



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 25, 2026

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

RE: License #: AS370011271  
Investigation #: 2026A1033020  
Adams Home

Dear Mr. Boyd:

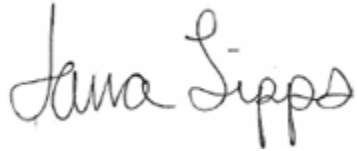
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Jana Lipps".

Jana Lipps, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
 BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
 SPECIAL INVESTIGATION REPORT  
 THIS REPORT CONTAINS QUOTED PROFANITY AND SEXUALLY EXPLICIT  
 CONTENT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS370011271
<b>Investigation #:</b>	2026A1033020
<b>Complaint Receipt Date:</b>	02/25/2026
<b>Investigation Initiation Date:</b>	02/25/2026
<b>Report Due Date:</b>	04/26/2026
<b>Licensee Name:</b>	Crisis Center Inc - DBA Listening Ear
<b>Licensee Address:</b>	107 East Illinois Mt Pleasant, MI 48858
<b>Licensee Telephone #:</b>	(989) 773-0326
<b>Administrator:</b>	Kaila Morris
<b>Licensee Designee:</b>	James Boyd, Designee
<b>Name of Facility:</b>	Adams Home
<b>Facility Address:</b>	208 S. Adams Street Mount Pleasant, MI 48858
<b>Facility Telephone #:</b>	(989) 317-8717
<b>Original Issuance Date:</b>	03/11/1987
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/04/2025
<b>Expiration Date:</b>	10/03/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL



## II. ALLEGATION(S)

	<b>Violation Established?</b>
Direct care staff, Andrew Podvin and Conner Byrne, were involved in a physical altercation at the facility while they were on shift providing for resident care and supervision.	Yes
Direct care staff, Isaac Dietz and Nathan Cook, engaged in sexually explicit conversations in the presence of residents.	Yes

## III. METHODOLOGY

02/25/2026	Special Investigation Intake- 2026A1033020
02/25/2026	Special Investigation Initiated – Letter- Email correspondence sent to Central Michigan Community Mental Health Recipient Rights Advisors, Katie Hohner and Keagan Sarkar.
02/26/2026	Contact - Document Received- Email correspondence received from CMH-CM, Katie Hohner and Keagan Sarkar.
03/02/2026	Inspection Completed On-site- Interviews conducted with direct care staff, Kimberly Jones, Brian Recker, Milissa Torres, and Resident A. Review of resident records initiated.
03/12/2026	Contact - Telephone call made- Interview conducted with direct care staff, Andrew Podvin, via telephone.
03/12/2026	Contact - Telephone call made- Interview conducted with direct care staff, Conner Byrne, via telephone.
03/12/2026	Contact - Telephone call made- Attempt to interview direct care staff, Nathan Cook, via telephone. Voicemail message left, awaiting returned call.
03/12/2026	Contact - Telephone call made- Interview conducted with direct care staff, Shawn McCoppin, via telephone.
03/12/2026	Contact - Telephone call made- Attempt to interview direct care staff, Isaac Dietz, via telephone. Voicemail message left, awaiting response.
03/12/2026	APS Referral- No current suspicion of abuse, neglect, exploitation.
03/12/2026	Contact - Document Sent- Email correspondence sent to licensee designee, Jim Boyd.

03/17/2026	Inspection Completed-BCAL Sub. Compliance
03/20/2026	Contact – Telephone call made- Attempt to interview direct care staff, Nathan Cook. Voicemail message left, awaiting response.
03/20/2026	Contact – Telephone call made- Attempt to interview direct care staff, Isaac Dietz. Voicemail message left, awaiting response.
03/20/2026	Contact – Telephone call made- Interview conducted with CMCMH, ORR Advisor, Katie Hohner, via telephone.
03/20/2026	Contact – Telephone call made- Interview conducted with Administrator, Kaila Morris, via telephone.
03/20/2026	Exit Conference Conducted via telephone with Administrator, Kaila Morris, and via email with licensee designee, Jim Boyd.

**ALLEGATION: Direct care staff Andrew Podvin and Conner Byrne, were involved in a physical altercation at the facility while they were on shift providing for resident care and supervision.**

**INVESTIGATION:**

On 2/25/26 I received an online complaint regarding the Adams Home, adult foster care facility (the facility). The complaint alleged that direct care staff members Andrew Podvin and Conner Byrn, were involved in a physical altercation while at the facility providing for resident care. The complaint alleged that this incident occurred on 2/16/26. On 2/25/26 I had email correspondence with Community Mental Health for Central Michigan, Recipient Rights Advisor, Keegan Sarkar. Ms. Sarkar reported that she had already interviewed the four direct care staff members present on 2/16/26 and received statements from each regarding the physical altercation that occurred at the facility between Mr. Podvin and Mr. Byrne on 2/16/26. Ms. Sarkar reported that there was also a verbal altercation reported between Mr. Podvin and Mr. Byrne on 2/13/26. Ms. Sarkar identified the other two direct care staff members present on 2/16/26 as Nathan Cook and Shawn McCoppin.

On 3/2/26 I completed an unannounced on-site investigation at the facility. I interviewed direct care staff/assistant home manager, Kimberly Jones, regarding the allegation. Ms. Jones reported that she was not present at the facility on 2/16/26 during the time of the reported physical altercation between Mr. Podvin and Mr. Byrne. She reported that she was told that the altercation occurred around 11pm, at shift change. She reported that Mr. Podvin was ending his shift and Mr. Byrne was arriving for his shift. Ms. Jones reported that direct care staff, Nathan Cook and Shawn McCoppin were present at the facility at the time of the altercation. She reported that it was stated to her that the

altercation occurred outside the facility in the parking area. Ms. Jones reported that there was still blood on the front door when she arrived for her next shift after the altercation. Ms. Jones reported that she was told the police were called and Mr. Podvin was transported to the emergency department for injuries sustained during the altercation. Ms. Jones reported that Mr. Byrne remained at the facility and finished his shift as he was scheduled to work from 11pm to 7am that evening. Ms. Jones stated that it was reported to her that the altercation occurred outside the facility and Mr. cook and Mr. McCoppin remained in the facility with the residents, who were all in their bedrooms.

On 3/2/26 during the unannounced, on-site investigation I interviewed direct care staff, Brian Recker, regarding the allegation. Mr. Recker reported that he has no direct knowledge of the alleged physical altercation between Mr. Byrne and Mr. Podvin on 2/16/26. He reported that he was uncertain where the residents were located at the time of the altercation, and he does not feel any of the residents are capable of providing a factual interview regarding the event.

On 3/2/26 during the unannounced, on-site investigation I interviewed direct care staff, Milissa Torres, regarding the allegation. Ms. Torres reported that she was not present at the facility on 2/16/26 and has no direct knowledge of the alleged incident between Mr. Podvin and Mr. Byrne. Ms. Torres reported that of the six current residents she felt Resident A might be capable of being interviewed and providing accurate statements.

On 3/2/26 during the unannounced, on-site investigation, I interviewed Resident A. Resident A reported that he is unaware of any verbal or physical altercations occurring at the facility amongst direct care staff workers. He reported no concerns at this time.

On 3/12/26 I interviewed Mr. Podvin, via telephone, regarding the allegation. Mr. Podvin reported that he worked at the facility from December 2025 thru February 2026. Mr. Podvin reported that he had been terminated from employment at the facility due to the physical altercation that occurred with Mr. Byrne on 2/16/26. Mr. Podvin reported that prior to this altercation, he and Mr. Byrne had a verbal altercation at the facility on 2/13/26. He reported that this was him standing up for himself, because Mr. Byrne was acting as though he was Mr. Podvin's supervisor and he had enough of him picking on his job performance. Mr. Podvin reported that on 2/16/26 he and Mr. Cook had worked together from 3pm to 11pm and were ending their shift. He reported that Mr. Byrne and Mr. McCoppin were arriving for their shift and they were in the middle of shift change. He reported that Mr. Byrne walked by him and "shoulder checked" him near the medication room inside the facility. Mr. Podvin reported that he found the telephone number for Administrator, Kaila Morris, and went out to his vehicle to call Ms. Morris and report the incident. Mr. Podvin reported that he had been sitting in his vehicle when Mr. Byrne came outside of the facility. He reported that Mr. Byrne circled around his own vehicle and then circled around Mr. Podvin's vehicle. He reported that Mr. Byrne then started to beat on his car and bent his front fender as he yanked open Mr. Podvin's driver's side door. He reported that Mr. Byrne stated, "Where the fuck is my coat!". Mr. Podvin reported that Mr. Byrne tried to pull him out of the vehicle and Mr. Podvin got out

of the vehicle. Mr. Podvin reported that Mr. Byrne began walking away and was able to get inside the facility near the medication room. He reported that he followed Mr. Byrne into the facility and the two began to “scuffle”. He reported that he and Mr. Byrne were hitting each other, throwing one another around, and wrestling on the ground at times. Mr. Podvin reported that this started inside the facility and then moved outside near the parking area. Mr. Podvin reported that Mr. Cook and Mr. McCoppin tried to stop the altercation and eventually it ended and Mr. Podvin called the police. Mr. Podvin reported that he sustained several gashes, scratches, and a bloody nose. He reported that the residents were in their bedrooms during the altercation but noted that Resident B was awake and could hear the entire altercation.

On 3/12/26 I interviewed Mr. Byrne via telephone, regarding the allegation. Mr. Byrne reported that he has been employed at the facility for the past three years. He reported that he had recently been terminated due to the physical altercation that ensued between himself and Mr. Podvin. Mr. Byrne reported that on 2/16/26 he arrived for his 11pm shift around 10:52pm. He reported that he began checking the bathroom chart to determine which residents required immediate care. He reported that he then noticed his coat was missing and remembered hanging his coat up upon arrival. He reported that he went outside the facility to check his car for his coat. He reported he observed Mr. Podvin sitting in his car and he knocked on the window to ask him if he had seen his coat. He reported that Mr. Podvin stated, “Don’t fucking touch my stuff” and tried to shut the car door on Mr. Byrne. He reported that at this time Mr. Podvin got out of the car and began charging Mr. Byrne. Mr. Byrne reported that he and Mr. Podvin then became engaged in a physical altercation, outside of the facility. He reported that this altercation never went inside the facility. Mr. Byrne reported that all residents were in their bedrooms and Mr. Cook and Mr. McCoppin were inside counting medications and providing for resident supervision. He reported that he and Mr. Podvin hit, scratched, and wrestled around outside the facility. He reported that Mr. Podvin kned him in the groin. Mr. Byrne reported that the altercation organically ended and Mr. Podvin called the police and Mr. Byrne went inside the facility and called Ms. Morris. Mr. Byrne reported that Ms. Morris was on the telephone with him the entire time the police were present and interviewing himself and Mr. Podvin. Mr. Byrne reported that he experienced a previous incident with Mr. Podvin on 2/13/26 when Mr. Podvin verbally assaulted him and stated he was going to beat Mr. Byrne up. Mr. Byrne stated that he reported that incident to direct care staff/home manager, Isaac Dietz, and Ms. Morris.

On 3/12/26 I interviewed Mr. McCoppin, via telephone, regarding the allegation. Mr. McCoppin reported that he was working 11pm to 7am on 2/16/26 with Mr. Byrne. He reported that he had been inside the facility with Mr. Cook when the physical altercation between Mr. Podvin and Mr. Byrne occurred outside the facility. Mr. McCoppin reported that the altercation was never inside the facility. He reported that he could hear the altercation while he was inside the facility and did run outside to intervene and break up the situation. Mr. McCoppin reported the residents were all in their bedrooms at the time of the altercation. Mr. McCoppin reported that the police came to the facility and took everyone’s statements and Mr. Podvin and Mr. Cook left. He reported that Mr. Byrne stayed and finished his shift. Mr. McCoppin reported that he had observed a previous

occurrence of Mr. Podvin verbally assaulting Mr. Byrne on 2/13/26. Mr. McCoppin reported that Mr. Podvin stated he was upset because Mr. Byrne was “bullying him”.

On 3/12/26 I reviewed the *Michigan Workforce Background Check* Eligibility letters for Mr. Byrne and Mr. Podvin. Both direct care staff were cleared through the background check system to provide care in a licensed adult foster care setting.

<b>APPLICABLE RULE</b>	
<b>R 400.621</b>	<b>Capability.</b>
	<b>Licensees, staff, volunteers, and members of the household shall be capable of ensuring the welfare of residents.</b>
<b>ANALYSIS:</b>	Based upon the interviews conducted during this investigation it can be determined that Mr. Podvin and Mr. Byrne became involved in a physical altercation on the premises of the facility on 2/16/26 and a verbal altercation at the facility on 2/13/26. It can be determined that both direct care staff members physically engaged in violence despite being scheduled and hired to provide for the supervision, protection, and personal care needs of the six residents at the facility. Even though, Mr. Cook and Mr. McCoppin, report being present in the facility and available for the needs of the current residents, the behaviors of Mr. Byrne and Mr. Podvin lack proper judgement and emotional temperament to put resident needs first and perform the required aspects of the positions they were hired to work. As a result, a violation has been established at this time.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION: Direct care staff Isaac Dietz and Nathan Cook, engaged in sexually explicit conversations in the presence of residents.**

**INVESTIGATION:**

On 2/25/26 I received an online complaint regarding the facility. The complaint alleged on 2/17/26 licensee designee, Jim Boyd, made a complaint to the Community Mental Health of Central Michigan Office of Recipient Rights to report that Mr. Podvin reported to him that two to three weeks prior Mr. Podvin overheard direct care staff/home manager Isaac Dietz, and direct care staff Nathan Cook, engaging in a sexually explicit conversation in the presence of Resident B and Resident C.

On 2/25/26 I had email correspondence with Community Mental Health of Central Michigan, Recipient Rights Advisor, Katie Hohner, regarding the allegation. Ms. Hohner reported that she had conducted an on-site investigation at the facility and she interviewed Mr. Podvin, Mr. Dietz, and Mr. Cook, regarding the allegation. She reported

that Mr. Podvin confirmed the allegation. She reported that Mr. Dietz denied the allegation. She reported that Mr. Cook confirmed the allegation and noted that Mr. Dietz initiated the sexually explicit conversation and identified that he did not do anything to end the conversation. Ms. Hohner reported that she attempted to interview Resident B and Resident C and these were unsuccessful interviews due to Resident B not being capable of being interviewed and Resident C ran from the room and refused to be interviewed. Ms. Hohner reported that she also interviewed Ms. Morris and Mr. Boyd regarding the allegation and was told that Mr. Dietz has been previously counseled regarding “professionalism” in the workplace, but they had no direct knowledge of Mr. Dietz conducting sexually explicit conversations in the presence of residents.

On 3/2/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Jones regarding the allegation. She reported that she has never observed or overheard any direct care staff members engaging in sexually explicit conversations in the presence of residents.

During the on-site investigation on 3/2/26 I interviewed Mr. Recker regarding the allegation. Mr. Recker reported that he has never observed direct care staff members engaged in sexually explicit conversations in the presence of residents.

During the on-site investigation on 3/2/26 I interviewed Ms. Torres regarding the allegation. Ms. Torres reported that she has never observed or overheard any direct care staff members engaging in sexually explicit conversations in the presence of the residents.

On 3/12/26 I interviewed Mr. Podvin via telephone regarding the allegation. Mr. Podvin reported that he cannot recall the exact date of the incident, but he was working with Mr. Cook and Mr. Dietz at the facility. He reported that Resident B and Resident C were present and Mr. Podvin could overhear Mr. Dietz talking with Mr. Cook about being able to get a “straight man to suck him off.” Mr. Podvin reported that Mr. Dietz carried on with this conversation noting that the individual who performed oral sex on him would now be considered homosexual. Mr. Podvin reported that this conversation offended him and he left the room to remove himself from the situation, but Resident B and Resident C were still present and could hear the conversation.

On 3/12/26 I interviewed Mr. Byrne via telephone regarding the allegation. Mr. Byrne reported that he has an extensive history of working with Mr. Dietz and has never observed him having sexually explicit conversations in the presence of residents.

On 3/12/26 I interviewed Mr. McCoppin via telephone regarding the allegations. Mr. McCoppin reported that he has been employed at the facility for almost one year and he has never observed or overheard Mr. Dietz having sexually explicit conversations in the presence of the residents.

On 3/12/26 I attempted to interview Mr. Dietz and Mr. Cook via telephone and have not received responses to my requests for interviews.

On 3/12/26 I reviewed the *Michigan Workforce Background Check* eligibility letter for Mr. Dietz. This letter identified Mr. Dietz having a background check completed and was provided clearance to work in a licensed adult foster care setting.

On 3/20/26 I attempted to interview Mr. Dietz and Mr. Cook via telephone and have not received responses to my requests for interviews.

On 3/20/26 I interviewed Ms. Hohner via telephone as a follow up to the email correspondence she sent on 2/25/26. I spoke with Ms. Hohner about the interview she conducted with Mr. Cook. She reported that Mr. Cook stated that Mr. Dietz did discuss receiving oral sex from a heterosexual male during their shift, while they were standing in the kitchen area and Resident B was sitting in the living room resting in his chair. Ms. Hohner reported that this conversation was within earshot of Resident B. Ms. Hohner reported that Mr. Cook stated that he knew it was inappropriate and did not stop the conversation and allowed it to continue.

On 3/20/26 I interviewed Administrator Kaila Morris via telephone regarding the allegation. Ms. Morris reported that she is aware Mr. Cook acknowledged the allegation to be true and reported Mr. Dietz did have a conversation with him about oral sex in the presence of Resident B. Ms. Morris reported that Mr. Dietz denied the allegations. Ms. Morris reported that Mr. Boyd was present for the interviews Ms. Hohner conducted with Mr. Dietz, Mr. Podvin, and Mr. Cook. Ms. Morris reported that Mr. Dietz had been provided a written consultation regarding his work performance on 12/30/25, specifically related to "professionalism" regarding how he interacts with fellow the direct care staff members. Ms. Morris reported that Mr. Dietz was provided with a second written consultation related to the incident in question regarding having sexually explicit conversations in the presence of residents.

On 3/20/26 Ms. Morris provided the following documents via email:

- Listening Ear Crisis Center, *General Consultation and Support Form*, for Mr. Dietz, dated 12/30/25. There were fifteen bullet points identified on this document, one of which being, "Refrain from blurring the line of friendship and coworker. Professionalism must be maintained." Mr. Dietz signed this document.
- *Verbal Reprimand*, for Mr. Dietz, dated 2/17/26. Under the section, *Violation*, it states, "Unprofessional Conduct". This document reads, "Recently, it was reported that you had an explicit conversation with a coworker in front of consumers. Your actions were unprofessional and inappropriate for the workplace. It is important that management members present professional behaviors and serve as positive role models."

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</b> <b>(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.</b>
<b>ANALYSIS:</b>	Based upon information obtained through interviews with Mr. Podvin, Ms. Hohner, and Ms. Morris, as well as documentation reviewed from Mr. Dietz's employee file, it can be determined that there is reasonable evidence to conclude that Mr. Dietz did engage in a sexually explicit conversation in the presence of Resident B. Mr. Podvin verbally reported this information during the interview I conducted with him and Mr. Cook verbally reported this information to Ms. Hohner during the interview she conducted on-site. Mr. Dietz's personnel file included two consultation documents for engaging in unprofessional behavior with fellow direct care staff members. Even though Mr. Dietz did not respond to my request for an interview and denied the allegations when questioned by Ms. Hohner, the two direct care staff working with him during the time of the alleged event both reported that this conversation did occur in the presence of Resident B. Therefore, a violation has been established at this time.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

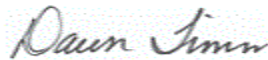


3/20/26

\_\_\_\_\_  
Jana Lipps  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



03/25/2026

\_\_\_\_\_  
Dawn N. Timm  
Area Manager

\_\_\_\_\_  
Date