



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 9, 2026

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

RE: License #: AS370011270
Investigation #: 2026A1029019
Isabella 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the licensee designee 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 (231) 922-5309.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Browning". The signature is written in a cursive, flowing style.

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AS370011270
Investigation #:	2026A1029019
Complaint Receipt Date:	01/16/2026
Investigation Initiation Date:	01/16/2026
Report Due Date:	03/17/2026
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois, Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-0326
Administrator:	James Boyd
Licensee Designee:	James Boyd
Name of Facility:	Isabella Home
Facility Address:	2599 S Isabella Road, Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-0326
Original Issuance Date:	10/10/1986
License Status:	REGULAR
Effective Date:	04/05/2024
Expiration Date:	04/04/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was not properly secured in her chest harness while she was transported in the van to MMI because direct care staff members did not put it on before she left Isabella Home.	Yes
Resident A was burned when direct care staff member Naomi Cook placed a sock filled with rice warmed in the microwave on her skin to soothe her menstrual cramps.	Yes

III. METHODOLOGY

01/16/2026	Special Investigation Intake 2026A1029019
01/16/2026	Special Investigation Initiated – Telephone call to ORR Sarah Watson
01/16/2026	Contact - Telephone call made – Phone interviews with Sarah Watson with direct care staff members Naomi Cook, Angela Trimmer, administrator Kaila Morris, Kim DeLong, Nicole Farnan, Edie Bowerman, Citizen A1, Julie Gilmore.
01/16/2026	APS Referral made to Centralized Intake
01/29/2026	Contact - Document Sent - Email to Caitlin Fick
01/30/2026	Inspection completed on-site - Face to Face with direct care staff members Julie Gilmore and Naomi Cook at Isabella Home
02/17/2026	Contact - Telephone call received from Ms. Fick
02/19/2026	Contact - Telephone call made to licensee designee Jim Boyd
03/03/2026	Contact - Telephone call received from Caitlin Fick
03/04/2026	Contact - Document Sent to APS Caitlin Fick
03/05/2026	Exit conference with licensee designee Jim Boyd

ALLEGATION: Resident A was not properly secured in her chest harness while she was transported in the van to Mid-Michigan Industries because direct care staff members did not put it on before she left Isabella Home.

INVESTIGATION:

On 01/16/2026 a complaint was received via Bureau of Community and Health Systems online complaint system alleging that Resident A was not properly secured in her chest harness while she was transported in the van to Mid-Michigan Industries (MMI) because direct care staff members did not put it on before she left Isabella Home. Adult Protective Services (APS) worker Caitlin Fick and Office of Recipient Rights (ORR) Sarah Watson are also investigating these concerns.

On 01/16/2026 ORR Ms. Watson and I interviewed direct care staff member whose role is home manager, Julie Gilmore. Ms. Gilmore stated “she thinks she just dropped the ball” because it was Resident A’s second day going to MMI on the bus and she missed putting the harness on. Ms. Gilmore stated she did not think to check to see if the harness was on her. Ms. Gilmore stated she found Resident A did not have the chest harness on in the van because MMI coordinator Emilee Bixby called and informed direct care staff member Ms. Trimmer to let her know she did not have the harness on. Ms. Gilmore stated Ms. Bixby came to the house to pick up the harness so Resident A would have it on the way home. Ms. Gilmore stated Ms. Trimmer was assigned to Resident A for the day but as the manager, she should have made sure the harness was on Resident A and she did not do this. Ms. Gilmore stated they didn’t notice that Resident A’s chest harness was not on her because she had a wheelchair blanket on her. It wasn’t until Resident A arrived at MMI, that it was realized Resident A did not have her chest harness. Ms. Gilmore stated she was trained prior to this incident on Resident A’s *Person Centered Plan*.

On 01/16/2026 I interviewed administrator Kaila Morris who stated the requirement for Resident A wearing the chest harness during transport is in the *Assessment Plan for AFC Residents* and in the *Person Centered Plan*. Ms. Morris stated they are going to implement a checklist by the door so this does not happen again.

On 01/16/2026 ORR Ms. Watson and I interviewed direct care staff member Angela Trimmer. Ms. Trimmer stated she was assigned to Resident A when this occurred. Ms. Trimmer stated she “simply forgot to put it on her.” Ms. Trimmer stated there is now a check system and safety measures are put in place now that this occurred, however, this was not in place before this incident. Ms. Trimmer stated she realized she was not wearing it because Ms. Bixby from MMI called to let her know. Ms. Trimmer stated Resident A had only resided in the home for two weeks but she was trained on her PCP before this incident so she should have known to have this on her before leaving the house.

On 01/30/2026 I completed an unannounced on-site investigation and interviewed direct care staff members Ms. Gilmore and Ms. Cook. Ms. Gilmore did not have additional

information other than what was reported on 01/16/2026. Resident A was not interviewed or observed because she was at MMI during the on-site. During the on-site investigation I reviewed the following documents:

- *Physicians Medication Order* for Resident A which included "Tilt and Space wheelchair with seatbelt, headrest, footrest, and chest harness."
- *Person Centered Plan (PCP)* that was written on 12/12/2025: (Typed as written in relevant parts) "Fall Risk.. These modifications including a seatbelt, chest harness on her wheelchair, a lift with a sling... based upon documented chronic health concerns (including Cerebral Palsy, Functional Quadriplegia, Ataxia, Muscle Weakness, and Stiffness of the Joints) are not expected to be relieved during the one-year IPOS period."

On 02/17/2026 I received a call from APS Caitlin Fick. Ms. Fick stated now there is a checklist next to the door which has to be completed and checked by two direct care staff members to make sure everything is correct for Resident A before leaving for MMI.

On 02/19/2026 I interviewed licensee designee Jim Boyd. Mr. Boyd stated there were checklists in place for the other residents so now they have one for Resident A as well. Mr. Boyd stated he would send a copy of this checklist which was put in place after this incident. Mr. Boyd stated she was transported to MMI in their van, however direct care staff members at Isabella Home should have had her ready to go with the appropriate assistive devices. Mr. Boyd stated he hopes with the checklists in place this will not occur again. On 03/06/2026 Mr. Boyd sent the checklist which lists everything she needs to go to MMI for the day including the chest harness and this is initialed by the direct care staff member who is getting her ready for the day. This checklist was filled out for the month of February showing this was implemented shortly after this incident.

On 02/20/2026 ORR Ms. Watson interviewed Brittany Boyd, Mid-Michigan Industries (MMI) Connection Coach. Ms. Boyd said she was the person who completed the Incident Report regarding this incident. Ms. Boyd said she noticed Resident A wasn't wearing her chest harness when Ms. Boyd took her coat off. Ms. Boyd said she contacted Emilee Bixby, MMI Program Specialist, who contacted the home and the home brought in the chest harness.

On 02/20/2026 ORR Ms. Watson interviewed Emilee Bixby MMI Program Specialist. Ms. Bixby said she remembered MMI staff asked Ms. Bixby to come observe Resident A when she arrived at MMI and MMI staff pointed out Resident A was not wearing her chest harness. Ms. Bixby said she notified the AFC home.

On 03/06/2026 I contacted ORR Ms. Watson who stated she substantiated these concerns for Neglect 3 because Resident A is a fall risk and needs the chest harness to safely transport in a vehicle.

APPLICABLE RULE	
R 400.689	Use of assistive devices, therapeutic support.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Direct care staff members Ms. Trimmer and Ms. Gilmore did not verify Resident A was wearing her required chest harness before she went to MMI on the van. Ms. Gilmore stated that “she thinks she just dropped the ball” and forgot to do this. During the on-site investigation I reviewed Resident A’s Physicians Medication Order which documented that “Tilt and Space wheelchair with seatbelt, headrest, footrest, and chest harness” was required for Resident A. Since this was not used while she was transported to MMI, she was put at risk. Mr. Boyd implemented a checklist by the door now so this does not occur in the future.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A was burned when direct care staff member Naomi Cook placed a sock filled with rice warmed in the microwave on her skin to soothe her menstrual cramps.

INVESTIGATION:

On 01/16/2026 a complaint was received via Bureau of Community and Health Systems online complaint system alleging that Resident A was burned when direct care staff member Naomi Cook placed a sock filled with rice warmed in the microwave on her skin to soothe her menstrual cramps. Adult Protective Services (APS) worker Ms. Fick and Office of Recipient Rights (ORR) Ms. Watson are also investigating these concerns.

On 01/16/2026 ORR Ms. Watson and I interviewed direct care staff member Ms. Cook. Ms. Cook stated before this incident she received information from Resident A’s previous AFC provider, Citizen 1, that she used a heated rice pack on Resident A when she had menstrual cramps in the past. Ms. Cook stated she also knew from reading the *Person Centered Plan* she had a lot of pain with her menstrual cycle and as the day became closer to get the shot the pain would increase. Ms. Cook stated she noticed that Resident A will be more vocal, cry, and rock more when she’s in pain and she could see these behavioral cues were coming from her. Ms. Cook stated on 01/09/2026 she was in the living room with the rest of the household and she noticed she was appearing more agitated than usual and since it was almost bed time, she took her back into her bedroom. Ms. Cook stated she made a rice pack in the microwave and used it on Resident A while she was in her bedroom with her. Ms. Cook stated to make the rice

pack she grabbed a sock, used instant rice on the counter, put it in the microwave for one minute, felt it, and put it back for thirty seconds. Ms. Cook stated she checked the heat on her wrist and it did not burn her but felt hot. Ms. Cook stated she grabbed a kitchen hand towel and put this under the rice sock on Resident A's abdomen. Ms. Cook stated she left the bedroom for about 45 seconds after she put the rice sock on to run out to the garage. Ms. Cook stated she was in there with her for about two minutes before she ran out to the garage. Ms. Cook stated she left the rice pack on the whole time she was there, talking with her while Resident A played with her sensory toys. Ms. Cook stated the rice pack was on her for about ten minutes and she never indicated behaviorally she was in pain or cried out. Ms. Cook stated when she was ready to leave the room for the night she went over, picked up the towel and sock and that's where she saw the burn on her. Ms. Cook stated half of the rice sock had shifted and was directly on her skin and not on the towel. Ms. Cook stated after she saw this, she got cotton balls and put cold water on the burn to take the heat off of it for a couple minutes. Ms. Cook stated after this she called Ms. Gilmore and told her what happened. Ms. Cook stated she was instructed to do an *AFC Incident / Accident Report* and that Resident A would need to be taken to the emergency room as soon as possible.

Ms. Cook stated when this incident occurred, Resident A has only resided at Isabella Home for about 1.5 weeks. Ms. Cook stated Resident A didn't come with ancillary orders for PRN medications for pain relief. Ms. Cook stated she made phone calls to see if they could find another direct care staff member to come in but no one was available so Ms. Gilmore took her in the morning. Ms. Cook stated after she left work the overnight direct care staff members took her vitals every two hours after she let the midnight staff know what occurred.

Ms. Cook stated Ms. Bowerman told her to put Vaseline and gauze on the burn and to check Resident A every hour to make sure she was okay. Ms. Cook stated she also looked to see if she had a PRN for pain relief but she did not see one on file. Ms. Cook stated she was "devastated and upset that it was at her expense" this occurred. Ms. Cook stated how horrible she felt several times and how she was just trying to help her. Ms. Cook stated when Resident A went for her follow up appointment for this, she did get her Depo-Provera shot so she would not be in so much pain during her menstrual cycles. Ms. Cook stated she "learned her lesson" about following the physicians orders now and she "had no right" putting something like this on Resident A without an order. Ms. Cook stated she was trained on Resident A's *Person Centered Plan* and it did not include using a heated rice pack for cramping.

On 01/16/2026 ORR Ms. Watson and I interviewed direct care staff member Ms. Trimmer. Ms. Trimmer stated she was informed about the blisters when she came into work the following day. Ms. Trimmer stated she had spoken with the previous AFC provider, Citizen 1, who said she had used a rice pack in the past for Resident A. Ms. Trimmer stated this was an informal conversation and there were no physicians orders with this information.

On 01/16/2026 ORR Ms. Watson and I interviewed direct care staff member Mr. Patterson. Mr. Patterson stated Ms. Cook came to him upset and said, “she hurt her really bad” referring to Resident A. Mr. Patterson stated Ms. Cook told him her previous AFC provider used a rice pack on her for cramps and she did the same. Mr. Patterson showed him the burn around 9:30 PM which was blistered, red, and approximately the size of an egg. Mr. Patterson stated the rice pack was not in the *Resident Care Agreement* or *Person Centered Plan* from what he has reviewed.

On 01/16/2026 ORR Ms. Watson and I interviewed direct care staff members Kim Delong and Ms. Farnan who worked after Resident A experienced the burn. Ms. Delong stated she worked third shift after Resident A received the burn from the rice pack and she was informed she had the burn so she did her vitals check every two hours and her temperature and vitals were normal. Ms. Delong stated Ms. Cook showed her the burn when she got there and it had blistered but Resident A did not cry out in pain. Ms. Farnan stated the area was kind of pink, raised, with some fluid. Ms. Farnan stated she did not seem to be in any pain when she was doing her checks either for the first few hours or when she was putting the ointment on the burn.

On 01/16/2026 ORR Ms. Watson and I interviewed Citizen 1. Citizen 1 stated Resident A did reside in her AFC before she moved to Isabella Home. Citizen 1 stated Resident A had a variety of pain issues surrounding her menstrual period where she would cry often about a week before her period and that’s why she was on the Depo-Provera shot to control the pain. Citizen 1 stated she never said anything to the AFC staff about having a rice pack in the past because she did not use this. Citizen 1 stated Resident A has Tylenol prescribed for pain medication but she did not recall if it was on the MAR listing or not but it was a PRN when she needed it.

On 01/16/2026 ORR Ms. Watson and I interviewed Ms. Bowerman who was on call and spoke to Ms. Cook about Resident A’s burn. Bowerman stated she was informed Resident A wasn’t in any pain and her vitals were normal but she informed Ms. Cook Resident A she had to be taken to the emergency room if there was a burn on her. Ms. Bowerman stated they were unable to find a direct care staff member to come in to cover so Resident A was taken to the hospital in the morning. Ms. Bowerman stated she didn’t tell her anything about Vaseline or gauze for the burn area and she only told her to leave it alone and keep it dry.

On 01/30/2026 I completed an unannounced on-site investigation and met with direct care staff members Ms. Gilmore and Ms. Cook. During the on-site investigation I reviewed the following documents:

- *After Visit Summary / Discharge Summary* with *instructions* from McLaren Central Michigan Emergency Department stating Resident A had a visit on 01/10/2026 for a partial thickness burn of abdomen along with discharge instructions for a burn care for an adult.
- *Person Centered Plan (PCP)* that was written on 12/12/2025 and *Assessment Plan for AFC Residents* and there was no information in either regarding Resident A’s menstrual cycles or how to relieve pain for her.

- I saw a picture of the burn which was blistered, red, and about 2 inches wide.
- Physician order showing Resident A has a prescription for Tylenol 1000 mg every four hours as a PRN for discomfort.

On 02/17/2026 I received a call from APS Ms. Fick. Ms. Fick stated she did speak with Ms. Cook and she was honest about the burn and stated she did not mean to cause the injury. Ms. Fick stated she will substantiate since there was an injury. Ms. Fick stated Michigan State Police Trooper Ratcliff is also investigating the burn.

On 02/19/2026 I interviewed licensee designee Mr. Boyd. Mr. Boyd stated he was informed the previous AFC provider tried this method with Resident A when she experienced cramps and I informed him Citizen 1 told me she did not say this. Mr. Boyd stated this experience is going to be a learning experience for Ms. Cook to always follow the physician orders in the future. Mr. Boyd stated he knows Ms. Cook felt awful and was in tears when this was discussed with her.

APPLICABLE RULE	
R 400.673	Use of assistive devices, therapeutic support.
	(1) An assistive device or therapeutic support must be authorized in writing by an appropriately licensed health care professional and the authorization must state the reason for and the term of the authorization.
ANALYSIS:	Ms. Cook made a rice heating pad for Resident A to assist with her menstrual cramps which was not an approved therapeutic support for her from her physician, her <i>Assessment Plan for AFC Residents</i> , or her <i>Person Centered Plan</i> . Ms. Cook stated she did not mean to cause her harm; however, this left a burn on Resident A's abdomen for which she received medical treatment.
CONCLUSION:	VIOLATION ESTABLISHED

