GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 13, 2025

James Boyd
Crisis Center Inc - DBA Listening Ear
PO Box 800
Mt Pleasant, MI 48804-0800

RE: License #: AS400069154
Investigation #: 2025A0009020
North Birch

Dear Mr. Boyd:

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 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 (231) 922-5309.

Sincerely,

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 #:	AS400069154
Investigation #:	2025A0009020
Complaint Receipt Date:	06/02/2025
Investigation Initiation Date:	06/02/2025
Report Due Date:	07/02/2025
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Sherry Kidd
Licensee Designee:	James Boyd
Name of Facility:	North Birch
Facility Address:	2200 N Birch Kalkaska, MI 49646
Facility Telephone #:	(231) 258-5105
License Status:	REGULAR
Effective Date:	02/23/2024
Expiration Date:	02/22/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On June 1, 2025, Resident A was given another resident's medication in error. As a result, he was treated in the emergency department.	Yes

III. METHODOLOGY

06/02/2025	Special Investigation Intake 2025A0009020
06/02/2025	Special Investigation Initiated – Telephone call received from administrator Sherry Kidd
06/02/2025	Contact – Document (email with attachment) received from administrator Sherry Kidd
06/03/2025	APS Referral
06/06/2025	Inspection Completed – Onsite Interview with home manager Kelly Happel Face to face contact with Resident A
06/12/2025	Contact – Telephone call made to former direct care worker Amie Wells
06/13/2025	Exit conference with administrator Sherry Kidd

ALLEGATION: On June 1, 2025, Resident A was given another resident's medication in error. As a result, he was treated in the emergency department.

INVESTIGATION: I received a telephone call from administrator Sherry Kidd on June 2, 2025. She reported that there had been a medication error at the North Birch adult foster care home. Resident A had received another resident's medication the day before. He was seen at the emergency department as a result. The agency planned on terminating the employment of the staff person involved. Ms. Kidd also provided me with an incident report on that day which detailed the medication error and what steps were taken afterwards to ensure the safety and well-being of Resident A.

I conducted a site visit at the North Birch adult foster care home on June 6, 2025. I spoke with home manager Kelly Happel at that time. I asked her about the recent medication error at the home. Ms. Happel said that she was not present in the home

at the time that it had happened. She had received a telephone call from the staff person involved, Amie Wells, shortly afterwards. Ms. Wells told her that she was distracted by a resident who was talking to her while she was preparing medication. She went out into the dining room and just handed the wrong medication to Resident A, which he took. Ms. Wells immediately called her, Ms. Happel, to tell her what had happened. She stated that it was an accident. Ms. Happel said that she has trained the staff to close the medication room door if there are any distractions. Ms. Wells did not follow this directive. She also did not follow the home's policy regarding having a second staff person double-check the medication pass. The home is always staffed by two direct care workers. The second staff is supposed to check each medication pass to ensure that it is the right time, right medication and right resident. If she had done this, the error likely would not have happened. Ms. Wells did do the right thing by calling as soon as she realized what she had done. Ms. Happel stated that she told Ms. Wells to have Resident A transported to the emergency department at that time. One of the medications that Resident A received was a "specialized seizure medication". They had also called Poison Control who recommended he be seen at the emergency department. Resident A was checked out at the hospital and the medical personnel there believed he was fine at that time. Resident A did have nausea and started vomiting the next morning. They took Resident A back to the emergency department and they gave him Zofran. Resident A was fine after that. Ms. Happel confirmed that Amie Wells' employment with them was terminated after the incident.

I asked Ms. Happel what medication Resident A had been given in error. She reported that he was given: 250 mg of Ethosuximide, 3 x 200 mg of Lamictal, 5 mg of Clobazam, 500 mg of Keppra, 50 mg of Senakot and 150 mg of Zoloft.

I spoke with former direct care worker Amie Wells by telephone on June 12, 2025. I asked her to tell me about the medication error that had happened at the North Birch adult foster care home. She said that all the residents were sitting at the dining room table and were "being noisy". One resident, in particular, was being quite loud and was distracting her. Ms. Wells said that she did prepare the medication in the medication room away from the residents but could still hear them. She felt that she was distracted when she went out to perform the medication administration. She accidentally gave it to the wrong person, Resident A. He did not get all the other resident's medication because she realized what she had done before he took all of it. Ms. Wells said that she called the agency's on-call person first and then 911. She said that she had an ambulance come for Resident A because he had taken some "strong pills". She knew that one of the pills was a psychotropic medication. I asked Ms. Wells about any other medication errors at the home that she is aware of. She replied that she had committed a medication error, herself, about 2 or 3 years ago. She said that there have been occasional medication errors in years past but the staff involved are usually terminated if the error is severe.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was confirmed through this investigation that the licensee did not take reasonable precautions to insure that prescription medication was not used by a person other than the resident for whom the medication is prescribed. On June 1, 2025, Resident A was given another resident's medication in error.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with administrator Sherry Kidd by telephone on June 13, 2025. 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.

06/13/2025

Adam Robarge Date
Licensing Consultant

Approved By:

06/13/2025

Jerry Hendrick Date
Area Manager