GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 18, 2025

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

RE: License #: AS410383295
Investigation #: 2025A0579023
Enriched Living - Highlander

Dear Laurie 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410383295
Investigation #:	2025A0579023
Complaint Receipt Date:	02/28/2025
Investigation Initiation Date:	03/05/2025
Report Due Date:	04/29/2025
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 - Highlander
Facility Address:	242 Highlander Dr. NE, Rockford, MI 49341
Facility Telephone #:	(616) 884-5117
Original Issuance Date:	12/06/2016
License Status:	REGULAR
Effective Date:	06/06/2023
Expiration Date:	06/05/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents are not treated with respect by direct care workers.	Yes

III. METHODOLOGY

02/28/2025	Special Investigation Intake 2025A0579023
03/05/2025	Special Investigation Initiated – Document sent Office of Recipient Rights
03/31/2024	Contact- Telephone call made Complainant
03/31/2025	Contact- Face to Face Resident A, Resident B, and Ricky Everett (Direct Care Worker)
03/31/2025	Contact- Telephone call received Complainant
03/31/2025	Contact- Document sent Office of Recipient Rights
04/01/2025	Contact- Document received Jeannie Haff, Kent County ORR
04/02/2025	Contact- Telephone call made Jeannie Haff, ORR
04/03/2025	Contact- Telephone call made Jeannie Haff, ORR
04/07/2025	Contact- Telephone call received Jeannie Haff, ORR
04/08/2025	Contact- Telephone call made Jeannie Haff, ORR
04/08/2025	Contact- Document sent Jeannie Haff, ORR
04/10/2025	Contact- Document sent Laurie Labie, Licensee Designee

04/14/2025	Contact- Telephone call made Perry Smith, Direct Care Worker
04/14/2025	Contact- Telephone call made Tom Stefanski, Direct Care Worker
04/15/2025	Contact- Telephone call received Perry Smith, Direct Care Worker
04/15/2025	Contact- Document received Additional Intake
04/15/2025	Contact- Document sent Milessa Leach, Montcalm County ORR
04/17/2025	Exit Conference Laurie Labie, Licensee Designee
04/18/2025	Contact- Telephone call received Laurie Labie, Licensee Designee

ALLEGATION: Residents are not treated with respect by direct care workers.

INVESTIGATION: On 2/28/25, I received this referral which alleged direct care workers (DCWs) are required to go back at the end of the month and add resident behaviors because they are told not enough resident behaviors are reported for residents each month. DCWs will go back and rewrite Incident/Accident Reports and change behavior logs. DCWs are told if residents are not having behaviors, DCWs are being “too soft on” them. DCW Perry Smith aggravates residents to provoke behaviors so there are behaviors to report. One day he took all but one of the residents out to get fast food to provoke the resident who was left out. He takes resident books out of the home and makes DCWs rewrite their notes and throws away the old ones.

On 3/5/25, I forwarded the allegations to network180 Office of Recipient Rights (ORR).

On 3/31/25, I attempted a telephone call with the complainant prior to arriving at the home. The call immediately went to voicemail and a message was not left as I intended to follow-up with the complainant after leaving the home.

On 3/31/25, I completed an unannounced on-site investigation at the home. Interviews were completed with Resident A and Resident B as they were the only residents at the home at that time. An interview was also completed with DCW Ricky Everett.

Resident A reported he feels safe in his home. He stated other residents in the home have behaviors, but his behavior log is good because he does not. He denied concerns regarding DCWs. He stated when residents are having behaviors, DCWs attempt to stop the behaviors and tell them to “cut it out.” He stated the behaviors residents have in the home are arguing and yelling but no one hurts each other. He stated DCWs do not encourage the arguing or yelling in the home, residents “do that themselves.” He denied having any concern regarding his care at this home.

Resident B stated he does not have concerns about current staff in the home. He reported he misses former DCW Perry Smith and DCW Shane (last name unknown). He stated he disliked a former DCW Tom Stefanski. He stated Mr. Stefanski worked in the home last year and he would call residents names and scream at them at the library and outside of the home. He stated he did not like Mr. Stefanski. Resident B talked about his dislike of Mr. Stefanski throughout the interview and often had to be redirected back to the topic being discussed. Resident B denied having any concern regarding any of the current DCWs in the home. Resident B stated he does not regularly have behaviors and DCWs do not encourage him to have behaviors, they try to remind him to follow his behavior plan. He stated he has accidentally had sexually harassing behaviors with another resident, where he reached for his groin as “horseplay” and DCWs told him that was not appropriate. He stated part of his treatment plan is not having sexual harassment behaviors. He stated his other behavior goals are not yelling and swearing. He stated none of the residents in the home hurt each other, but they may argue because they all live in the house together, but it is not serious and does not occur often. He stated DCWs support him in his behavioral treatment plan and since Mr. Stefanski no longer works at this home, he feels safe now.

Mr. Everett stated he is the lead worker for this home and began at this home approximately a month ago. He denied that DCWs encourage resident behaviors or falsify resident behavior logs. He stated as the lead worker, he prepares the monthly behavior logs to send to Ms. Labie, which he was doing when I arrived at the home, and I observed him. He stated he has no reason to think Ms. Labie or anyone at Enriched Living, LLC would alter documents or encourage resident behaviors. He stated in this home, residents “don’t really have behaviors.” He stated they may occasionally yell and swear, and Resident B has a behavioral treatment plan for specific behaviors but otherwise, residents in this home do not have behaviors. He stated he has not had to fill out an incident report form in the time he has worked in this home because there are no behaviors. He stated he has never felt pressure to encourage resident behaviors, nor has any DCW expressed this concern to him.

I reviewed the resident behavior logs and weekly notes that Mr. Everett was placing into an accordion folder that he reported would be delivered to Ms. Labie since it was the end of the month. I did not notice a pattern of behaviors increasing at the end of the month for any of the residents. None of the documents appeared altered. Mr. Everett reported DCWs fill the daily log out daily, which appeared consistent with the change of handwriting and pen colors on each section of the log. He stated if the

documents were altered, it would be clear to see. He stated he takes the logs from the binder they are in and prepares them for Ms. Labie. In reviewing the behavior log, no significant behaviors were noted. There were comments such as a resident was not feeling well or seemed upset due to a personal matter but nothing noting any significant behaviors for the residents.

On 3/31/25, I received a return phone call from the complainant. She stated she feels DCW Perry Smith intentionally instigated residents to make them upset. She stated she does not know if he was advised by administrative staff at Enriched Living, LLC to do this to increase resident behaviors or if it is his personality and something he enjoys doing on his own. She stated he was the first shift lead worker until October 2024 when he left for another position at Enriched Living, LLC. She stated now he has a position training DCWs, and he continues to come to the home and interact with residents in that role. She stated when he was the lead worker, he told DCWs in a meeting that they should be "documenting resident behaviors honestly" which she feels was him encouraging DCWs to document any behavior a resident has and "they weren't allowed to have a bad day." She stated the residents are adults and should be allowed to be upset, yell, and swear without it being noted as a behavior. She stated she feels that was wrong.

The complainant stated as the lead worker, Mr. Smith created inconsistency in the home which she feels was intentional to upset residents. She stated on one occasion; he allowed a resident to stay up playing video games in the basement of the home until third shift arrived which disturbed two residents who go to bed early whose rooms are in the basement. She stated the third shift DCW then had to encourage the resident to go to bed when they arrived. She stated the resident would say Mr. Smith told him it was his right to stay up. She stated this created conflict and inconsistency, and it potentially made three residents tired, and due to being tired, they would potentially have more behaviors.

The complainant stated on one occasion Mr. Smith took residents out to eat, one resident did not go, and the other residents returned and ate their food at the home so that resident was left out. She stated Mr. Smith did not need to bring the residents back to the home to eat their food, they could have remained at the restaurant to eat, instead of upsetting the resident who did not go and therefore encouraging him to have behaviors because he was upset.

The complainant stated Mr. Stefanski was verbally abusive to residents and was investigated by the Office of Recipient Rights (ORR) and no longer allowed to be in the home due to neighbors reporting they heard Mr. Stefanski screaming at residents in the driveway of the home. She stated Mr. Smith allowed this behavior and did not appropriately report it to Human Resources because Mr. Stefanski is his friend. She stated when this was reported to Human Resources, they believed Mr. Smith and did not investigate it seriously until ORR got involved. She stated Mr. Smith has continued to allow Mr. Stefanski to work in the home and remain a DCW, even though concerns were reported about Mr. Stefanski. She stated Mr. Smith

would threaten residents that he would kick them out because he had to “fire his best friend” or that he would sue them for false reports if they reported any DCW behaviors to ORR. She stated, overall, residents were not treated with respect by Mr. Stefanski and Mr. Smith, and this could be confirmed by ORR.

On 3/31/25, I contacted network180 ORR officer Jeannie Haff requesting assistance with the ORR referral for these allegations. She responded she investigated both Mr. Smith and Mr. Stefanski and Mr. Stefanski was substantiated due to his language and threatening behavior. She expressed concern regarding Mr. Smith’s behavior as well, although there was insufficient evidence to substantiate allegations against Mr. Smith. She stated Mr. Stefanski is no longer working as a DCW as of 2/4/25, per a letter submitted to her by Enriched Living, LLC and she does not have concern that he is continuing to work in the home.

On 4/8/25, I requested a copy of Ms. Haff’s report.

On 4/9/25, I received a copy of Ms. Haff’s report. Resident B expressed concern regarding Mr. Stefanski to Ms. Haff as well. Resident C, Resident D, and Resident E also expressed concern that Mr. Stefanski “should not be working with people who need help” and that he has yelled at, sworn at, and threatened them and slammed objects in the home. Ms. Haff attempted to interview Mr. Stefanski but he did not respond to multiple attempts at interviewing. It was confirmed that Mr. Stefanski had resigned from his position and was no longer working in the home. Ms. Haff asked residents if Mr. Smith threatened to “kick them out” because he “fired his best friend” and the residents denied that occurring. Ms. Haff interviewed a former DCW who reported he witnessed Mr. Stefanski treat residents poorly and swear at them, to the point that some would not come out of their room when Mr. Stefanski was in the home. He reported there was a previous incident where due to Mr. Stefanski’s behavior, his employment was terminated, but he was instead moved to another AFC home and then returned to this home. This former employee reported they resigned due to Mr. Smith’s behavior toward DCWs and residents because Mr. Smith comes across as aggressive and threatening even when he may not intend to. Ms. Haff attempted contact with Mr. Stefanski multiple times but he did not respond.

On 4/10/25, I requested contact information for Mr. Stefanski and Mr. Smith from Ms. Labie. Ms. Labie expressed concern that allegations involving Mr. Smith and Mr. Stefanski were made by a disgruntled former employee and already investigated by several agencies. I advised her they were not investigated by licensing until this investigation, so I would need to speak to Mr. Smith and Mr. Stefanski as well.

On 4/14/25, I attempted a telephone interview with Mr. Smith. A voicemail message was left requesting a return phone call.

On 4/14/25, I attempted a telephone interview with Mr. Stefanski. A voicemail message was left requesting a return phone call. A return phone call was not received at the time of report disposition.

On 4/15/25, I completed a telephone interview with Mr. Smith. He reported he is aware that a disgruntled former employee is spreading false claims about him to ORR and in the community. He stated nothing she says is true and he is pursuing a “Cease and Desist” action against her. He denied falsifying documentation, instigating resident behaviors, directing other DCWs to instigate resident behaviors, directing DCWs to report increased behaviors at the end of the month, and not addressing concerns regarding Mr. Stefanski. He stated residents in the home are “tough” and Resident F, especially, has challenging behaviors so there are a lot of behaviors in this home. He denied that resident behaviors are in any way falsified or manipulated.

Mr. Smith stated Mr. Stefanski is “a direct person” who does not “show emotion” so he would have to speak to Mr. Stefanski about “setting the tone for the day” with residents but it was not reported to him that Mr. Stefanski was inappropriate, he could have just shown more emotion toward the residents to make them more comfortable. He denied that residents ever addressed concerns for Mr. Stefanski’s behavior with him until the incident that led to Mr. Stefanski resigning from the home. He stated, as far as he knows, there was only one reportable incident involving Mr. Stefanski and then Mr. Stefanski resigned. He stated the incident was that residents had gone to the library and returned with items from the trash and placed them out in the home. He stated this upset Mr. Stefanski and due to Mr. Stefanski being upset, he ignored Resident F when he asked for a PRN medication and therefore Resident F did not receive the PRN he requested. He stated once this incident was reported to him, he addressed it immediately, and Mr. Stefanski decided to resign and no longer provides direct care. He denied not appropriately reporting concerns for Mr. Stefanski to Human Resources.

Mr. Smith denied that he threatened residents after Mr. Stefanski resigned. He stated Resident F is often upset and you must be direct with Resident F. He stated one time when he was in the home after Mr. Stefanski resigned, all the residents were at the table talking to him and Resident F expressed that he was not happy at the home. He stated he told Resident F if he was unhappy at the home, Resident F could request to find a new placement. He stated he was not rude or threatening and it was not related to Mr. Stefanski’s resignation that he made that statement.

On 4/15/25, I received an additional intake which alleged Montcalm Care Network's ORR was made aware at the beginning of February 2025 that Mr. Stefanski was yelling and swearing at residents. It was reported Mr. Stefanski was “blowing up” on residents and due to him being friends with Mr. Smith, Enriched Living was not addressing Mr. Stefanski’s behavior. Two DCWs reported Mr. Stefanski said in front of residents that they were “nasty”, called them a vulgar name, and said the residents were going to give him communicable diseases. These allegations were investigated by ORR officer Milessa Leach.

On 4/15/25, I contacted Ms. Leach who reported she was unable to interview Resident F, who is the only resident who receives services through Montcalm Care

Network in this home, due to his declining mental health but he left her a voicemail message stating everything he previously said about Mr. Smith is a lie. She stated she attempted to interview Mr. Stefanski three times with no response. She stated she is also substantiating Mr. Stefanski due to his treatment toward residents and Mr. Smith for not properly reporting Mr. Stefanski's treatment of Resident F to ORR.

On 4/18/25, I received a telephone call from Ms. Labie. She stated that Resident B has a known behavior for lying and she has concern that Resident B is still discussing Mr. Stefanski since the allegations involving Mr. Stefanski occurred in February 2025 and Mr. Stefanski has not been in the home since that time. She stated these allegations stem from a disgruntled former employee who did not like the "culture change" that occurred when a new employee accountability system was implemented through Enriched Living, LLC. She gave the example that the former employee liked to arrive up to 20 minutes after her scheduled shift start time and it was allowed, to help maintain staffing, prior to this accountability system being implemented. She stated it was no longer allowed once the new system was put in place. She stated due to not liking this program, the employee ended her employment and has gone on to report varying allegations to numerous agencies.

Ms. Labie stated she is always accessible to DCWs, they have her contact information, and employees have regular 1:1 meetings with management. She stated the former employee also had an immediate supervisor, who was not Mr. Smith, that she regularly contacted. She stated the concerns that are being reported now were never brought up to her or the immediate supervisor. She stated this employee worked with Mr. Smith for four years and worked with Mr. Stefanski, as well, and never expressed these concerns. She denied that the initial allegations are true. She denied that Mr. Stefanski was ever removed from the home due to his behavior and allowed back into the home. She confirmed the only incident of inappropriate behavior she was aware of was Mr. Stefanski's refusal to give Resident F a PRN which ultimately led to his resignation.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	The complainant expressed concern that residents were not treated with consideration and respect by former direct care worker Mr. Stefanski and current Enriched Living, LLC administrative worker Mr. Smith. Resident B continuously expressed concern regarding his treatment by Mr. Stefanski when interviewed and had to be redirected often. He reported Mr. Stefanski would scream at residents and call them names. Ms. Haff from network180 Office of Recipient Rights confirmed she also investigated the allegations and found sufficient evidence regarding Mr. Stefanski's behavior. During her investigation, Resident B, Resident C, Resident D, and Resident E expressed concern regarding Mr. Stefanski yelling at, swearing at, and threatening residents. Ms. Leach from Montcalm Care Network Office of Recipient Rights reported she investigated the allegations as well and substantiated Mr. Stefanski for his behavior and Mr. Smith for failing to appropriately report Resident F's treatment by Mr. Stefanski. Mr. Smith denied concerns regarding Mr. Stefanski's behavior were brought to his attention until an incident where Mr. Stefanski became upset and ignored Resident F which led to Resident F not receiving a PRN he requested. He stated that incident was addressed appropriately and after that incident, Mr. Stefanski resigned. He stated any other allegations against him are false. Telephone interviews were attempted Mr. Stefanski by licensing and both ORRs. He did not respond to any requests for interview. Ms. Labie confirmed Mr. Smith's account of the allegations, noting a disgruntled former employee has made varying allegations to multiple agencies. She stated the former employee never reported while employed by Enriched Living, LLC although the former employee had access to and regular meetings with Ms. Labie and management. Based on the interviews completed, there is sufficient evidence that residents were not treated with consideration, respect, and dignity due to the behavior of Mr. Stefanski.

CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/17/25, I attempted an exit conference via telephone with Ms. Labie. The call was not answered, so I left a voicemail message. I followed-up with an email explaining the allegations, findings, concerns that arose during the investigation, and requested a reply.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 04/18/2025

Cassandra Duursma, LLMSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 04/18/2025

Jerry Hendrick Date
Area Manager