GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2026

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

RE: License #:	AS090237189
Investigation #:	2026A0123048
	Independence House

Dear Cindy Whaley:

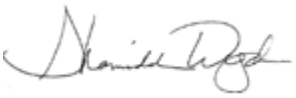
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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 #:	2026A0123048
Complaint Receipt Date:	07/23/2026
Investigation Initiation Date:	07/24/2026
Report Due Date:	09/21/2026
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:	12/05/2025
Expiration Date:	12/04/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 07/19/2026, staff Ricky Allen was cooking, and left medications on the table for Resident B. Resident A took the medications by accident.	Yes

III. METHODOLOGY

07/23/2026	Special Investigation Intake 2026A0123048
07/24/2026	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
07/31/2026	Contact - Telephone call made I made a call to the facility. I spoke with home manager Rachel Collins.
07/31/2026	Contact - Telephone call made I interviewed staff Ricky Allen.
07/31/2026	Contact - Document Received I received a copy of the incident report from Staff Collins.
08/03/2026	APS Referral Information received regarding APS Referral.
08/03/2026	Exit Conference I spoke with Licensee Designee Cindy Whaley.
08/03/2026	Contact- Telephone call received I spoke with adult protective services investigator, Chris Shores.

ALLEGATION: On 07/19/2026, staff Ricky Allen was cooking, and left medications on the table for Resident B. Resident A took the medications by accident.

INVESTIGATION: On 07/24/2026, I conducted an unannounced on-site at the facility. I interviewed Resident A. Resident A stated that it was breakfast time on 07/19/2026. She grabbed her food and saw medication on the table. Resident A thought the medications were hers, and staff told Resident A they were not Resident A's pills. Resident A reported having to go to the hospital and had to get a blood test

done. Resident A stated that all she saw was two white pills and does not know how many pills she took in total. Resident A said staff was talking to her as she was swallowing the medication. Resident A reported feeling okay and denied having any symptoms. Resident A stated this was the first time ever taking someone else's medication. Resident A stated the medication belonged to Resident B, and they were Resident B's morning medication. Resident A stated staff do not usually have pills lying around in pill cups, and Resident B was not out (in the dining room) yet.

During this onsite, staff Deb Schlib and all six residents were present in the facility. All the residents appeared clean and appropriately dressed.

During this on-site, I observed the locked medication cart, and resident medications. No issues were noted. I also took photos of Resident A and Resident B's documentation. Resident A is diagnosed with cognitive impairment, schizophrenia, and dementia per Resident A's *Health Care Appraisal* dated 03/05/2026. Resident A's *Assessment Plan for AFC Residents* dated 03/04/2026 notes that staff are to administer medications to Resident A per physician orders. A professional order dated 07/21/2026 notes that the facility's home nurse requested staff to watch for confusion, dizziness, falls, and observe urine and bowel output. Staff were also instructed to monitor Resident A for swallowing and drooling. Vitals are to be taken three times a day until Friday (07/24/2026), and staff are to call if they are any abnormal changes. Resident A and Resident B's medication administration records were reviewed. Staff initials are noted as passed for 8:00 am medications on 07/19/2026 for both Resident A and Resident B.

On 07/31/2026, I made a follow-up call to the facility. I spoke with home manager Rachel Collins. She stated that Resident A did not get sick behind taking Resident B's medication. A call was made to poison control, and Resident A went to the hospital. Staff had to check Resident A's vitals for a week, three times per day, and kept an eye on Resident A's urine and bowel output. She stated that staff Ricky Allen has been at the company for about two to three years. Staff Allen was retrained in medication administration and finished the retraining this week. She stated that there is one incident report from a year ago in July 2025 where Staff Allen forgot to pass Resident A's medication on 07/11/2025.

On 07/31/2026, I received a copy of the *AFC Licensing Division Incident/Accident Report* dated 07/19/2026. The incident report notes that at 8:15 am, "*While staff was cooking left meds on table for different peer. [Resident A] took meds with the impression of them being her meds by accident. Home manager contacted nurse and poison control. [Resident A] was immediately taken to hospital by staff*." Corrective measures state "*taken to hospital to be tested and monitored for signs of overdose. Vitals to be taken hourly, labs done. 24-48 hours, PCP will be called*."

On 07/31/2026, I interviewed staff Ricky Allen. Staff Allen stated that on 07/19/2026, he was in the kitchen cooking. He noticed Resident A and Resident B were not out of their rooms yet. Staff Allen had Resident B's medication on the table. While he was

seasoning chicken for dinner that day, Resident A took Resident B's medications. Staff Allen stated his back was turned at the time Resident A sat at the table and took the medication. He stated that Resident A usually comes out of her bedroom in the morning and speaks first. Resident A did not say anything and went straight to the table. He stated that he called the nurse, poison control, and got Resident A to the hospital. He stated that Resident A swallowed the medication without any food or drink. He stated Resident B takes about eight to twelve pills in the morning, and Resident A took all of them. Resident A only has three morning pills.

On 08/03/2026, I spoke with adult protective services investigator Chris Shores. Chris Shores confirmed that he is investigating the allegations as well.

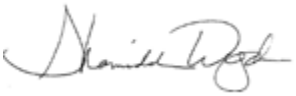
On 08/03/2026, I conducted an exit conference with LD Cindy Whaley, LD Whaley stated that staff Ricky Allen was retrained in medication passing and passed the training. LD Whaley stated that Staff Allen did three supervised medication passings, and a fourth one with a Bay Arenac Behavioral Health nurse. I informed her of the findings of this special investigation.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	On 07/24/2026, I conducted an unannounced on-site at the facility. I interviewed Resident A. Resident A confirmed accidentally taking Resident B's medication that was on the table in a pill cup. On 07/31/2026, I interviewed staff Ricky Allen. Staff Allen confirmed leaving Resident B's medications out on the table, and Resident A took the medication while Staff Allen was not paying attention. On 07/31/2026, I made a follow-up call to the facility. I spoke with home manager Rachel Collins who confirmed Staff Allen was responsible for the medication error, and Staff Allen was re-trained. During the course of the investigation, I reviewed an *AFC Licensing Division Incident/Accident Report* dated 07/19/2026 that documented the medication error. There is a preponderance of evidence to substantiate a rule violation, as Resident A took medication on 07/19/2026 that

	was not ordered by a physician for Resident A, due to Staff Allen leaving Resident B's medications out in the open.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



08/05/2026

Shamidah Wyden Date
Licensing Consultant

Approved By:

08/05/2026

Mary E. Holton Date
Area Manager