



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2026

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

RE: License #: AS180010526
Investigation #: 2026A1038028
Oakleaf 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.
- 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,

A handwritten signature in black ink that reads "Johnnie Daniels".

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 #:	AS180010526
Investigation #:	2026A1038028
Complaint Receipt Date:	03/23/2026
Investigation Initiation Date:	03/23/2026
Report Due Date:	05/22/2026
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:	Oakleaf Home
Facility Address:	2032 Seelinger Harrison, MI 48625
Facility Telephone #:	(989) 539-2803
Original Issuance Date:	01/27/1985
License Status:	REGULAR
Effective Date:	10/30/2025
Expiration Date:	10/29/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff member was sleeping in a bed with the Resident.	Yes

III. METHODOLOGY

03/23/2026	Special Investigation Intake 2026A1038028
03/23/2026	Special Investigation Initiated - Telephone was made to the complainant
03/27/2026	Contact - Telephone call made to DCS Nikki Sheppard.
04/16/2026	Inspection Completed On-site
04/16/2026	Contact - Face to Face interview was conducted with Resident A.
04/16/2026	Contact - Face to Face interview was conducted with DCS Jennifer Vietti and home manager William Brewer.
04/24/2026	Contact - Telephone call made to Guardian A1.
04/24/2026	Contact – Telephone call made To administrator Sherry Kidd.
04/24/2026	Inspection Completed-BCAL Sub. Compliance
04/24/2026	Exit Conference- With LD Jim Boyd.

ALLEGATION:

Staff member was sleeping in a bed with the Resident.

INVESTIGATION:

On 3/23/26, I conducted an interview with the complainant who verified the information.

On 3/27/26, I conducted an interview with direct care staff (DCS) Nikki Shepard via telephone. Recipients' rights advisor Sarah Watson was present for the interview. DCS Shapard stated she was not laying in the bed with Resident A. DCS Shapard stated she was sitting on the side of the bed watching a movie with the resident. DCS Shapard stated she was awake the entire time. DCS Shapard stated she would not be laying down with a resident.

On 4/16/26, I conducted an unannounced investigation at the facility. I conducted an interview with assistant manager Jennifer Vietti. Ms. Vietti stated on 3/16/26 she witnessed DCS Shapard laying in the bed of Resident A. Ms. Vietti stated she was looking for DCS Shapard during the nightshift and could not find her. Ms. Vietti stated she went into Resident A's room and all the lights and T.V was off in the room. Ms. Vietti stated she turned on the lights to find DCS Shapard laying in the bed with Resident A. Ms. Vietti stated DCS Shapard was laying in front of Resident A facing the door and Resident A was laying behind DCS Shapard facing the wall. Ms. Vietti stated DCS Shapard woke up when Ms. Vietti turned on the lights and asked her what she was doing. Ms. Vietti stated DCS Shapard did not answer but left the room and nothing else happened. Ms. Vietti stated Resident A did not show any signs of being upset about the situation or that she was aware of the incident.

On 4/16/26, I conducted an interview with home manager William Brewer who stated he was not present for the incident. Mr. Brewer stated he was made aware of the incident and the Guardian was contacted and made aware of what happened.

On 4/16/26, I was unable to conduct an interview with the resident due to their inability to communicate.

On 4/24/26, I conducted an interview with Guardian A1 who stated she is aware of the incident. Guardian A1 stated she found the incident odd as this was the first time something like this occurred. Guardian A1 stated she does not know how Resident A feels do to her not being able to communicate. Guardian A1 stated she feels as though Resident A is safe at the facility and does not think anything bad happened while the staff was sleep in the bed. Guardian A1 stated the staff was on the covers and Resident A was under the covers.

On 4/24/26, I conducted an interview with administrator Sherry Kidd who advised DCS Shapard was terminated. Ms. Kidd stated DCS Shapard was written up for the incident. Ms. Kidd stated the facility had been retrained on overnight shifts and policies. Ms. Kidd stated the facilities policy is all staff must be awake overnight.

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 upon my investigation and the interview with staff. There was corroborating evidence of the staff member sleeping in the bed with a resident.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

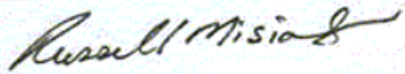


4/24/26

Johnnie Daniels
Licensing Consultant

Date

Approved By:



4/27/26

Russell B. Misiak
Area Manager

Date