



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 2, 2025

Kim Lich
3014 Marvin Drive
Adrian, MI 49221

RE: License #: AF460402901
Investigation #: 2025A1032046
Liberty Place

Dear Kim Lich:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (616) 356-0100.

Sincerely,

A handwritten signature in black ink, appearing to read "Dwight Forde".

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF460402901
Investigation #:	2025A1032046
Complaint Receipt Date:	08/19/2025
Investigation Initiation Date:	08/27/2025
Report Due Date:	10/18/2025
Licensee Name:	Kim Lich
Licensee Address:	3014 Marvin Drive Adrian, MI 49221
Licensee Telephone #:	(517) 265-9354
Name of Facility:	Liberty Place
Facility Address:	3014 Marvin Drive Adrian, MI 49221
Facility Telephone #:	(517) 265-9354
Original Issuance Date:	03/06/2020
License Status:	REGULAR
Effective Date:	11/08/2024
Expiration Date:	11/07/2026
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's supervision needs were not met.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/19/2025	Special Investigation Intake 2025A1032046
08/27/2025	Special Investigation Initiated - On Site
08/29/2025	Contact - Document Received
08/29/2025	Contact - Document Received
08/29/2025	Inspection Completed On-site
08/29/2025	Contact - Document Received MiCourt review

ALLEGATION:

Resident A's supervision needs were not met.

INVESTIGATION:

On 8/19/25, I received notice of a complaint at Liberty Place from Officer Brian Burke, where Resident A was found wandering the street. I was advised that law enforcement responded to the call for service at approximately 8:30 PM. He stated a concerned citizen had called the police department when they noticed Resident A wandering the streets appearing lost just before the dark of night. Officer Burke stated when he arrived at the home with the resident the alarm on the door was loudly sounding, and the staff were not aware the resident had left. He stated that they believed the resident was in their bed and not outside the home.

On 8/27/25, I interviewed employee Cathy Edmon in the home. Ms. Edmon reported that Resident A had left the home at night while licensee Kim Lich was using the restroom. She advised that Resident A had disabled the alarms on the door before

leaving. I was told that Resident A was on hospice and was recently admitted to the home. I asked to see copies of Resident A's assessment plan and care agreement, for the purpose of determining what level of supervision was required, but Ms. Edmon stated that she did not have access to that information. I conveyed to Ms. Edmon that I would need copies of all resident care agreements and assessment plans, and Ms. Edmon stated that she would deliver the message to Ms. Lich, who reportedly had that information in her area of the home.

Ms. Edmon stated that the home has six residents.

I interviewed Resident A in the home. Resident A expressed satisfaction with the care provided. When asked about the episode that brought her to the department's attention, Resident A had no recollection of the event.

During my onsite inspection I observed all six residents. They mingled in the living room, dining room and the back porch.

On 8/29/25, I interviewed an employee who identified herself as "Shawny", in the home. Ms. Shawny allowed me access to the resident files, where I reviewed Resident A's assessment plan. The plan detailed Resident A's need for staff prompting and direction with tasks due to cognitive decline.

I observed Ms. Shawny redirecting a resident who was trying to walk out of the home, and I noted that an alarm was triggered sounding loudly.

Resident A did not recognize me from the previous visit.

I reviewed Resident A's assessment plan, which indicated that Resident A was able to move independently in the community.

APPLICABLE RULE	
R 400.1407	Resident admission and discharge criteria;
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: (a) The amount of personal care, supervision, and protection required by the resident is available in the home.

FOR REFERENCE: MCL 400.703	Definitions; A.
	(9) "Assessment plan" means a written statement prepared in cooperation with a responsible agency or person that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services taking into account the preferences and competency of the individual.
ANALYSIS:	Resident A's assessment plan indicated that she moves independently in the community. However, based on Resident A's confusion related to dementia cognitive decline, it does not appear that an accurate assessment plan was developed for staff to reference to ensure her safety needs were met. As a result, Resident A left the home, without the employees' knowledge, was found and returned to the home by the local police.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

On 5/3/24, I sent licensee Kim Lich a copy of special investigation # 2024A1032033, where I issued a citation for not following health care recommendations. At that time, I also made a referral that initiated law enforcement involvement. This resulted in Ms. Lich being charged, then convicted of vulnerable adult abuse 4th degree.

On 8/29/25, I noted through an internet search of *MiCourt Case Search* that Ms. Lich had been convicted of *Misdemeanor 4th degree vulnerable adult abuse* and was placed on probation through 2A District Court in Lenawee County. She was sentenced on 8/1/25.

APPLICABLE RULE	
MCL 400.713	License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.
	(25) A licensee, licensee designee, owner, partner, or director of the licensee shall not be permitted on the premises of an adult foster care facility or have direct access to residents or resident records if he or she has been convicted of any of the following: adult abuse, neglect, or financial exploitation; or listed offenses as defined in section 2 of the sex offenders registration act, 1994 PA 295, MCL 28.722.
FOR REFERENCE: MCL 400.703a	Definitions; A.
	(5) "Adult foster care family home" means a private residence with the approved capacity to receive at least 3 but not more than 6 adults to be provided with foster care. The adult foster care family home licensee must be a member of the household and an occupant of the residence.
ANALYSIS:	Licensee Kim Lich was convicted of Misdemeanor Vulnerable Abuse, 4 th degree by the Lenawee County District Court. This conviction disqualifies her from having direct access to residents in an adult foster care home. She is non-compliant with this statute as an adult foster care family home licensee, required to live within the home, and convicted of this crime.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommend summary suspension and revocation of the license.

Dwight Ladd

9/2/25

Dwight Forde
Licensing Consultant

Approved By:

Russell Mission

9/2/25

Russell B. Misiak
Area Manager