GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 2, 2025

Laurie Labie
Enriched Living, LLC
242 Highlander Dr. N.E.
Rockford, MI 49341

RE: License #: AS590406991
Investigation #: 2025A1029017
Enriched Living - Legion

Dear Ms. Labie:

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 licensee designee 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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AS590406991 |
| | |
| **Investigation #:** | 2025A1029017 |
| | |
| **Complaint Receipt Date:** | 02/11/2025 |
| | |
| **Investigation Initiation Date:** | 02/11/2025 |
| | |
| **Report Due Date:** | 04/12/2025 |
| | |
| **Licensee Name:** | Enriched Living, LLC |
| | |
| **Licensee Address:** | 242 Highlander Dr. N.E., Rockford, MI 49341 |
| | |
| **Licensee Telephone #:** | (586) 295-1674 |
| | |
| **Administrator:** | Laurie Labie |
| | |
| **Licensee Designee:** | Laurie Labie |
| | |
| **Name of Facility:** | Enriched Living - Legion |
| | |
| **Facility Address:** | 344 Legion St, Howard City, MI 49329 |
| | |
| **Facility Telephone #:** | (586) 295-1674 |
| | |
| **Original Issuance Date:** | 04/22/2021 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/22/2023 |
| | |
| **Expiration Date:** | 10/21/2025 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED<br>TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On February 11, 2025, direct care staff member Brenda Johnson fell asleep while working third shift at Enriched Living Legion and was not available to respond to an emergency situation. | Yes |
| On February 11, 2025, Resident A was not provided line of sight supervision according to the supervision guidelines outlined on his Assessment *Plan for AFC Residents* and his *CMH Behavior Treatment Plan* because he eloped during third shift, stole from a gas station and had to be returned to the AFC by law enforcement. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 02/11/2025 | Special Investigation Intake 2025A1029017 |
| 02/11/2025 | Special Investigation Initiated – Letter to Cecelia McIntyre - Office of Recipient Rights (ORR) |
| 02/11/2025 | APS Referral made to Centralized Intake |
| 02/12/2025 | Contact - Telephone call received from APS specialist, Carole Dreyer |
| 02/13/2025 | Contact - Telephone call made to APS specialist Carole Dreyer |
| 02/19/2025 | Contact - Document Sent -Montcalm County Sheriff Department by email and sent a FOIA request to obtain police reports from the incident. |
| 02/20/2025 | Inspection Completed On-site- face to face and Interviewed Shannon Richards, Mr. Everett, Resident B, Resident C, Resident D at Enriched Living Legion |
| 02/20/2025 | Contact - Document Sent MSP Lakeview Post Trooper Hannah MacMillen regarding police report |
| 02/21/2025 | Contact - Document Received Montcalm Co. Sheriff Department - they did not respond to incident. Check with MSP. |
| 02/21/2025 | Contact - Document Sent – email sent to licensee designee Laurie Labie requesting documentation |

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|---|---|
| 02/25/2025 | Contact - Telephone call made to licensee designee Laurie Labie |
| 02/26/2025 | Contact – Telephone call to direct care staff member Brenda Johnson and documentation received from licensee designee Laurie Labie. |
| 02/26/2025 | Exit conference with licensee designee Laurie Labie |

**ALLEGATION: On February 11, 2025, direct care staff member Brenda Johnson fell asleep while working third shift at Enriched Living Legion and was not available to respond to an emergency situation.**

**INVESTIGATION:**

On February 11, 2025 a complaint was received via Bureau of Community and Health Systems online complaint system with allegations that on February 11, 2025, direct care staff member Brenda Johnson fell asleep while working third shift at Enriched Living Legion and was not available to respond to an emergency situation.

On February 13, 2025 I received a call from Adult Protective Services (APS) specialist, Carole Dreyer. Ms. Dreyer stated she spoke with licensee designee Laurie Labie about the situation and she was informed direct care staff member Brenda Johnson who fell asleep remains employed at Enriched Living Legion and she is a long-term direct care staff member.

On February 20, 2025, I completed an unannounced on-site investigation at Enriched Living Legion and interviewed direct care staff member, whose current role is home manager, Shannon Richards. Ms. Richards stated she was not present the night Resident A left the home and stole from the gas station but she does know direct care staff member Ms. Johnson was asleep during this incident. Ms. Richards stated direct care staff members assigned to third shift are allowed to sleep during their shift as long as they are available for emergency situations that arise with the residents. Ms. Richards stated the AFC is small enough that when one of the doors open, the direct care staff member will wake up.

On February 20, 2025, I interviewed direct care staff member Richard Everett. Mr. Everett stated the direct care staff members are able to sleep during their shift on third shift, however, since it's a small home, they can typically hear if they are needed and wake up.

I reviewed the Original Licensing Study Report written on April 19, 2021 for Enriched Living-Legion which indicated the following regarding supervision:

*"The applicant intends to provide 24-hour supervision, protection, and personal care to six (6) male or female adults whose diagnosis is Alzheimer's, physically handicapped,*

*mental illness, developmentally delayed or traumatic brain injured in the least restrictive environment possible. If required, behavioral intervention and crisis intervention program will be developed as identified in the resident's assessment plan. These programs shall be implemented by trained staff, with the prior approval of the resident, guardian, and the responsible agency. The applicant will have a minimum of 2 staff per waking hours and 1* ***non-sleeping staff*** *during sleeping hours. The applicant will increase direct care staff in the event of an increase in the level of protection, or personal care required by a resident."*

On February 20, 2025, I interviewed Resident B who stated sometimes two direct care staff members work during third shift but typically there is one. Resident B stated direct care staff members are usually cleaning, organizing, or working on the medications or books, however, sometimes they do sleep throughout the night because "they also need their rest." Resident B stated he did not know if Ms. Johnson was sleeping during this incident. I interviewed Resident C and Resident D who both stated Resident A left at night and the police had to come wake up Ms. Johnson so she could handle the situation. Resident D stated Ms. Johnson sleeps "quite a bit" on third shift when she is working.

On February 25, 2025, I interviewed licensee designee Laurie Labie. Ms. Labie stated Resident A was brought back to the home by law enforcement and direct care staff member Ms. Johnson was asleep during that time. Ms. Labie stated she immediately dealt with Ms. Johnson and has talked to her about this. Ms. Labie stated Ms. Johnson wrote the incident report and she told on herself and that's how they found out it happened. Ms. Labie stated Resident A is not returning to the home but they were trained on his plan and were informed they should not be sleeping while on third shift. Ms. Labie stated there is an in-home staff meeting and she will make sure the sleeping arrangements at night will be added to their agenda so the staff are clear on the requirement to stay awake.

Ms. Labie provided the following documentation which I reviewed:

1. Documentation showing Ms. Johnson has completed all required AFC licensing trainings.
2. Verification from the staffing schedule that Ms. Johnson was the only direct care staff member assigned to provide care and supervision between the hours of 10 PM -8 AM.
3. Employee Notice of Remedial Action which was provided to Ms. Johnson on February 11, 2025 for this incident- *"Staff were sleeping and Recipient eloped and was brought home by law enforcement. Recipient is an elopement risk with a behavior treatment plan." Corrective Action Taken: Discussed with Ms. Johnson that she must be alert at all times while on shift. Management will continue to check in with her to confirm.*
4. Office of Recipient Rights Intervention written by Cecelia McIntyre on February 17, 2025 which stated *"Ms. Johnson reported she had fallen asleep around 4 AM and Resident A was brought back to the home at 5 AM. A preponderance of*

*evidence was found to substantiate a violation of Mental Health Services Suited for Ms. Johnson."*

On February 26, 2025, I interviewed direct care staff member Brenda Johnson and she stated around 4 AM she fell asleep and around 5 AM she was woken up with the police bringing Resident A bringing him back to the home. Ms. Johnson stated she has not had any instances of falling asleep on shift. Ms. Johnson stated she believed she was allowed to sleep on shift but she was supposed to be aware of what of what was going on. I asked her how she would be aware of an emergency if she was asleep and she stated, "you would have to be a light sleeper, I guess." Ms. Johnson stated Resident A was "extra sneaky" because she did not hear him leave the AFC.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14204** | **Direct care staff; qualifications and training.** |
| | **(2) Direct care staff shall possess all of the following qualifications:**<br>**(b) Be capable of appropriately handling emergency situations.** |
| **ANALYSIS:** | Direct care staff member Ms. Johnson was not able to appropriately handle emergency situations because she was asleep on third shift when Resident A eloped from the facility. Ms. Johnson did not wake up until law enforcement brought Resident A back to the facility and had to wake her up. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: On February 11, 2025, Resident A was not provided line of sight supervision according to the supervision guidelines outlined on his *Assessment Plan for AFC Residents* and his *CMH Behavior Treatment Plan* because he eloped during third shift, stole from a gas station and had to be returned to the AFC by law enforcement.**

**INVESTIGATION:**

On February 11, 2025 a complaint was received via Bureau of Community and Health Systems online complaint system with allegations that on February 11, 2025 Resident A was not provided supervision according to his *Assessment Plan for AFC Residents* and *CMH Behavior Treatment Plan* because he eloped during third shift, stole from a gas station and had to be returned to the AFC by law enforcement.

On February 20, 2025, I completed an unannounced on-site investigation at Enriched Living Legion and interviewed direct care staff member whose current role is home manager, Shannon Richards. Ms. Richards stated Resident A has left the home before but typically he will do this during the day after saying he is going to get the mail but he will just keep going down the street. Ms. Richards stated Resident A has had several

manic episodes lately and is now in the hospital for evaluation so he was not available to interview. Ms. Richards stated when Resident A goes outside to smoke, direct care staff must make sure they keep an eye on him so he does not walk down the street. Ms. Richards stated there are always two direct care staff members assigned on first and second shift and one direct care staff member on third shift. Ms. Richards stated Michigan State Police Lakeview Post responded to the incident.

On February 20, 2025, I interviewed direct care staff member Richard Everett. Mr. Everett stated when Resident A elopes they are to follow him out of the home and keep line of sight supervision while in the community. Mr. Everett stated if they cannot see him, then they will call management and law enforcement. Mr. Everett stated they limit Resident A's caffeine intake and redirect behaviors when he is talking about leaving the AFC. Mr. Everett stated third shift direct care staff members are allowed to sleep during their shift but in the last three weeks Resident A has been trying to leave more during the night.

During the on-site, I reviewed the following information in Resident A's resident record:

1. *Assessment Plan for AFC Residents* which indicates Resident A does not move independently in the community and requires "line of sight while in community with AFC staff."
2. Documentation Ms. Johnson was trained on Resident A's *Person Centered Plan* and *Behavior Treatment Plan*.
3. *Health Care Appraisal* completed November 5, 2024 which includes documentation Resident A has the following diagnosis bipolar 1 disorder, current or most recent episode manic: with psychotic features, ADHD and that he is fully ambulatory.
4. State of Michigan Uniform Law Citation from the incident on February 11, 2025 which states he was cited for a misdemeanor retail fraud – third degree from stealing at the gas station. This was incident # 64-718-25 and he has a court appearance on March 4, 2025 for this issue.
5. I received documentation on February 11, 2025 from Montcalm Care Network Rights Officer, Cecelia McIntyre with Resident A's *Person Centered Plan* and *Behavior Treatment Plan.* Two of the goals on his *Behavior Treatment Plan* are eloping and stealing with the following instructions:
    a. *To address stealing: Staff should maintain a "line of sight" monitoring with him during all community outings including any time that he is at a store. He has a lengthy history of being banned from stores secondary to stealing.*
    b. *To address eloping:*
        1. *If [Resident A] begins walking toward the exit door of the AFC home in order to elope, remind him in a calm manner that he is not allowed to go into the community without a staff member accompanying him.*
        2. *If he does elope from the home then a staff member will need to immediately follow after him you should stay with him and should maintain "line of sight" monitoring in order to*

*ensure his safety until you are able to verbally redirect him back to the home*

3. *Once he returns to the home gain his involvement in an acceptable activity provide verbal praise and reinforcement as he participates in this activity.*

On February 20, 2025, I interviewed Resident B who stated Resident A informed him that he had some Mt. Dew Stackers which are energy drinks the day he stole from the gas station so “he was wired.” Resident B stated Resident A told him “I am out of here” but since they are allowed to go for walks, he did not think it was concerning. Resident B stated Resident A is allowed to walk down to the stop sign and return. Resident B stated direct care staff members working usually are aware that he leaves and they will call upper management and law enforcement if he does not return.

On February 20, 2025, I interviewed Resident C and Resident D. Resident D stated Resident A is his roommate but he was sleeping when Resident A left the home. Resident C stated he was aware Resident A stole from the store but did not know when he left or how often he did this. Resident D stated sometimes Resident A will elope at night most evenings, however, there are some weeks he will only leave once. Resident D stated sometimes he will slip outside during shift change when the direct care staff members are busy and they do not see him leave.

On February 25, 2025, I interviewed licensee designee Laurie Labie. Ms. Labie stated Resident A was at another licensed AFC in the past and they had wanted him at Enriched Living but she was not sure about it because there was not a lot of restrictions at Enriched Living Legion. Ms. Labie stated she wanted it work out with him and she thought Resident A only needed line of sight while he was in the community and not during the night time. Ms. Labie stated it appears Resident A needs more supervision and he will not be returning to Enriched Living Legion at this time.

| **APPLICABLE RULE** | |
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| **R 400.14303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.** |

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|---|---|
| **ANALYSIS:** | Resident A was not supervised appropriately during third shift because direct care staff member Ms. Johnson fell asleep allowing Resident A to elope from the facility without her knowledge, walk to the gas station, and steal items causing law enforcement to return him to the home. Resident A has a history of eloping from the facility. Mr. Everett and Resident D both stated Resident A has tried to elope several times throughout the last few weeks in February 2025. According to Resident A's *Assessment Plan for AFC Residents* and *Behavior Treatment Plan*, he requires "line of sight' supervision within the community which he did not have during this incident. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_____02/26/2025_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

02/26/2025

_____

Dawn N. Timm
Area Manager

Date