GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

June 10, 2025

RE: License #: AS260419003
Investigation #: 2025A1038034
Spring St AFC

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.

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 #:	AS260419003
Investigation #:	2025A1038034
Complaint Receipt Date:	05/08/2025
Investigation Initiation Date:	05/09/2025
Report Due Date:	07/07/2025
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:	Spring St AFC
Facility Address:	1411 N Spring St Gladwin, MI 48624
Facility Telephone #:	(989) 426-0424
Original Issuance Date:	04/30/2025
License Status:	TEMPORARY
Effective Date:	04/30/2025
Expiration Date:	10/30/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff are not providing proper safety for the residents.	Yes

III. METHODOLOGY

05/08/2025	Special Investigation Intake 2025A1038034
05/09/2025	Special Investigation Initiated - Telephone call made to complainant
05/16/2025	Contact - Face to Face interviews were conducted with DCS Lydia Hayward and DCS Donald Long
05/16/2025	Contact - Face to Face interview was conducted with Resident A.
06/03/2025	Contact - Telephone call made to Guardian B1
06/03/2025	Contact - Telephone call made to DCS Ashley Staley
06/06/2025	Contact - Telephone call made to DCS Amanda Simpson.
06/09/2025	Contact - Telephone call received from DCS Amanda Simpson
06/09/2025	Contact - Telephone call made to Guardian A1.
06/09/2025	Exit Conference with Jim Boyd
06/10/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff are not providing proper safety for the residents.

INVESTIGATION:

On 5/9/25, I interviewed the complainant who verified the information on the complaint.

On 5/16/25, I conducted an investigation at the facility and recipient's rights advisor Angela Wend was present for all the interviews. I interviewed direct care staff (DCS) Lydia Hayward who stated on 5/6/25 Resident A was in the closet looking for a jacket to wear to go outside. DCS Hayward stated DCS Amanda Simpson told Resident A he did not need a jacket. DCS Hayward stated DCS Simpson walked over to Resident A turned his wheelchair around and pushed him out of the closet. DCS Harward stated DCS Simpson pushed Resident A with enough force to make his head jerked back. DCS Hayward added DCS Simpson pushed Resident A away with her hands not on the wheelchair. DCS Hayward stated Resident A did not have his seat belt on when he was pushed. DCS Hayward stated there was another incident on 5/13/25 when DCS Hayward was called into the bathroom by DCS Simpson and noticed Resident B was bleeding from his eye. DCS Hayward asked DCS Simpson what happened. DCS Hayward stated she was told Resident B was sitting in his wheelchair when he jerked back. DCS Hayward stated she was told Resident B fell out of his chair and hit his head on the side of the dresser. DCS Hayward stated Resident B was not wearing his seatbelt when he fell out of his chair. DCS Hayward stated Resident B is a fall risk. DCS Hayward stated DCS Simpson is known to yell at residents when they do not move fast enough or listen.

On 5/16/25, I conducted an interview with DCS Donald Long who provided a statement consistent with those made by DCS Hayward.

I reviewed the incident report verifying the incident regarding Resident B.

On 5/16/25, I was unable to interview Resident A and Resident B as they were unable to communicate.

On 6/3/25, I interviewed home manager Ashley Staley via telephone. Ms. Staley stated she did not witness any of the incidents mentioned. Ms. Staley stated she has not witnessed DCS Simpson being physically violent with the residents, being verbally abusive with the residents or treating the residents unfairly. Ms. Staley stated DCS Simpson can be bossy with the residents but not in a mean or disrespectful way.

On 6/3/25, I interviewed Guardian B1 via telephone, who stated he has no concerns with the staff at the facility. Guardian B1 stated the staff treat Resident B very well. Guardian B1 stated he knows about the incidents and still has no concerns.

On 6/9/25, I interviewed DCS Amanda Simpson via telephone. DCS Simpson stated the incidents were true. DCS Simpson stated Resident A was in the closet getting a jacket and she did tell him it was not needed. DCS Simpson stated she did not push his wheelchair away. DCS Simpson stated she only turned it around and closed the closet door and told him it was too hot out for a jacket, but he could still go outside. DCS Simpson stated Resident B did fall in the bathroom and in his room while in her care, which resulted in stitches. DCS Simpson stated both incidents Resident B jerked himself back and fell. DCS Simpson stated he has his Velcro wheelchair belt on, but it does not prevent him from falling out of the wheelchair. DCS Simpson stated she is a loud talker and does not yell at the residents.

On 6/9/25, I conducted an interview with Guardian A1 via telephone. Guardian A1 stated she has no concerns for Resident A at the facility. Guardian A1 stated she was made aware of the incident regarding Resident A. Guardian A1 stated the staff treat Resident A very well while at the facility.

On 6/9/25, I conducted an exit conference with licensee designee Jim Boyd. Mr. Boyd advised he understood the situation and will conduct a meeting with DCS Simpson regarding the incidents and concerns.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon my interviews with staff, guardians, and the review of documents, there was corroborating evidence of staff not maintaining Resident B's safety. Resident B fell multiple times while in the care of staff resulting in him receiving stitches.
CONCLUSION:	**VIOLATION ESTABLISHED**

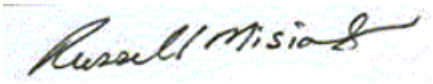
IV. RECOMMENDATION

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

6/10/25

Johnnie Daniels Date
Licensing Consultant

Approved By:



6/11/25

Russell B. Misiak Date
Area Manager