



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 26, 2026

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

RE: License #: AS400069154
Investigation #: 2026A0009014
North Birch

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.
- 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 cursive script that reads "Adam Robarge".

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 #:	2026A0009014
Complaint Receipt Date:	02/10/2026
Investigation Initiation Date:	02/10/2026
Report Due Date:	03/12/2026
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-0326
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:	02/23/2026
Expiration Date:	02/22/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A staff from the facility was seen at a local church trying to shove food into a resident’s mouth while he was choking. She also was observed roughly pulling him up in his wheelchair. The staff took the food away from another resident before he was done eating and told him to “Shut up”.	Yes

III. METHODOLOGY

02/10/2026	Special Investigation Intake 2026A0009014
02/10/2026	APS Referral
02/10/2026	Special Investigation Initiated – Telephone call received from adult protective services worker Kelly Schaub
02/11/2026	Contact – Telephone call made to Complainant, left message
02/11/2026	Inspection Completed On-site Interview with direct care worker Courtney Lester
02/23/2026	Contact – Document (email) sent to adult protective services worker Kelly Schaub
02/23/2026	Contact – Document (email) received from adult protective services worker Kelly Schaub
02/23/2026	Contact - Telephone call made to Complainant
02/23/2026	Contact - Telephone call made to home manager Kelly Happel
02/23/2026	Contact - Telephone call made administrator Sherry Kidd
02/24/2026	Contact - Telephone call made direct care worker Krystal Wood
02/26/2026	Exit conference with administrator Sherry Kidd

ALLEGATION: A staff from the facility was seen at a local church trying to shove food into a resident’s mouth while he was choking. She also was observed roughly pulling him up in his wheelchair. The staff took the food

away from another resident before he was done eating and told him to “Shut up”.

INVESTIGATION: I received a call from adult protective services worker Kelly Schaub on February 10, 2026. She told me that she is investigating a case in which direct care worker Krystal Wood was observed interacting with Resident A and Resident B in a manner which concerned them. This occurred at a local church on January 18, 2026. Ms. Schaub said that she is looking into the matter and will send me the information regarding what she has been told.

I conducted an unannounced site visit at the North Birch adult foster care home on February 11, 2026. I spoke with direct care worker Courtney Lester while I was there. I asked her about the report that I had received. Ms. Lester replied that she knew that Ms. Wood had taken three or four residents to church that Sunday. She said that Resident A has dysphagia and so it sounds like he is choking when he eats. He is actually coughing. They break his food into small pieces and use Thick-It with his drink so that he doesn't choke. Ms. Lester said that if someone observed Resident A eating who doesn't know him, they might believe he was choking. She couldn't speak to the fact that the person who observed this reported that she was “shoving” food into his mouth while it seemed he was choking. Ms. Lester said that she has never seen Ms. Wood do anything like that. She has worked with Ms. Wood for quite some time and has never seen her do anything inappropriate with the residents. I asked if Resident A and Resident B were present. She said they were not there at the time of my visit. She said that they wouldn't be able to tell me what had happened due to their limited verbal ability.

I spoke with the Complainant on February 23, 2026. She told me that Ms. Wood brought some residents from the North Birch adult foster home to church on a Sunday. The Complainant said that she observed Ms. Wood be rough with the two male residents. She said that Resident A seemed to be choking while she was feeding him and that she was quickly “shoving” food down his throat. It seemed like he couldn't keep up with how fast she was feeding him. I asked the Complainant what she might think if she knew that Resident A has a condition which caused him to sound as if he is choking when he eats. She replied that even if that were true, it was her impression that Ms. Wood was making him eat too fast. She said that she also observed Ms. Wood roughly pull Resident A up in his wheelchair. I asked if this might have just been her assisting Resident A so he could be higher up in his wheelchair. She said that it had seemed quite rough to her. Ms. Wood pulled him up by his arms and it looked like she pulled him harder and faster than she needed to. At that point, Ms. Wood seemed to realize that everyone was looking at her. She got up quickly, grabbed Resident B's plate of food which was full and threw it in the garbage. He told her that he wasn't done eating and she told him to “Shut up”. I asked the Complainant if she was sure those were the words she used instead of, possibly, just asking him to be quiet. The Complainant said that she was sure that she had used the words “Shut up” in a sharp tone. I asked the Complainant if she knows Ms. Wood and she said that she does not.

I spoke with home manager Kelly Happel by telephone on February 23, 2026. Ms. Happel stated that Resident A does have an eating disorder. Every time he eats, he makes sounds. He produces saliva and then gags and coughs when he is eating. She wanted me to know that Ms. Wood did receive resident specific training on Resident A. They had gone over his written assessment and his specific care needs including how to prepare his food and feed him. I told Ms. Happel that the Complainant had been adamant about what she had seen and heard. Ms. Happel said that she knows that Ms. Wood does have a voice that carries and that Resident B is hard of hearing.

I also spoke with administrator Sherry Kidd by telephone on February 23, 2026. She said they did have a staff meeting to address all Resident A's specific eating needs. The staff were trained on how to prepare his food and feed him due to his eating disorder. We talked about what the Complainant had said had happened. I told her the Complainant had been quite adamant that Ms. Wood seemed to be hurrying Resident A and that she used the word "shoving" to describe the way Ms. Wood was feeding him. I also shared the other concerns that the Complainant had reported.

I sent and received emails from adult protective services worker Kelly Schaub. She reported that she was substantiating an adult protective services case in his matter.

I spoke by telephone with direct care worker Krystal Wood on February 24, 2026. Ms. Wood said that she did "break up" Resident A's food with a fork into smaller pieces. When she got up to go get dessert, someone told her that Resident A was choking. She said that Resident A was not choking but was coughing. He does that when he is eating. She said that she was just feeding him normally. I asked her about the report that she had roughly pulled Resident A up in his chair. She denied that it had been rough, saying that she had barely helped him. Ms. Wood said that he is supposed to be sitting up straight when he is eating. I asked her about the report of her taking Resident B's food away from him and him saying he wasn't done eating. She said that he was just "playing" with his food and she believed he was done. I asked her about the report of her telling him to "Shut up". She denied that she had. She said that the church was having a memorial service at the time and she did tell the residents to be quiet. They were being loud and she didn't want them to disrupt the service.

On February 24, 2026, I received an email with attached documents from administrator Sherry Kidd. The first document was a training log listing direct care workers who had received resident specific training on Resident A's AFC Assessment. It listed that Krystal Wood received this training on October 17, 2026. The second document was Resident A's Assessment Plan for AFC Residents (BCHS-3265). The assessment indicated that Resident A does require assistance with Eating/Feeding and that, *"(Resident A) needs prompts to eat. He uses a toddler size spoon and fork to encourage small bits and prompted to take drinks between bites. His food needs to be cut into small pieces to prevent choking and gagging."* For Special Diets the assessment indicates, *"Staff need to cut up (Resident A's) food*

into small size pieces. (Resident A) needs to use a toddler size spoon and fork to eat and to encourage smaller bites. He will pocket food in his cheeks and needs reminders to chew and swallow and to alternate food and drinks to assist with this. No really dry foods. He may struggle with peanut butter. All hard fruits or veggies like apples, pears, need to be pureed or warmed until softened. No nuts. (Resident A) is on a dysphagia 3 diet and has GERD so it is necessary for him to stay upright for at least 45 minutes after eating. He also has a PRN meal replacement (Ensure/Boost) for when he refuses to eat.”

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	<p>On January 18, 2026, direct care worker Krystal Wood was observed “shoving” food in a hurried manner while feeding Resident A. She was also observed roughly pulling him up in his chair. Resident A does have an eating disorder which causes him to make sounds that sound as if he is choking. He also needs to sit up straight in his chair when eating and for 45 minutes after eating.</p> <p>Direct care worker Krystal Wood was not patient with Resident A which he requires because of his specific eating disorder when she fed him in a hurried fashion. She was also rough with him when pulling him in his chair.</p> <p>It was confirmed through this investigation that on January 18, 2026, Resident A’s personal care was not provided as specified in his written assessment plan.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, protected and safe.

ANALYSIS:	<p>On January 18, 2026, direct care worker Kathryn Wood took a full plate of food away from Resident B even when he indicated to her that he wasn't finished with it. She also told him and possibly the other residents with him to "Shut up" using a sharp tone.</p> <p>In consideration of the above information, it is determined that Resident B and possibly the other residents were not treated with dignity and respect at that time.</p>
CONCLUSION:	VIOLATION ESTABLISHED

I conducted an exit conference with administrator Sherry Kidd by telephone on February 26, 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.



02/26/2026

Adam Robarge
Licensing Consultant

Date

Approved By:



02/26/2026

Jerry Hendrick
Area Manager

Date