GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2026

Joshua Stirbu
Amy's Place Assisted Living LLC
18361 Norwich
Livonia, MI 48152

RE: License #: AS820408857
Investigation #: 2026A0993017
Hope Haven Assisted Living LLC

Dear Mr. Stirbu:

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 (313) 456-0380.

Sincerely,

DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820408857
Investigation #:	2026A0993017
Complaint Receipt Date:	06/15/2026
Investigation Initiation Date:	06/16/2026
Report Due Date:	08/14/2026
Licensee Name:	Amy's Place Assisted Living LLC
Licensee Address:	17251 Mayfield St Livonia, MI 48152
Licensee Telephone #:	(847) 477-5801
Administrator:	Roxanne Stirbu
Licensee Designee:	Joshua Stirbu
Name of Facility:	Hope Haven Assisted Living LLC
Facility Address:	17251 Mayfield St Livonia, MI 48152
Facility Telephone #:	(847) 477-5801
Original Issuance Date:	03/29/2022
License Status:	REGULAR
Effective Date:	04/06/2025
Expiration Date:	04/05/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained a bad bed sore due to neglect.	Yes

III. METHODOLOGY

06/15/2026	Special Investigation Intake 2026A0993017
06/16/2026	Contact - Telephone call made Telephone call made to Complainant. Left a message.
06/16/2026	Special Investigation Initiated - Telephone Telephone call made to Relative A1
06/16/2026	APS Referral Forwarded allegations to Adult Protective Services (APS)
06/16/2026	Contact - Telephone call made Telephone call made to Veterans Affairs social worker, Crystal Jones. Left a message.
06/17/2026	Inspection Completed On-site Conducted an unannounced onsite investigation. I interviewed staff, Samantha Thorpe and staff, Renae Lingard. I also interviewed home manager, Josh Stirbu via telephone.
06/18/2026	Contact - Telephone call made Telephone call made to Veterans Affairs social worker, Crystal Jones. Left a message.
06/18/2026	Contact - Telephone call made Telephone call made to Relative A1
06/23/2026	Contact - Telephone call made Telephone call made to APS specialist, Kimberly Richie
06/23/2026	Contact - Telephone call made Telephone call made to Veterans Affairs Ann Arbor Medical Records. Left a message.
06/23/2026	Contact - Telephone call made

	Telephone call made to Veterans Affairs social worker, Crystal Jones. Left a message.
06/29/2026	Contact - Telephone call made Telephone call made to Veterans Affairs social worker, Crystal Jones. Left a message.
06/29/2026	Contact - Telephone call made Telephone call made to Relative A1
06/30/2026	Contact - Document Sent Requested medical records from Veterans Affairs Ann Arbor
07/14/2026	Contact - Telephone call made Followed up on the request for medical records from Veterans Affairs Ann Arbor
07/14/2026	Contact - Document Received Received medical records from Veterans Affairs Ann Arbor
07/17/2026	Contact - Document Received Received statement from licensee designee, Josh Stirbu
07/17/2026	Exit Conference Held with licensee designee, Josh Stirbu

ALLEGATION:

Resident A sustained a bad bed sore due to neglect.

INVESTIGATION:

On 06/15/2026, I received allegations from Licensing and Regulatory Affairs (LARA) Bureau of Child and Adult Licensing (BCAL) Online Complaints.

On 06/16/2026, I conducted a telephone interview with Relative A1. Relative A1 stated she transported Resident A to the Veteran Affairs Ann Arbor Hospital on 05/22/2026. When he arrived at the hospital, it was discovered that he had a level three abscess pressure wound. Relative A1 did not know how or when Resident A sustained the wound as she was not notified of it. In addition, Resident A has dementia. Relative A1 stated she talked to home manager Josh Stirbu about the wound, and he stated he was informed unaware of the wound. He stated when Resident A went to the hospital, staff did not notice anything. Mr. Stirbu did not state which staff he was referring to when he made that statement. Mr. Stirbu informed Relative A1 that Resident A was showered twice per week, and he stood up when was showered. Relative A1 questioned how staff

did not notice the wound if they were really showering Resident A. Relative A1 stated Resident A was still in the hospital.

On 06/17/2026, I conducted an unannounced onsite investigation. I interviewed staff, Samantha Thorpe and staff, Renae Lingard. I also interviewed home manager, Josh Stirbu via telephone.

Ms. Thorpe denied ever observing a wound on Resident A. She stated staff showered him twice weekly. Resident A was also cleaned and wiped down daily. Per Ms. Thorpe, Resident A was the most watched resident, and there are always two staff per shift. If there was a wound, staff would have noticed it.

Ms. Lingard stated she was working in the facility the day Resident A was transported to Veterans Affairs Hospital. She did not observe a wound on him. Per Ms. Lingard, Resident A was sent to the hospital due to not urinating much, and his private area was enlarged.

At the time of the unannounced investigation, Resident A was hospitalized.

On 06/18/2026, I conducted a follow-up interview with Relative A1. She stated Resident A was at Veterans Affairs Ann Arbor Hospital awaiting placement. He is not returning to the facility.

On 06/23/2026, I conducted a telephone interview with APS specialist, Kimberly Richie. Her investigation is pending.

On 07/14/2026, I received medical records from Veterans Affairs Ann Arbor. Resident A admitted to the hospital from 05/22/2026 to 06/11/2026 and treated for “sepsis 2/2 MSSA bacteremia, likely source right ischial wound which grew ESBL and MSSA.” In addition, the records, documented Resident A “presented with sepsis and found to have MSSA bacteremia on blood cx 5/22, suspect due to R hip wound.”

On 07/17/2026, I received a statement from licensee designee, Josh Stirbu. Mr. Stirbu stated Resident A was transferred from the facility to the hospital on 05/22/2026 due to pneumonia and a urinary tract infection. Mr. Stirbu denied knowledge of “any pressure ulcer, skin breakdown, or gluteal abscess.” On 05/26/2026, he learned Resident A was “diagnosed with a Stage II pressure wound.” Mr. Stirbu stated staff provided direct care to Resident A and did not observe any skin breakdown. Resident A “remained mobile and was able to stand for toileting and showers, providing staff with regular opportunities to observe his skin during routine care.” He stated he was informed Resident A developed “a deep gluteal abscess with significant infection and tunneling. His daughter advised me that a wound care specialist documented and photographed the wound on May 26, four days after his hospital admission. She also stated that emergency department staff verbally indicated there may have been a wound present upon admission; however, I have not been provided with any medical documentation from May 22 confirming the presence of a pressure wound or abscess at the time of

admission." Mr. Stirbu stated given Resident A's "multiple medical conditions, serious infection, and declining health status, I am unable to determine when the wound originated. However, based on the care provided in my home and the observations of staff, I do not believe neglect occurred while [Resident A] was a resident in my care."

O7/17/2026, I contacted license designee, Josh Stirbu and conducted an exit conference. I informed him of the findings. He disagreed with the findings. He stated that when Resident A was transported to the hospital, he did not have a wound. It is likely that his skin broke while in the hospital, and he sustained the wound as result.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Ms. Thorpe, Ms. Lingard and Mr. Stirbu denied observing a wound on Resident A prior to being transported to the hospital on 05/22/2026. Ms. Lingard stated Resident A was transported to the hospital due to not urinating much, and his private area was enlarged. Per Resident A's medical records, Resident A was admitted to the hospital from 05/22/2026 to 06/11/2026 and treated for "sepsis 2/2 MSSA bacteremia, likely source right ischial wound which grew ESBL and MSSA". In addition, the records, documented Resident A "presented with sepsis and found to have MSSA bacteremia on blood cx 5/22, suspect due to R hip wound." Evidence support staff did not obtain health care immediately when there was a sudden adverse change in the resident's health condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/21/2026

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:

07/23/2026

Ardra Hunter — Date
Area Manager