behavior management. Ms. Lovell reported she had not realized the degree to which Resident A's behaviors had escalated. Ms. Lovell reported that she has not been contacted by any direct care staff regarding concerns about their ability to meet Resident A's needs. She stated that this matter will be addressed with the home manager, Jolie Porubsky, and the operations director, Kathleen Redmer. Ms. Lovell also confirmed that she was aware of the injuries Resident B sustained as a result of being assaulted by Resident A. She reported that she, the home manager, and the operations director have been in communication with CMHCM regarding the escalation of Resident A's behaviors.

On April 22, 2026, I interviewed Jolie Porubsky, whose role is home manager and direct care staff, who reported Resident A is prescribed as needed Haloperidol to help with decreasing aggressive or inappropriate behaviors. However, Ms. Porubsky reported that Resident A becomes more aggressive and agitated towards herself, direct care staff, and Resident B after the Haloperidol is administered. Ms. Porubsky stated, "I think this is because the medication is supposed to relax [Resident A] and it makes her drowsy and in return she fights the medications because she does not want to sleep." Ms. Porubsky reported that these concerns about the Haloperidol have been brought to the attention of Kathleen Redmer Operations Director, Emma Lentz, CMHCM Case Manager, and CMHCM Psychiatrist, with no changes or guidance being provided from these individuals.

On April 22, 2026, Ms. Porubsky emailed me copies of Resident A's Medication Administration Record (MAR) and the physician's order for Haloperidol. Per the physicians orders, Haloperidol was prescribed to be administered one 10mg tablet, twice a day and also prescribed as one 10mg tablet daily as needed (PRN). Upon my review of the MAR for February 2026, Haloperidol-PRN was administered on February 7th, 10th, 15th, 20th, and 27th with notes on the MAR documenting Haloperidol was effective only on February 27th. Resident A's March MAR documented that Haloperidol-PRN was administered on the 2nd, 3rd, 11th, 13th, 21st, 22nd, 30th and 31st of March 2026. Per the MAR, staff documented that Haloperidol was effective on the 2nd, 3rd, and 13th but ineffective on the 11th, 21st 22nd 30th 31st. Resident A's April 2026 MAR,

documented that Resident A was administered Haloperidol-PRN on 2nd, 5th, 10th, 14th, and 19th of April. Per the April 2026 MAR, staff documented that the Haloperidol PRN was ineffective on the 2nd, 10th, 14th, and 19th and effective only on the 5th.

On April 22, 2026, I interviewed operations director Kathleen Redmer who reported that LoveJoy Special Needs Center Corporation does not support physical management when a resident is being aggressive or assaultive unless it is in the *Behavior Treatment Plan* or *Person Centered Plan*. Ms. Redmer reported she completed the *Assessment Plan for AFC Residents* prior to Resident A being admitted into the facility to determine if Resident A was compatible with residents currently residing in the facility and if direct care staff were able to meet Resident A's needs. Ms. Redmer reported that some direct care staff from Resident A's previous placement were now working at this facility and were familiar with Resident A's personal care and supervision needs. Ms. Redmer confirmed Resident A had behaviors at her previous placement, but these were mostly towards direct care staff and were not as frequent as what is now being observed. Ms. Redmer reported that she understands the interventions direct care staff are currently using include enhanced 1:1 supervision 16 hours a day, verbal prompts and verbal redirection, and the use of PRN medications. Ms. Redmer stated she also understands that these interventions are not working to address or stop Resident A's physically aggressive behavior. Ms. Redmer reported that she has been in contact with Community Mental Health Central Michigan regarding Resident A's assaultive behaviors with no changes made to Resident A's *Behavior Treatment Plan, Person Centered Plan* or medications at this time.

On May 05, 2026, Ms. Kathleen Redmer, Operation Directors provided me with a timeline which documented staff contacts with CMHCM and the outcome of the conversations. The timeline is outlined below:

- August 06, 2025- Teams meeting with CMHCM case worker Rebecca Shebester, DCS/home manager Jolie Porubsky, and Operation Director Kathleen Redmer. Discussed concerns about the severity of Resident A's behaviors with a recommendations that Ms. Porubsky follow up with the psychologist at the next appointment. On
- October 17, 2025- home visit with CMHCM case worker Rebecca Shebester, DCS/home manager Jolie Porubsky. Concerns were presented regarding Resident A's increased behaviors and targeting of Resident B, the inaccuracy of the PCP documenting that Resident A can complete most of the self-care tasks herself when she really requires hands on assistance, progress notes are not reviewed by CMHCM case managers unless an incident has been brought to their attention and discussed the PCP not including self-injurious behaviors. The behavior tracking log would be updated to include self-injurious behaviors. On November 14, 2025, DCS/home manager Jolie Porubsky requested an increase in hours of Resident A's 1:1 enhanced supervision from 8 hours a day to 16 hours a day, this was approved and sent to Hope Lovell on November 14, 2025.
- January 20, 2026- email from CMHCM Lindsey to Hope Lovell an updated contract for signature that requested approval for 8 hours of 1:1 staffing. Ms. Lovelle asked Kathleen Redmer, Operations Director to review. Ms. Redmer

brought it to Ms. Lovell's attention that the contract still stated 8 hours but should have shown 16 hours (per the new BTP approved in December). Ms. Lovell responded to Lindsey requesting clarification. Per CMHCM case manager replied on 1/21/26 Lindsey replied: "Upon discussion with our treatment team I was made aware of the increase from 8 hours of 1:1 to 16 hours, however, we have not received guardian consent and were under the impression that her staffing hours have not yet increased due to this."

- Ms. Redmer reported from February through April 08, 2026, all communication with CMHCM was between DCS/home manager Jolie Porubsky and CMHCM case manager, no additional contacts to CMHCM were made by Ms. Lovell or Ms. Redmer.

APPLICABLE RULE	
R 400.621	**Capability.**
	Licensees, staff, volunteers, and members of the household shall be capable of ensuring the welfare of residents.

ANALYSIS:	Based upon interviews conducted, documentation reviewed, as well as observations made during the unannounced on-site investigation there is substantial evidence that licensee designee Hope Lovell and direct care staff members are not capable of meeting the needs of Resident A and Resident B. Multiple direct care staff interviewed stated that physical management cannot be used to address Resident A's physically aggressive behavior toward Resident B despite this being listed as a last resort option in both Resident A's *Behavior Treatment Plan* and *Person Centered Plan*. Direct care staff interviewed stated that licensee designee Hope Lovell and other "upper management" instructed direct care staff to continually use redirection, verbally prompting, and PRN medication administration to address Resident A's physical aggression and restricted their ability to attempt crisis intervention physical management strategies during Resident A's aggressive behavioral episodes even though this is approved in both Resident A's BTP and PCP. It is documented through incident reports and verbal accounts of all direct care staff interviewed that the direct care staff are not allowed to place hands on Resident A during episodes of aggressive behaviors. These incident reports and staff interviews identify multiple instances when Resident A has physically assaulted Resident B to the point that he has been sent to the hospital for injuries sustained during these assaults. The direct care staff identify that Resident A physically assaults them which has caused multiple direct care staff to quit due to physical aggression from Resident A. The incident reports continually note that verbal prompting and redirection were ineffective in managing Resident A's behavioral outbursts. Ms. Lovell further reported that she was unaware of the escalation in Resident A's aggressive behaviors despite the multitude of incident reports identifying this very issue. Direct care staff are not being provided with proper support and guidance in how to manage Resident A's behaviors from Ms. Lovell. Therefore, the welfare of the residents at the facility is at risk due to this lack of education and support in managing the escalation of these behaviors and licensee designee Hope Lovell and direct care staff are not capable of meeting the protection and safety needs of Resident A or Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based upon review of 22 IR's from March 2026 to April 08, 2026, including three additional IR's dated July 30, 2025, August 11, 2025, and March 10, 2026, Resident B's protection and safety needs were not attended to by direct care staff members as he was assaulted or harassed by Resident A 22 times during this period. Resident B was provided medical attention and was diagnosed with cracked ribs after the March 10,2026, assault, laceration of occipital region of scalp after the August 11, 2025 assault, and a fracture of the T11 and L1 vertebrae after the July 30, 2025 assault. Despite Resident A's Behavior Treatment Plan and Person Centered Plan both allowing the use of least restrictive physical techniques necessary to maintain the safety of residents and to avoid injury to residents, direct care staff used mainly verbal redirection and body positioning to attempt to stop Resident A's physically aggressive behavior toward Resident B. These interventions were ineffective resulting in injury to Resident B. Further, Resident A has broken Resident B's bedroom door handle on five separate occasions in efforts to enter his bedroom to assault or harass him. Every direct care DCS interviewed for this investigation noted that Resident A walks around the facility stating that Resident B must die. Each direct care staff interviewed reported that they do not feel they can keep Resident B safe from Resident A due to her fixation on him. Ms. Lovell reported that she was unaware of the escalation in these behaviors, despite the 22 IRs documenting Resident A's assaultive behavior from March 2026 through April 2026. Consequently, licensee designee Hope Lovell and direct care staff members did not provide Resident B with safety and protection from Resident A's physically aggressive behavior. Per interviews with direct care staff, Licensee Designee Hope Lovell, and Operations Director Kathleen Redmer, LoveJoy Special Needs Center Corporation does not support the use of approved physical intervention even though all of the direct care staff have been certified in CPI Crisis Intervention by Community Mental Health.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On April 09, 2026, during the onsite investigation I received and reviewed a copy of Resident A's *Assessment Plan for AFC Residents*.

On April 15, 2026, DCS/home manager Jolie Porubsky, emailed me the *Assessment Plan for AFC Residents* for Resident B, Resident C, Resident D, Resident E, and Resident F.

Upon my review of the *Assessment Plan for AFC Residents,* the plans documented the following information:

- Resident A, Resident C, and Resident D's *Assessment Plans for AFC Residents* were completed on December 29, 2025. There was no evidence, such as her signature or a letter, that licensee designee Hope Lovell had completed or reviewed these documents as required.
- Resident B's *Assessment Plan for AFC Residents* was completed on December 26, 2025, and was signed by Kathleen Redmer, Operations Director. There was no evidence, such as her signature or a letter, that licensee designee Hope Lovell had completed or reviewed this document as required.
- Resident E's *Assessment Plan for AFC Residents* was completed on March 21, 2025. This was the only *Assessment Plan for AFC Residents* in Resident E's resident record. There was no evidence, such as her signature or a letter, that licensee designee Hope Lovell had completed or reviewed this document as required. Resident E's assessment plan was completed on March 21, 2025, and has not been completed and signed annually.
- Resident F's *Assessment Plan for AFC Residents* was completed on December 26, 2025, and was signed by Kathleen Redmer, Operations Director. There was no evidence, such as her signature or a letter, that licensee designee Hope Lovell had completed or reviewed this document as required.

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 my review of the *Assessment Plans for AFC Residents* for Residents A- F, none of the assessment plans were signed by licensee designee Hope Lovell as required and were incomplete. Also, the most current *Assessment Plan for AFC Residents* for Resident E was completed on March 21, 2025, and has not been completed and signed annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the quality of care violations cited in the report, an approved corrective action plan is required. Upon receipt of an acceptable corrective action plan, I recommend the issuance of a six month provisional license.

Bridget Vermeesch

05/20/2026

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

05/20/2026

_____

Dawn N. Timm Date
Area Manager