GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 27, 2026

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

RE: License #: AS260419003
Investigation #: 2026A1038036
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 #:	2026A1038036
Complaint Receipt Date:	04/08/2026
Investigation Initiation Date:	04/09/2026
Report Due Date:	06/07/2026
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 member did not maintain line of sight for resident A ensuring his safety.	Yes
The facility was not providing proper medical services to Resident A.	No

III. METHODOLOGY

04/08/2026	Special Investigation Intake 2026A1038036
04/09/2026	Special Investigation Initiated - Telephone call made to the complainant.
04/21/2026	Inspection Completed On-site
04/21/2026	Contact - Face to Face interviews were conducted with Resident A and Resident B.
04/21/2026	Contact - Face to Face interviews were conducted with assistant manager Donald Long and home manager Ashley Staley
04/24/2026	Inspection Completed-BCAL Sub. Compliance
04/24/2026	APS Referral not required as there is no suspected abuse or neglect.
	Exit conference-

ALLEGATION:

Staff member did not maintain line of sight for resident A ensuring his safety.

INVESTIGATION:

On 4/9/26, I conducted an interview with the complainant who verified the information.

On 4/21/26, I conducted an investigation at the facility. Recipient rights advisor Keegan Skarkar was present for the interviews. I conducted an interview with home

manager Ashley Staley who verified direct care staff Jane Ramsey was assigned line of sight for Resident A. Ms. Staley stated DCS Ramsey was cooking when Resident A went out the facilities back door and was found in the garage area. Ms. Staley stated the line of sight policy advised the staff is required to maintain line of sight of the resident they are assigned to.

On 4/21/26, I reviewed Resident A's assessment plan, health care appraisal and the primary care plan which stated Resident A is required line of sight supervision. I reviewed the facilities policy which verified an employee is assigned line of sight of residents. The policy stated staff are allowed to complete other task, as long as they can remain in line of sight of the residents. I reviewed the incident report (IR) which verified DCS Ramsey was not in line of sight of Resident A. The IR advised, assistant manager Donald Long and community mental health case manager Kristen Ehlers were present during the incident.

On 4/21/26, I conducted an interview with assistant manager Donald Long. Mr. Long provided a statement consistent with those made by home manager Staley. Mr. Long added DCS Ramsey was written up regarding the incident.

On 4/21/26, I was unable to interview Resident A and Resident B due to their inability to communicate.

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, interview with staff and the review of documents. There is corroborating evidence of the staff not maintaining line of sight of Resident A. Resident A documents along with the facilities policy advise line of sight needs to be maintained.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility was not providing proper medical services to Resident A.

INVESTIGATION:

Ms. Staley stated Resident B has had his appointment for the medical specialist in neuroendocrinology scheduled and rescheduled by the doctors office multiple times. Ms. Staley stated Resident B has a follow-up on 7/8/26 with his primary care physician. Ms. Staley stated the medical specialist does not have any appointments until almost a year out. Ms. Staley stated Resident B is on a list to get called if there are any cancelations.

Mr. Long provided a statement consistent with those made by Ms. Staley.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(m) Employ the services of a health care professional of choice for obtaining medical, psychiatric, or dental services.**
ANALYSIS:	Based on my investigation, interviews with staff and the review of documents. There is no corroborating evidence of the facility not providing proper medical services to the resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

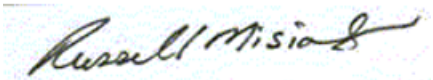
IV. RECOMMENDATION

Contingent upon the approval of a corrective action plan. I recommend the status of the license to remain unchanged.

4/27/26

Johnnie Daniels Date
Licensing Consultant

Approved By:



4/27/26

Russell B. Misiak Date

Area Manager