GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 4, 2025

Angela Sydor
Northpointe Behavioral Healthcare Systems
715 Pyle Drive
Kingsford, MI 49802

RE: License #: AM360395407
Investigation #: 2025A0234014
Boyington Place

Dear Ms. Sydor:

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 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 (616) 356-0111.

Sincerely,

Maria DeBacker

Maria DeBacker, Licensing Consultant
Bureau of Community and Health Systems CAMP Office
350 Ottawa Ave
Grand Rapids MI 49503
(906) 280-8531

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

I. IDENTIFYING INFORMATION

License #:	AM360395407
Investigation #:	2025A0234014
Complaint Receipt Date:	07/28/2025
Investigation Initiation Date:	07/30/2025
Report Due Date:	09/26/2025
LicenseeName:	Northpointe Behavioral Healthcare Systems
Licensee Address:	715 Pyle Drive Kingsford, MI 49802
Licensee Telephone #:	(906) 774-0522
Licensee Designee:	Angela Sydor
Name of Facility:	Boyington Place
Facility Address:	115 W Boyington Iron River, MI 49935
Facility Telephone #:	(906) 774-0522
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2025
Expiration Date:	05/28/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Resident ran out of insulin	Yes
Resident reported that that a staff kissed him on the cheek in the shower	No

II. METHODOLOGY

07/28/2025	Special Investigation Intake 2025A0234014
07/30/2025	Special Investigation Initiated - Telephone
09/05/2025	Inspection Completed On-site
09/05/2025	Inspection Completed-BCAL Sub. Compliance
09/18/2025	Email Received Manager Staci Dye emailed to say a resident made an allegation that staff kissed him in the shower.
09/20/2025	Investigation was delayed. Awaiting Police investigation.
09/20/2025	Email from APS
10/08/2025	Email from APS
10/22/2025	Email from APS – Police report from 8/27/24 with similar charges
10/28/2025	On site investigation
11/13/2025	Police will not be pressing charges. Report requested.
12/01/2025	Police report requested
12/03/2025	Police report requested

12/04/2025	Exit Conference

ALLEGATION:

Resident ran out of insulin

INVESTIGATION:

On 9/5/25, I interviewed manager Staci Dye at the facility. Ms. Dye stated on July 21st during the 8PM medication administration, it was discovered that Resident A had run out of their prescribed insulin and had one diabetic test strip left. She stated that a refill request for these medications had been previously faxed to the pharmacy on July 1st, but the medication had not arrived. Resident A is prescribed 40 units of insulin. However, due to the shortage, she only received 11 units. Ms. Dye stated that she has since sent out a memo to the staff at Boyington Place stating that all staff must be aware of what medication the residents have and ensure they always have the medication they need to prevent this from happening again.

On 9/5/25, I interviewed Resident A at the facility. Resident A appeared to be well cared for and in good spirits. Resident A is unaware of medication issues and stated that she is well cared for.

APPLICABLE RULE	
R 400.675	**Resident Medications**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Resident A is prescribed 40 units of insulin per day. The facility had 11 units.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident reported that that a staff kissed him on the cheek in the shower

INVESTIGATION:

On 9/18/25, I received an email from manager Staci Dye. Ms. Dye stated that Resident B had reported that staff Andrew Coble kissed him on his cheek in the shower.

On 9/20/2025, I spoke with APS worker Josh Demarois on the phone. Mr. Demarois stated that the police were investigating the allegation. At this time investigation will be on hold to allow police to do a proper investigation.

On 10/22/25, I spoke to Josh Demarois by phone. He stated that police had provided a report from 8/27/24 stating that staff Andrew Coble was accused of inappropriate sexual behavior at the Iron River Care Center. A male resident stated that Mr. Coble took him to the shower room and stroked his penis and sucked his penis. Mr. Coble was fired and no longer allowed on the premises. Charges were not pressed. Mr. Demarois provided the police report.

On 10/28/25, I interviewed manager Staci Dye at the facility. Ms. Dye stated that Mr. Coble worked at the facility May 2025 to October 8th 2025. Ms. Dye stated that Mr. Coble was suspended immediately when the abuse was reported. He was later terminated from employment when they learned of his history.

On 11/13/25, I spoke to APS worker Josh Demarois by phone. Mr. Demarois stated that he spoke to Officer Wicklund at the Iron River PD. He was told that no charges were going to be filed. I called Iron River PD and requested a copy of the report.

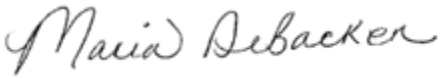
On 12/1 and 12/3, I called Iron River PD to request a copy of the report.

On 12/4/25, I spoke to APS Josh Demarois by phone. He has not received a copy of the report and does not believe one was done.

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:	There is no evidence that the facility was aware of inappropriate behavior.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

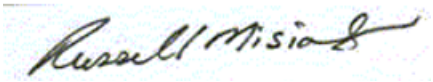
I recommend no change to the status of this license contingent on an appropriate corrective action plan.



12/4/25

Maria Debacker Date
Licensing Consultant

Approved By:



12/5/25

Russell B. Misiak Date
Area Manager