GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 26, 2026

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

RE: License #:	AS090254908
Investigation #:	2026A0123013
	Wilson House

Dear Cindy Whaley:

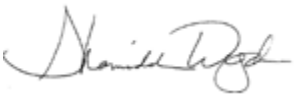
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS090254908
Investigation #:	2026A0123013
Complaint Receipt Date:	01/07/2026
Investigation Initiation Date:	01/07/2026
Report Due Date:	03/08/2026
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:	Wilson House
Facility Address:	500 Wilson Street Bay City, MI 48708
Facility Telephone #:	(989) 894-8592
Original Issuance Date:	02/05/2003
License Status:	REGULAR
Effective Date:	08/07/2025
Expiration Date:	08/06/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/04/2026, Staff Terry LaFond, while arguing with Resident A, grabbed Resident A's shirt and pushed Resident A.	Yes

III. METHODOLOGY

01/07/2026	Special Investigation Intake 2026A0123013
01/07/2026	Special Investigation Initiated - Telephone I spoke with APS investigator Chris Shores.
01/07/2026	APS Referral Information received regarding APS referral.
01/08/2026	Inspection Completed On-site I conducted an unannounced on-site at the facility.
01/21/2026	Contact- Document Sent Sent email requesting documentation from the facility.
01/22/2026	Contact- Documents Received Received requested documentation via fax.
01/23/2026	Contact - Telephone call made I interviewed staff Terry LaFond.
01/23/2026	Contact - Telephone call made I interviewed staff Kim Kihn.
01/26/2026	Contact- Telephone call made I interviewed Resident A via phone.
01/26/2026	Exit Conference I spoke with licensee designee Cindy Whaley.

ALLEGATION: On 01/04/2026, Staff Terry LaFond, while arguing with Resident A, grabbed Resident A's shirt and pushed Resident A.

INVESTIGATION: On 01/05/2026, the Bureau of Community Health Systems received an online complaint regarding the allegations noted above. The complaint also notes that Staff Kim Kihn witnessed the incident at shift change, intervened and

informed Staff Terry LaFond his behavior was unacceptable. Other residents were present. Resident B informed management that Staff LaFond grabbed Resident A and threw Resident A on the bed. On 01/05/2026, Staff LaFond reported the incident to management, describing it as a "*scuffle*" and they "*went at each other*." Staff LaFond laughed it off and reported apologizing to Resident A.

On 01/07/2026, I spoke with adult protective services worker Chris Shores via phone. Chris Shores stated that he interviewed Resident A. Resident A reported having words with Staff LaFond. Staff LaFond grabbed Resident A's shirt on the shoulders and pushed Resident A back into Resident A's bedroom. Resident A grabbed the door jamb to stop Staff LaFond from pushing Resident A. Resident A said Staff LaFond was not trying to hurt Resident A, just trying to get Resident A to his room. Staff LaFond came back and apologized to Resident A a few minutes later.

On 01/08/2026, I conducted an unannounced on-site at the facility. I interviewed Resident B and Resident C. Both residents reported witnessing the incident between Resident A and Staff LaFond on 01/04/2026. Resident A was not present.

Resident B was interviewed. Resident B stated that last weekend, Staff Kim Kihn was at the facility. Staff Terry LaFond came in. Staff LaFond had previously asked residents to wash their bedding. Staff LaFond became upset that Resident A did not get his laundry done. Resident B stated that Staff LaFond picked Resident A up and threw Resident A against the wall, then across the room by Resident A's neck. Resident B reported believing Resident A is scared of Staff LaFond, because Resident A said he'd stay in his room all day and night if Staff LaFond comes back. Resident B stated that when Staff LaFond becomes upset if they (the residents) don't do what Staff LaFond asks, Staff LaFond will yell at them in response. Resident B stated that Staff LaFond has not put his hands on other residents, that Resident B is aware of. Resident B stated that the incident happened at the start of Staff LaFond's shift. Resident B stated that everyone was worried about Resident A. Resident B reported that it was the first time seeing Staff LaFond act like that. Resident B stated that Staff LaFond should be fired, because they no longer trust Staff LaFond, don't care for him, and because of the violence Staff LaFond caused. Resident B stated that Resident A did not receive an apology from Staff LaFond.

Resident C was interviewed. Resident C reported being at the kitchen counter when Staff LaFond came around the corner, grabbed Resident A by the shirt/collar. Staff Kim Kihn came around the corner and told them "*Hey boys! Don't be doing that*." Resident C stated that Resident A said to Staff LaFond, "*Go ahead, I dare you. I'll call recipient rights.*" Resident C stated Resident A was frustrated because Staff LaFond wanted their sheets changed and told them they all should have had their sheets changed before his shift started. Resident A got upset, threw a wood shelf on the floor (that was already broken), and that is when Staff LaFond came around and yelled, "*Hey, you can't be doing that shit*!" Staff LaFond then grabbed Resident A by the shirt really tight. Resident C reported this was the first time seeing Staff LaFond act this way. Resident C stated Resident A was frustrated about not having enough

time to put laundry in the washer, but everyone else did. Resident C stated that Staff LaFond said he was not feeling good (i.e., migraine). Resident C stated it made him feel mad/angry that Staff LaFond did what he did. Resident C stated that Staff LaFond tried to push Resident A into his bedroom. Resident A planted his feet to stop Staff LaFond from pushing him into the bedroom. Resident C stated Resident A's bedroom door was half closed at the time. Resident C stated that Staff LaFond released his grip when Staff Kihn got in the middle of Staff LaFond and Resident A and told them to cut it out. Resident C stated that Staff LaFond should either quit or be fired because Resident C does not want to see any more violence.

On 01/22/2026, I received requested documentation via fax. A copy of Resident A's *Assessment Plan for AFC Residents* dated 11/04/2025 was received. Resident A's assessment plan notes that Resident A is mostly independent with personal care, only needing occasional reminders for showers and prompting for hygiene tasks. The assessment plan also notes that Resident A participates in household chores when asked or encouraged.

On 01/23/2026, I interviewed staff Terry LaFond via phone. Staff LaFond stated that he has worked for Liberty Living, Inc. for about six to seven years. Staff LaFond stated that on 01/04/2026, he was tired. Staff LaFond stated that his relationship with Resident A goes back about five to six years, and he thinks of Resident A as a little brother. Staff LaFond stated that he "*just kind of lost it*" after Resident A broke a board. Staff LaFond stated that he approached Resident A and grabbed Resident A's shirt. They looked at one another, and he let Resident A's shirt go. Staff LaFond stated that he and Resident A had a talk afterwards. Staff LaFond stated that he regrets that the situation occurred. When asked what was said between Staff LaFond and Resident A during this incident, Staff LaFond stated that they were arguing about bed sheets, and that he said some things, and Resident A said some things, but stated he did not remember exactly what was said. Staff LaFond stated that prior to this, he had never put his hands on Resident A. Staff LaFond stated that Resident A is like "*my little brother*" and that "*it's killing me, to be honest*." Staff LaFond stated that it was a regular day after everything calmed down. Staff LaFond stated that staff Kim Kihn was present, witnessed the situation, and told them to stop. Staff LaFond stated that he was already done at that point.

On 01/23/2026, I interviewed staff Kim Kihn via phone. Staff Kihn stated that the situation happened quickly. Staff LaFond arrived at work, they were having their shift change conversation, and Staff LaFond appeared to have an attitude. Staff LaFond got upset with Resident A over something. Staff Kihn stated that she was sitting at the med table, and Resident A's bedroom door was behind her. Staff Kihn heard yelling, turned around and observed that Staff LaFond had grabbed Resident A's shirt and pushed Resident A into Resident A's bedroom. Staff Kihn stated that Staff LaFond let go of Resident A. Staff Kihn stated that from what she heard, Staff LaFond had pushed Resident A onto Resident A's bed. Staff Kihn stated that afterwards, Resident A came out and sat at the dining room table with Staff LaFond, and they talked about how what happened between them should not have happened.

Staff Kihn stated that she asked Resident A if Resident A was okay, and Resident A said yes. Staff Kihn stated that she left the facility, then called home manager Rachel Collins. Staff Kihn met up with Staff Collins and reported what she witnessed. Staff Kihn stated that Staff LaFond raised his voice that day and has raised his voice before one other time that she's witnessed. Staff Kihn stated that Staff LaFond grabbing Resident A and pushing Resident A into the bedroom did not sit well with her at all. Staff Kihn stated that last weekend, Resident A mentioned Staff LaFond and was talking about how he is scared of Staff LaFond now. Staff Kihn stated the other residents were around, and Resident B said he was afraid of Staff LaFond as well. Staff Kihn stated that the altercation was over Resident A not having his sheets (laundry) washed. Staff Kihn stated that Resident B had come upstairs and told Resident A that the washer was available for Resident A to use. Staff LaFond overheard this and escalated the situation. Staff Kihn stated that she did not know Resident A had picked up a board until after Resident A threw it and it made a loud noise.

On 01/26/2026, I made a call to the facility. I interviewed Resident A via phone. Resident A stated that on 01/04/2026, Resident A was stripping bedding off the bed. Staff Terry LaFond said to Resident A "*Hurry up. Get your bedding done*." Resident A said Staff LaFond came at Resident A, Resident A then dropped a board. Staff LaFond grabbed Resident A by both shoulders and tried to push Resident A back into the bedroom. Resident A grabbed the doorway, so Staff LaFond could not continue to push Resident A all the way into the room. Resident A stated that Staff LaFond got mad and told Resident A to get the laundry done. Resident A stated that staff Kim Kihn had stepped in and told Staff LaFond to "*cut it out*." Resident A stated "*nope*" when asked if he feels safe around Staff LaFond. Resident A denied seeing Staff LaFond that angry before or treating other residents in a similar fashion. Resident A stated that he and Staff LaFond shook hands about two hours later, but Resident A still felt scared afterwards. Resident A denied having any marks or anything from the incident.

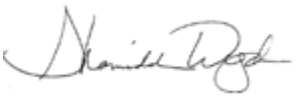
On 01/26/2026, I conducted an exit conference with Cindy Whaley phone. I informed her of the findings and conclusion. She stated that she will submit documentation of Staff LaFond's termination.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	On 01/08/2026, I conducted an unannounced on-site at the facility. I interviewed Resident B and Resident C. Both residents reported that staff Terry LaFond was physically aggressive with Resident A, grabbing and pushing Resident A.

	On 01/23/2026, I interviewed staff Terry LaFond via phone. Staff LaFond stated that he exchanged some words with Resident A and grabbed Resident A by Resident A's shirt. Staff LaFond stated that staff Kim Kihn was present, witnessed the situation, and told them to stop. On 01/23/2026, I interviewed staff Kim Kihn via phone. Staff Kihn stated that Staff LaFond arrived at work on 01/04/2026 and appeared to have an attitude. Staff LaFond got upset with Resident A over laundry. She heard yelling, and saw Staff LaFond had grabbed Resident A by the shirt and pushed Resident A. On 01/26/2026, I interviewed Resident A via phone. Resident A stated that Staff LaFond grabbed Resident A by the shoulders and tried to push Resident A into the bedroom. Resident A stated that Staff LaFond was mad that Resident A's laundry was not done. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

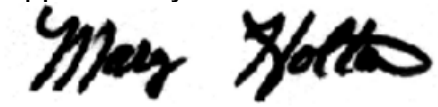
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



01/26/2026

Shamidah Wyden — Date
Licensing Consultant

Approved By:



01/26/2026

Mary E. Holton — Date
Area Manager