



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

August 21, 2018

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

RE: License #:	AS410391964
Investigation #:	2018A0356041
	Enriched Living

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 responsible party and a date.

If you desire technical assistance in addressing these issues, please 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410391964
Investigation #:	2018A0356041
Complaint Receipt Date:	07/19/2018
Investigation Initiation Date:	07/19/2018
Report Due Date:	09/17/2018
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
Facility Address:	929 Maplerow Ave. NW Walker, MI 49534
Facility Telephone #:	(586) 295-1674
Original Issuance Date:	04/20/2018
License Status:	TEMPORARY
Effective Date:	04/20/2018
Expiration Date:	10/19/2018
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, TRAUMATICALLY BRAIN INJURED, AGED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents were unsupervised on 07/14/2018 because staff was sleeping in the basement of the facility.	Yes

III. METHODOLOGY

07/19/2018	Special Investigation Intake 2018A0356041
07/19/2018	Special Investigation Initiated - Face to Face Gathered info. from LC, A. Smith who also received additional information from Network 180, Ed Wilson.
07/30/2018	Contact - Face to Face facility-interviewed Jeff Labie at the facility.
07/30/2018	Contact - Telephone call received Licensee Laurie Labie.
08/03/2018	Contact - Face to Face Licensee Laurie Labie and Jeff Labie.
08/06/2018	APS Referral
08/06/2018	Contact - Telephone call made DCW Tiffany Johnson.
08/13/2018	Contact - Document Sent Laurie Labie (text to her) stating Tiffany has not responded for interview.
08/13/2018	Contact - Document Received Laurie Labie will contact Tiffany again to ask her to contact me for an interview.
08/20/2018	Contact - Document Sent Laurie Labie, Tiffany still has not contacted me for interview.
08/20/2018	Contact-Document Received Laurie Labie, Tiffany did not show up for work and is not answering my phone calls or texts.
08/20/2018	Exit Conference Laurie Labie-Licensee Designee

ALLEGATION: Residents were unsupervised on 07/14/2018 because staff was sleeping in the basement of the facility.

INVESTIGATION: On 07/19/2018, I received an anonymous BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported on 07/14/2018 from 4-5:00PM, the complainant was visiting a relative at the facility and noticed there was no staff around. The complainant reported they looked all over for staff, went downstairs and found staff in a bed in the basement sleeping under the covers. The complainant reports staff was gone for at least one hour or more. The complainant stated they called the home owner and the home owner stated the staff would be let go that day. The complainant stated they came back the following day, 07/15/2018 and the staff was still working. The complainant stated staff said she started working on Friday night 07/13/2018 and was still working on Sunday 07/15/2018 with no break in her work day.

On 07/30/2018, I conducted an unannounced inspection at the facility. I met Jeff Labie at the facility and he acknowledged there was a Direct Care Worker (DCW), Tiffany Johnson working the weekend of 07/13/2018-07/15/2018 that fell asleep while working at the facility during the day while the residents were up. Mr. Labie stated staff has already been given extra training and Ms. Johnson has been disciplined but she is still part of the staff.

On 07/30/2018, I interviewed Licensee Laurie Labie via telephone. Ms. Labie stated the weekend schedule for Ms. Johnson is from Saturday 8:00AM through Sunday night at 10:00PM, every other weekend. Ms. Labie stated considering this incident, the weekend schedule has been changed to 8:00AM on Saturday to 8:00AM on Sunday. Ms. Labie stated staff is given breaks where they can leave the facility for periods of time, but they are required to remain awake while at the facility including throughout the night time hours. Ms. Labie stated Ms. Johnson fell asleep at the facility during day time hours while residents were in the facility. Ms. Labie stated she received a telephone call from a relative and dealt with the situation within 48 minutes of the call from the visiting relative. Ms. Labie stated Ms. Johnson is new and she has been disciplined and retrained including the decrease in the weekend shift hours. Ms. Labie stated none of the residents were harmed during the time, but Ms. Johnson was sleeping and emphasized this is not the way the facility is run.

On 08/06/2018 & 08/13/2018, contacts with Ms. Johnson were attempted with no return telephone call or contact. On 08/20/2018, Ms. Labie reported Ms. Johnson no longer works at the facility and will no longer return any texts or telephone calls to her either.

On 08/20/2018, I conducted an Exit Conference with Ms. Labie, Licensee Designee. Ms. Labie stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	<p>On 07/14/2018 from 4-5:00PM, the complainant noticed there was no staff around and found staff in a bed in the basement sleeping under the covers.</p> <p>Mr. Labie & Ms. Labie acknowledged staff Ms. Johnson fell asleep at the facility on 07/14/2018 while residents were there.</p> <p>On 08/06/2018 & 08/13/2018, attempts were made to contact Ms. Johnson for an interview with no response.</p> <p>Residents were left without supervision at the facility from approximately 4:00PM-5:00PM on 07/14/2018.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Elizabeth Elliott

08/21/2018

Elizabeth Elliott
Licensing Consultant

Date

Approved By:

Jerry Hendrick

08/21/2018

Jerry Hendrick
Area Manager

Date