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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 27, 2023

Cindy Whaley
Liberty Living Inc.
P O Box 1273
Bay City, MI 48706

RE: License #:	AS090237189
Investigation #:	2023A0123019
	Independence House

Dear Ms. Whaley:


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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,

A handwritten signature in cursive script, appearing to read "Shamidah Wyden".

Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090237189
Investigation #:	2023A0123019
Complaint Receipt Date:	01/17/2023
Investigation Initiation Date:	01/17/2023
Report Due Date:	03/18/2023
Licensee Name:	Liberty Living Inc.
Licensee Address:	P O Box 1273 Bay City, MI 48706
Licensee Telephone #:	(989) 892-0247
Administrator:	Cindy Whaley
Licensee Designee:	Cindy Whaley
Name of Facility:	Independence House
Facility Address:	1306 38th Street Bay City, MI 48708
Facility Telephone #:	(989) 893-0856
Original Issuance Date:	06/05/2001
License Status:	REGULAR
Effective Date:	12/05/2021
Expiration Date:	12/04/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
A fire occurred at the home on 01/15/2023 which caused extensive damage.	Yes

III. METHODOLOGY

01/17/2023	Special Investigation Intake 2023A0123019
01/17/2023	Special Investigation Initiated - Telephone I made a follow-up call to licensee designee Cindy Whaley in regard to an email sent from her on 01/16/2023 regarding the facility fire.
01/17/2023	Contact - Document Received I received and reviewed the incident report and photos regarding the fire damage.
01/19/2023	Contact- Document Received Documentation received via fax.
02/03/2023	Inspection Completed On-site I conducted an on-site at the facility.
02/03/2023	Contact- Document Sent I sent an email to Ms. Whaley requesting information.
02/08/2023	Contact- Document Received I received requested information via email.
02/08/2023	Contact - Telephone call made I made a call to Resident B, Resident C, and Resident D's case manager.
02/08/2023	Contact - Telephone call made I made a call to Resident E's case manager.
02/08/2023	Contact - Telephone call made I left a voicemail for Resident F's case manager, requesting a return call.
02/08/2023	Contact - Telephone call made I left a voicemail for staff Jared Bombly requesting a return call.

02/08/2023	Contact - Telephone call made I left a message requesting a return call from the Fire Marshall Jeff Ross.
02/09/2023	Contact - Telephone call received I spoke with the Fire Marshall via phone.
02/10/2023	Contact - Document Sent I emailed a request to the fire department for a copy of their report on the fire.
02/10/2023	Contact - Document Received I received a copy of the fire report.
02/23/2023	Contact- Telephone call made I attempted to contact staff Jared Bombly via phone.
02/23/2023	Contact- Telephone call received I spoke with Staff Bombly via phone.
02/23/2023	Contact-Telephone call made I spoke with case manager Malinda Framboise via phone.
02/23/2023	Exit Conference I spoke with Cindy Whaley via phone.
02/24/2023	Contact- Telephone call made I made an attempt to contact Resident A's case manager via phone.
02/27/2023	Contact- Telephone call made I spoke with Resident A's case manager via phone.

ALLEGATION: A fire occurred at the home on 01/15/2023 which caused extensive damage.

INVESTIGATION: On 01/17/2023, I spoke with licensee designee Cindy Whaley via phone. Ms. Whaley stated that the initial reporting from the fire department says the cause of the fire may have been electrical. She stated that a neighbor saw the fire, called the facility, and told staff about it. The staff and residents evacuated, and a head count was conducted. The whole back of the home is completely wiped out. She stated that coincidentally Resident A was placed in the home right before the fire occurred. Resident A is a smoker, and reportedly said "If they don't do what I want, I will tear this place down." She stated that this resident had went out to smoke. There is a trash can at the back of the home. You can no longer tell that there were two trash cans in the exact area where the fire started. She stated that Resident A had

took off and was found in the field smoking and was being belligerent. She stated that she is not saying Resident A started the fire. Ms. Whaley stated that there were six residents displaced, and they are in a hotel currently. She stated that they are looking into temporary placements, and the goal is to get the group back together. Ms. Whaley stated that the resident books and medications are secured, and they were able to salvage some clothing from the back bedrooms. She stated that the Bay City Fire Department responded.

On 01/17/2023, I received a copy of the *AFC Licensing Division- Incident/Accident Report* which states that around 5:00 am to 5:30 am staff Jared Bombly received a phone call that Independence Home was on fire. Everyone was evacuated, staff did a head count, and everyone made it out safely. It states that they took shelter at a neighbor's home who called him about the fire. It further states that the fire department arrived, the residents were relocated to a hotel, and that staff will supervise them 24/7. All of the guardians were notified as well as licensing and case managers.

On 01/19/2023, I received a letter written by licensee designee Cindy Whaley via fax regarding Resident A which stated that she moved in on 01/12/2023 and left the facility on 01/15/2023 after given the option to re-locate with the rest of the residents. It states that Resident A made it clear to staff she did not want to live there and that she made a threat "*If they don't let me do what I want, I'm going to tear that place down and they'll be sorry!*" The letter notes that Resident A was discharged from the home, and because she chose to re-locate, the home is not able to meet her needs.

On 02/03/2023, I conducted an on-site at the facility. I observe the outside of the home and took photos. Majority of the fire damage appeared to be on the southwest side of the home, which is the back right corner of the home (if facing the front of the home). There was a dumpster in the driveway.

On 02/08/2023, I made a call to Bay Arenac Behavioral Health case manager Craig Kanicki via phone. Mr. Kanicki is the case manager for Resident B, Resident C, and Resident D. He stated that the residents are at a hotel. He denied having any concerns. He stated that to his understanding, the home will be repaired, and they will move back into the facility. He stated that to his understanding, staff are at the hotel around the clock. He stated that he has no information on the timeframe for repairs, and that the fire started near some trash cans. He stated that Resident B lost all of his belongings but is slowly getting things replaced. He stated that the residents are enjoying the hotel, but eager to get back home.

On 02/08/2023, I made a call to Bay Arenac Behavioral Health case manager Heather Buckley via phone. She is the case manager for Resident E. She denied having any concerns, and that everyone went to the hotel. She stated that they are trying to keep everyone together until the home is repaired, and there is an investigation going on whether the fire was electrical or not. She stated that the plan is for everyone to move back into the facility.

On 02/09/2023, I received a return call from Jeff Ross, a Fire Marshall from Bay City Fire Department. He stated that the cause of the fire was undetermined, and there was cigarette waste material around where the fire started. He stated that a staff person had smoked earlier that night, and there are residents that smoke as well. He stated that no one is going to admit to starting the fire.

On 02/10/2023, I received a copy of the Bay City Fire Department report. The report states that the department responded to the home on 01/15/2023 for a structural fire, and all occupants were out of the building. The fire appeared to be in the attic area. A property manager was assisted inside to retrieve medications and belongings. The facility was then locked. The windows remained intact, so the facility did not need to be boarded up. A section of the report appears to have been written by Fire Marshall Jeff Ross. It states:

"I observed heavy heavy fire damage on the southwest corner of the structure. The fire damage appeared to have started at ground level, due to heavy charring observed, and traveled upward. Within the area of origin, I located a coffee can and numerous cigarette butts. Also within the area of origin, a City of Bay City trash receptacle was observed to be completely melted to the ground. Inside of the melted receptacle, an additional cigarette butt was located at the bottom of it."

"Bombly stated that he was a staff member for the adult foster home and that he was working at the time of the fire. Bombly stated that on that morning, sometime between 5:00AM-5:30AM, the neighbor called and told him that the house was on fire. Bombly then looked outside and saw that the outside of the house was on fire. He stated at that point the fire had spread about halfway up the house from the bottom. Bombly then immediately getting the residents out of the house. While he was having the residents exit, the neighbor ran over with fire extinguishers and stated that he had called 911. When questioned if he smoked cigarettes, Bombly stated that he does. He stated that he last smoked at approximately 2:00 AM the morning of the fire; however, he places the cigarette butt into the metal coffee can and covers it with the lid. He also stated that two other residents smoke as well (Resident A and Resident F). He believes one of them smoked outside after he had but is unsure when."

On 02/23/2023, I spoke with Resident F's case manager Malinda Laframboise via phone. She denied having any concerns and stated that things were handled well. She stated that she was informed of what happened, that the residents got to safety, and they are secure at their hotel. She stated that she plans to see Resident F next week, and things are going okay at the hotel. She stated that the residents are looking forward to going back to the home, and she heard they are working on a complete remodeling of the facility.

On 02/23/2023, I interviewed staff Jared Bombly via phone. He stated that he was in the house, and it was between 5:00 am and 5:30 am on 01/15/2023. He stated that

he received a call from the neighbor that the home was on fire. He stated that he smoked about two to three hours before the fire, and he thinks that the newest resident (Resident A) may have caused the fire by not putting out her cigarette butt properly. He stated that he called 911 and got everyone evacuated. He then stated that they went to the neighbor's home for shelter. He stated that he asked Resident A to stay with everyone else, but she walked over to the ambulance, and appeared to be shaken up. He stated that Resident A's behavior appeared odd. He stated that he had instructed Resident A before to discard her cigarette butts in the tin outside. He stated that he thought that she had went to her bedroom, after she asked him to come outside to smoke. He stated that he told her no, and that he is 50/50 on whether she went back to her bedroom or went outside to smoke. He stated that it was his first night working with Resident A in the home, and that Resident A was the only resident awake that night. He stated that Resident A seemed sneaky. He stated that everything is going good at the hotel, and the residents are okay.

On 02/27/2023, I spoke with Resident A's case manager Nekeia Hopkins from ACT (Assertive Community Treatment). She stated that Resident A chose after the fire to go to her sister's home. She is currently placed in another AFC facility. She stated that Resident A was hospitalized shortly after the fire for mental health reasons. She stated that Resident A experiences delusions, but no serious behavior issues.

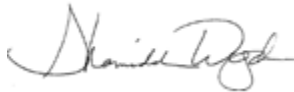
APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	<p>On 01/17/2023, an incident report was received that stated that the residents were evacuated from the home due to a fire.</p> <p>During this investigation, the residents were placed temporarily at a hotel. Resident A has since been placed in another AFC home in Bay County.</p> <p>Case managers for Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F denied having any concerns with how staff handled the situation.</p> <p>A copy of the Bay City Fire Department reported was obtained. The cause of the fire is noted to be undetermined per Fire Marshall Jeff Ross.</p> <p>Due to the extensive damage of the fire, the home is not suitable for residents to reside in currently.</p>

	There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

On 02/23/2023, I conducted an exit conference with licensee designee Cindy Whaley via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 1-6).

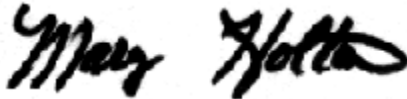


02/27/2023

Shamidah Wyden
Licensing Consultant

Date

Approved By:



02/27/2023

Mary E. Holton
Area Manager

Date