GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 13, 2026

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

RE: License #: AS260419003
Investigation #: 2026A1038017
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 #:	2026A1038017
Complaint Receipt Date:	01/22/2026
Investigation Initiation Date:	01/23/2026
Report Due Date:	03/23/2026
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:	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:	REGULAR
Effective Date:	10/31/2025
Expiration Date:	10/30/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff gave Resident A the medication prescribed for Resident B.	Yes
Staff did not keep Resident B in the line of sight.	Yes

III. METHODOLOGY

01/22/2026	Special Investigation Intake 2026A1038017
01/23/2026	Special Investigation Initiated - Telephone call made to the complainant.
02/03/2026	Inspection Completed On-site
02/03/2026	Contact - Face to Face interviews were conducted with Resident A, Resident B and Resident C.
02/03/2026	Contact - Face to Face interview was conducted with admin Robyn Castrop.
02/03/2026	Exit Conference with administrator Robyn Castrop
02/09/2026	Contact - Face to Face interview was conducted with DCS Donald Long and Angilina.
02/09/2026	Inspection Completed-BCAL Sub. Compliance
02/09/2026	APS Referral made.

ALLEGATION:

Staff gave Resident A the medication prescribed for Resident B.

INVESTIGATION:

On 1/23/26, I conducted an interview with the complainant who verified the information.

On 2/3/26, I conducted an unannounced investigation at the facility. I conducted an interview with assistant home manager (AHM) Donald Long. AHM Long stated on 1/14/26, he accidentally gave Resident A, Resident B's medication. The medications that were given to Resident A were Inderal, fish oil, Keppra, lithoid, Flomax, Protonix, Tegretol, vitamin D3 and singular. AHM Long stated Resident A had a seizure due to the medication being given and was taken to the emergency room. Resident A was released the same day. The guardians and the physicians were made aware of the error.

On 2/3/26, I conducted an interview with direct care staff (DCS) Angilina Cuadras who was working on 1/14/26. DCS Cuadras provided a statement consistent with those made by AHM Long.

On 2/3/26, I conducted an interview with administrator Robyn Castrop. Ms. Castrop provided a statement consistent with those made by AHM Long and DCS Cuadras.

I reviewed the incident reports, medication administration records, and assessment plans of Resident A and Resident B. These documents verified the information.

On 2/3/26, I attempted to conduct an interview with Resident A. I was unable to interview Resident A due to him not being able to communicate.

On 2/3/26, I attempted to conduct an interview with Resident B. I was unable to interview Resident B due to him not being able to communicate.

On 2/3/26, I conducted an exit conference with Ms. Castrop. Ms. Castrop stated AHM Long has been retrained on medication and received a verbal counseling for the incident. Ms. Castrop stated all staff were retraining on medications and what to do if an medication error occurs.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Based on my investigation, interviews with staff and the review of documents. There was enough evidence of staff giving the wrong medication to Residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not keep Resident B in the line of sight.

INVESTIGATION:

AHM Loing stated Resident B is required to always be in line of sight. AHM Loing stated on 1/16/26 he was assigned to Resident B as the line-of-sight worker. AHM Loing stated another resident needed help. AHM Loing stated he went to help another resident and Resident B went to the bathroom by himself. AHM Loing stated during this time Resident B fell and only had scraped knuckles. AHM Loing stated Resident B did have his wheelchair seat belt on before going to the bathroom. AHM Loing stated Resident B does know how to remove the seatbelt on his own.

Ms. Castrop provided a statement consistent with those made by AHM Loing.

DCS Cuadras stated she was not working on that day and did not witness the incident.

I attempted to conduct an interview with Resident A. I was unable to interview Resident A due to him not being able to communicate.

I attempted to conduct an interview with Resident B. I was unable to interview Resident B due to him not being able to communicate.

I reviewed the incident reports, assessment plans and the primary care plan, of Resident B. These documents verified the information.

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 investigation, interviews with staff and the review of documents. There was enough corroborating evidence of staff not properly maintaining line of sight for Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

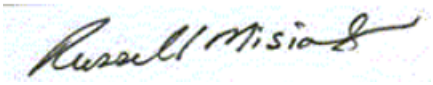
IV. RECOMMENDATION

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

2/13/26

Johnnie Daniels Date
Licensing Consultant

Approved By:



2/13/26

Russell B. Misiak Date
Area Manager