



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 6, 2026

Marla Garchow
Heart and Soul Living, LLC
1855 Carlisle Road
Traverse City, MI 49696

RE: License #: AS280417032
Investigation #: 2026A0009018
Heart And Soul Living, LLC

Dear Ms. Garchow:


Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame 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) 356-0100.

Sincerely,

A handwritten signature in black ink that reads "Adam Robarge". The signature is written in a cursive style with a large initial "A".

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS280417032
Investigation #:	2026A0009018
Complaint Receipt Date:	03/13/2026
Investigation Initiation Date:	03/13/2026
Report Due Date:	04/12/2026
Licensee Name:	Heart and Soul Living, LLC
Licensee Address:	1855 Carlisle Road Traverse City, MI 49696
Licensee Telephone #:	(231) 342-4878
Administrator:	Marla Garchow
Licensee Designee:	Marla Garchow
Name of Facility:	Heart And Soul Living, LLC
Facility Address:	1855 Carlisle Road Traverse City, MI 49696
Facility Telephone #:	(231) 342-4878
Original Issuance Date:	10/04/2023
License Status:	REGULAR
Effective Date:	09/12/2024
Expiration Date:	09/11/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The licensee engaged in a heated verbal exchange with Resident A's guardian in the presence of three residents on March 11, 2026.	No
Additional Finding	Yes

III. METHODOLOGY

03/13/2026	Special Investigation Intake 2026A0009018
03/13/2026	Special Investigation Initiated – Letter (email) sent to Brian Newcomb, Northern Lakes Community Mental Health (CMH) recipient rights officer
03/16/2026	Contact – Document (email) sent to Lisa Jones, Northern Lakes CMH recipient rights officer
03/16/2026	Contact – Document (email) received from Lisa Jones, Northern Lakes CMH recipient rights officer
03/18/2026	Inspection Completed On-site Interview with CMH caseworker Tina Bruning, licensee Marla Garchow and direct care worker Diane Garchow Face to face (interview) with Resident B
03/31/2026	APS Referral
03/31/2026	Contact – Telephone call made to Daryl Stallworth, Grand Traverse County adult protective services
04/06/2026	Exit conference with licensee Marla Garchow

ALLEGATION: The licensee engaged in a heated verbal exchange with Resident A's guardian in the presence of three residents on March 11, 2026.

INVESTIGATION: I conducted an unannounced on-site visit at the Heart and Soul Living adult foster care home on March 18, 2026. Community Mental Health (CMH) caseworker Tina Bruning was present and I spoke with her. She stated that she was aware of the verbal assault that took place between Resident A's guardian and Ms. Garchow. They have had meetings with the two of them before to try to preserve

the placement for Resident A. I asked why she thought Ms. Garchow was responsible for the situation. Ms. Bruning stated that she knew Ms. Garchow could be quite defensive and wondered if she had diffused the incident quickly enough given that there were residents within earshot. She thought that the situation should have been taken elsewhere away from the residents. Ms. Bruning went on to say that Resident B can get upset whenever anyone uses a “tone” in her presence.

Licensee Marla Garchow arrived while I was at the home and I spoke with her about the incident with Resident A’s guardian. She stated that she and the guardian have had a difficult relationship since Resident A moved in two years ago. They have fought about everything including any medication and when Resident A’s leg braces are supposed to be worn or not worn. Ms. Garchow said that she has honored all her requests but does discuss other options with her when it involves something she thinks is in Resident A’s best interest. This has caused some friction between the two of them over the last two years. Last week, Resident A’s guardian came into the facility as she often does and complimented Ms. Garchow on her jeans. Resident A’s guardian then asked another staff who she was. When she found out it was Ms. Garchow, her demeanor changed swiftly and she started to verbally assault Ms. Garchow. I asked what she was saying. Ms. Garchow said that she had recently gotten a “no trespass order” against Resident A’s father. Even though they are not still together, Resident A’ guardian has relied on Resident A’s father for many things such as bringing and picking up medication. She was very upset that she was no longer able to rely on him to do these things. Ms. Garchow reported that the reason for the “no trespass order” was their belief that Resident A’s father had touched Resident B sexually during a time he had stopped into the home.

I asked for a more detailed description of what had happened with Resident A’s guardian when she had verbally assaulted her. Ms. Garchow said that when she realized it was her, she just started yelling at her about Resident A’s father not being allowed at the facility. Ms. Garchow was trying to explain to her that they did that because of what they believed to had done and their need to protect the residents from him. Resident A’s guardian was not listening and was only trying to convince her that he should be allowed to come to the home. Ms. Garchow said that after a couple of minutes, she realized that Resident A’s guardian was not going to calm down or agree with anything she was saying. She asked her to leave as calmly as she could manage at that time. Resident A’s guardian continued to yell and Ms. Garchow acknowledged she did then raise her voice at that time to say, “Just go”. Ms. Garchow said that she kept trying to engage with her in a calm and reasonable way but Resident A’s guardian would not deescalate. She tried to stay as calm as possible herself and had Resident A’s guardian leave as soon as she realized she was not going to calm down.

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:	<p>On March 11, 2026, Resident A's Guardian verbally assault the licensee in the presence of or within earshot of three residents. This was initiated by the guardian. Ms. Garchow stated that she tried to stay calm and explain the situation the best she could to Resident A's guardian. Ms. Garchow stated that as soon as she realized that the guardian was not going to deescalate, she tried to have her leave as quickly as she could.</p> <p>In consideration of the above information, it was determined that the guardian initiated a verbal confrontation and that the licensee tried to deescalate and end the interaction as soon as she was able.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

While I was investigating the verbal assault by the guardian of the licensee, Ms. Garchow disclosed that they believed that Resident A's father had touched Resident B in a sexual manner during a visit. I asked what had happened. Ms. Garchow explained that Resident A's father often comes to drop off or pick up medications at the facility. He was there a lot and would sometimes stay in common areas with his daughter and visit with staff. Three months ago, direct care worker Diane Garchow had come out to the common area and observed Resident A's father sitting side by side with Resident B at the counter near the kitchen. Ms. Diane Garchow had seen him move away quickly from Resident B when he realized she had entered the room. She thought he "looked guilty" of having done something he shouldn't have. Resident A's father then gathered what he had come for and left quickly, which was also quite unusual for him. He usually stays to visit with his daughter and staff. After he left, Ms. Diane Garchow believed that Resident B was upset and that she tried to tell her in her fashion that Resident A's father had done something of a sexual nature to her. They called adult protective services and law enforcement at that time and a police officer came to the home to talk to them and then spoke with Resident A's father. The police officer had been the one to suggest they get a "no trespass order" against Resident A's father and agreed that he would pass along to him that he was no longer to visit the home. Ms. Garchow stated that was why Resident A's guardian had attacked her verbally, because of that situation. I asked Ms. Garchow about him just being able to walk into the facility and be alone with one of the residents. She said that parents and guardians of residents had always had access to the facility. She said that there are almost always one or more staff in the common area but on that occasion there were no staff in the common area. Ms. Garchow denied that they had completed a criminal history check on Resident A's father. I spoke with Ms. Garchow about the fact that the set up would need to

change there and that she would no longer be able to leave the doors unlocked and allow people to walk in unchecked. I told her that only staff and volunteers who are completely cleared are ever allowed to be unsupervised with residents.

I then spoke with Ms. Diane Garchow. She said that she was the one to find Resident A's father near Resident B. She had been in one of the bedrooms taking care of a couple of residents and did not hear Resident A's father come in. Usually when he does come in, he sits in one of the office chairs that they have in the common area. When she came out to the common area, she observed him sitting very closely to Resident B at the counter. This is where Resident B will often sit when she is working on her tablet. He was sitting right next to her, his chair touching her chair, and seemed to be leaning over her. Ms. Diane Garchow asked, "What are you doing here?" Resident A's father jumped up "real quick" and seemed to have a "guilty look on his face". He did what he came there for and then left quickly. I asked her if she had seen him touch Resident B. She said no because their backs were to her and she couldn't see his hands. After he left, Ms. Diane Garchow said she went over to check on Resident B. She was obviously upset and was trying to talk quickly which was unintelligible. Ms. Diane Garchow asked her to use her tablet. She typed, "DAD HANDS". She asked her if she was talking about her dad, she indicated no. She asked her about the other resident's dads, she indicated no. When she asked about Resident A's dad, she indicated yes and nodded towards the door he had just left. She wrote "DADS HANDS BAD". After she wrote that, she kept brushing her breast which is not a usual thing for her. Ms. Diane Garchow said that she thought that was her way of communicating what had been done to her. She said that she spoke with adult protective services worker Daryl Stallworth and he told her to contact law enforcement. A police officer came out and spoke with Resident B. She typed on her tablet to communicate with him and also touched her own breast when he was there. The police officer spoke with Resident A's father and told him he was not to go to the facility any longer.

After I spoke with Ms. Diane Garchow, another staff approached us and said that Resident B wanted to talk to her and "that man". Ms. Diane Garchow told me "that man" was me. We then went to Resident B's bedroom. Resident B knew me from previous visits to the home. I asked Resident B if she wanted to tell me something. She nodded and started brushing her breast with her hand. Ms. Diane Garchow asked, "Your breast?" Resident B nodded. Ms. Diane Garchow asked, "Do you know the person who did that?". Resident B nodded again. Ms. Diane Garchow asked, "Was it your dad?" She shook her head. She asked about each of the other resident's dads and each time Resident B shook her head. When Ms. Diane Garchow asked about Resident A's father, Resident A nodded her head.


I spoke with adult protective services worker Daryl Stallworth by telephone on March 31, 2026. He confirmed that they had received a complaint on the matter on December 15, 2025. This was referred to law enforcement. They do not currently have an open adult protective services case on the matter.

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:	In December of 2025, a resident's father was allowed to have unsupervised contact with a female resident who he has no connection with except that his daughter shares the same home. He had enough time to place a chair side by side with her and lean over her. It is unknown what occurred but the licensee and the direct care worker who observed them believed that something of a sexual nature occurred. It was confirmed through this investigation that Resident B was not kept protected and safe when another resident's father, who has no connection to her, was allowed to have unsupervised contact with her.
CONCLUSION:	VIOLATION ESTABLISHED

I conducted an exit conference by telephone with licensee Marla Garchow on April 06, 2026. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



04/06/2026

Adam Robarge
Licensing Consultant

Date

Approved By:



04/06/2026

Jerry Hendrick
Area Manager

Date