GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2025

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

RE: License #: AS180010533
Investigation #: 2026A1038004
Parkview Home

Dear Mr. Boyd:

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.

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,

Johnnie Daniels, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW
Grand Rapids MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS180010533
Investigation #:	2026A1038004
Complaint Receipt Date:	10/28/2025
Investigation Initiation Date:	10/28/2025
Report Due Date:	12/27/2025
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Licensee Designee:	James Boyd
Name of Facility:	Parkview Home
Facility Address:	816 Oaklawn St Harrison, MI 48625
Facility Telephone #:	(989) 539-2704
Original Issuance Date:	10/27/1989
License Status:	REGULAR
Effective Date:	04/17/2024
Expiration Date:	04/16/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member did not verify Resident A's safety while transporting in a vehicle.	Yes

III. METHODOLOGY

10/28/2025	Special Investigation Intake 2026A1038004
10/28/2025	Special Investigation Initiated - Telephone call made to the complainant.
10/28/2025	Contact - Telephone call made to ORR regarding the facility.
11/04/2025	Contact - Face to Face interview was conducted with Resident A
11/04/2025	Contact - Face to Face interviews were conducted with DCS Amanda Blumerich and CMH Case manager Chrystal Hayes
11/04/2025	APS Referral submitted.
11/04/2025	Contact - Telephone call made to DCS Layci McCullen
11/04/2025	Inspection Completed On-site
11/04/2025	Contact - Document Received from admin Robyn Castrop.
11/17/2025	Inspection Completed-BCAL Sub. Compliance
11/17/2025	Exit Conference with admin Robyn Castrop.

ALLEGATION:

Staff member did not verify Resident A's safety while transporting her in a vehicle.

INVESTIGATION:

On 10/28/25, I conducted an interview with the complainant who verified the information.

On 10/28/25, I conducted an interview with recipient's rights advisor Sarah Watson. Ms. Watson verified they are currently investigating the incident regarding Resident A breaking her arm. Ms. Watson stated she has already conducted interviews with all parties involved. Ms. Watson stated home manager Sierra Reinhard, direct care staff (DCS) Layci McCullen and Resident A all provided consistent statements. Ms. Watson stated they stated DCS McCullen was driving Resident A to an appointment on 10/23/25. Ms. Watson stated she was advised DCS McCullen was driving the facilities bus with Resident A. DCS McCullen slammed on the brakes causing Resident A to fall out of her wheelchair. Ms. Watson stated it was letter learned Resident A broke her arm.

On 11/4/25, I conducted an unannounced investigation at the facility. I conducted an interview with DCS Amanda Blumerich. DCS Blumerich provided a statement consistent with those made by Ms. Watson.

On 11/4/25, I conducted an interview with Resident A who provided a statement consistent with those made by MS. Watson and DCS Blumerich. Resident A added DCS McCullen forgot to fasten her seat belt which caused her to fall out of her wheelchair and injure herself.

On 11/4/25, I conducted an interview with community mental health case manager Chrystal Hayes who provided a statement consistent with those made by Ms. Watson, DCS Blumerich and Resident A. Ms. Hayes stated Resident A is required to be always wearing her wheelchair seat belt while in the chair. Ms. Hayes advised Resident A is required to be in a seatbelt while in transit in a vehicle.
On 11/4/25, I reviewed Resident A's primary care physician notes, Assessment Plan and Health Care Agreement. These documents verified Resident A is required to be in a seatbelt while in her wheelchair. I reviewed the incident report which verified the parties involved in the incident along with the date the incident occurred.

On 11/4/25, I conducted an interview with DCS Layci McCullen via telephone. DCS McCullen verified she forgot to buckle Resident A into her wheelchair while in transit in the vehicle. DCS McCullen stated it was only her and Resident A in the vehicle at the time.

On 11/17/25, I conducted an Exit Conference with administrator Robyn Castrop regarding the incident. Ms. Castrop advised the facility will be conducting refresher training regarding transporting residents. Ms. Castrop advised the facility currently has a transport policy.

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:	Based on my interview with Staff, Residents and the review of documents. There is corroborating evidence of staff member not verifying the safety of the resident before driving in the vehicle. This oversight caused the resident to suffer an injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/1/25

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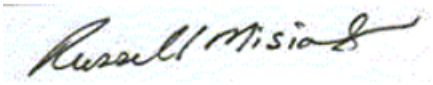
Johnnie Daniels Date
Licensing Consultant

Approved By:



12/2/25

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Russell B. Misiak Date
Area Manager