GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 30, 2026

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

RE: License #: AS340285830
Investigation #: 2026A0622031
Prairie Creek

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 (517) 335-5985.

Sincerely,

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

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS340285830
Investigation #:	2026A0622031
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:	Jenny Jacobs
Licensee Designee:	James Boyd
Name of Facility:	Prairie Creek
Facility Address:	1017 Prairie Creek Rd. Ionia, MI 48846
Facility Telephone #:	(616) 522-0513
Original Issuance Date:	04/23/2007
License Status:	REGULAR
Effective Date:	10/22/2025
Expiration Date:	10/21/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was hospitalized on 3/14/26 due to a seizure. Her seizure medication was not refilled, and her medication was not administered from 3/8/26-3/14/26.	Yes

III. METHODOLOGY

03/23/2026	Special Investigation Intake 2026A0622031
03/23/2026	Special Investigation Initiated – Telephone call with Recipient Rights Officer, Jennifer Morgan.
03/23/2026	Inspection Completed On-site
04/28/2026	Inspection Completed-BCAL Sub. Compliance
04/28/2026	Contact - Telephone call made to direct care workers, Miranda Verdugo-Zunin and Stephanie Gunter.
04/29/2026	Interview and exit conference with administrator, Jenny Jacobs

ALLEGATION: Resident A was hospitalized on 3/14/26 due to a seizure. Her seizure medication was not refilled, and her medication was not administered from 3/8/26-3/14/26.

INVESTIGATION:
On 03/23/2026, I received this complaint through a direct phone call. According to the complaint Resident A was hospitalized on 3/14/26 due to a seizure. Her seizure medication was not refilled, and her medication was not administered from 3/8/26-3/14/26. The complaint stated that Resident A returned home from the hospital on 3/18/2026.

On 03/23/2026, I interviewed Recipient Rights Officer, Jennifer Morgan via phone and received documents. An appointment to complete an on-site investigation was scheduled for the afternoon of 3/23/26.

On 03/23/2026, I completed an unannounced onsite investigation to Prairie Creek AFC. During the investigation, I observed Resident A, but she is non-verbal and unable to be interviewed. I viewed documentation and interviewed direct care workers.

On 03/23/2026, I interviewed direct care worker (DCW), Toni Smith in person. DCW Smith reported that she was working on 3/14/26 when Resident A had a seizure. She reported that Resident A was watching a movie and was having hiccups, but was responding to staff. She reported that her co-worker thought Resident A was having seizure behavior and was concerned, therefore she called the manager on-call. DCW Smith reported that Resident A took a huge breath and appeared like she was snoring before calling 911 and putting Resident A on the floor to start compressions until EMT arrived and took over. DCW Smith stated that EMT had a pulse for Resident A and she was taken to the hospital. DCW Smith reported that all staff were aware that Resident A was out of her Levetiracetam 500mg. DCW Smith stated that when she brought up Resident A needing additional Levetiracetam 500mg she was informed by the home manager/DCW Miranda Verdugo-Zunin and DCW Stephanie Gunter that the pharmacy has been called. DCW Smith stated that there is no protocol on who needs to re-fill medications, as she thinks any direct care worker can call. DCW Toni Smith reported that she did not call the pharmacy or doctor as she was informed it had already been handled.

On 03/23/2026, I interviewed direct care worker, Amber Soles in person. DCW Soles stated that she asked the home manager/DCW Miranda Verdugo-Zunin and DCW Stephanie Gunter about the medication not being filled and available for administration and was informed that they were waiting for the pharmacy to fill the prescription. DCW Soles stated that she was informed that DCW Stephanie Gunter was asked many times to call the pharmacy. DCW Soles stated that DCW Gunter stated to her that she called the pharmacy.

On 03/23/2026, I viewed documentation within the home. I viewed a document called medication count for Resident A. The form listed Resident A's Levetiracetam 500mg from dates March 1st-22nd. According to the medication count, on March 8th, Resident A had one pill left for her morning dose. After her morning dose the count stated "0". According to the medication count for Resident A's Levetiracetam 500mg, on March 8th for the evening dose she had 0 and March 9th- March 18th the count was 0. On March 19th, Resident A had 29 Levetiracetam 500mg pills. Direct care workers on first, second and third shifts initialed their counts, meaning all staff that worked from March 8th-18th were aware that Resident A had zero (0) Levetiracetam 500mg.

According to Resident A's medication order, she should receive Levetiracetam 500mg twice a day for her seizures.

On 03/23/2026, I viewed Resident A's QuickMar for the administration of Levetiracetam for March 2026. The following were documented for reasons why Resident A did not receive Levetiracetam 500mg twice a day.

- March 8th at 8:38pm; Physically unable to take
- March 9th at 10:02am; pending pharmacy delivery
- March 9th at 8:33pm; pending pharmacy delivery

- March 10th at 9:07am; no comment entered by the home manager Miranda Verdugo-Zunin
- March 10th at 8:52pm; pending pharmacy delivery
- March 11th at 9:31am; pending pharmacy delivery
- March 11th at 8:30pm; pending pharmacy delivery
- March 12th at 9:09am; no comment entered by DCW Stephanie Gunter
- March 12th at 8:32pm; pending pharmacy delivery
- March 13th at 9:34am; out of facility; waiting for doctor to send over new script
- March 13th at 8:48pm; pending pharmacy delivery
- March 14th at 9:52am; pending pharmacy delivery
- March 14th-March 17th' out of facility at hospital.

On 03/23/2026, I viewed a daily communication log for Resident A from 3/8-3/14 and there was no documentation communicating to staff that Resident A was out of her medication Levetiracetam 500mg documented on the daily communication logs.

On 03/23/2026, I viewed a discharge summary for Resident A from University of Michigan-Sparrow hospital dated 3/18/2026. According to the discharge summary, Resident A was admitted to the hospital on 3/15/26 at 7:18pm. Her admission diagnosis was seizure, pulmonary embolism and acute pulmonary embolism. The discharge summary also stated: "was presented to U of M Health-Sparrow Ionia for possible seizure on 3/14/26 and was transferred to Sparrow Main on 3/15 for neurology evaluation. Seen by Neurology attributed this was a breakthrough seizure, it was likely due to missed medications and provoked by her PE."

On 04/28/2026, I interviewed DCW Miranda Verdugo-Zunin via phone. She described her role as the previous AF home manager and stated that she no longer works there after being let go around 4/1/26. DCW Verdugo-Zunin stated that she asked DCW Stephanie Gunter to call the pharmacy many times to get Resident A's Levetiracetam medication refilled. She also reported that the pharmacy was down for a short period of time too. DCW Verdugo-Zunin stated that when Resident A was in the hospital, she called the pharmacy and found out that a new prescription was needed from Resident A's doctor because there were no refills left on the previous Levetiracetam 500mg prescription. DCW Verdugo-Zunin explained that a doctor at the hospital was able to review the medication and send in a new prescription to Resident A's pharmacy, so the medication could be refilled when she returned to Prairie Creek AFC. DCW Verdugo-Zunin stated that they did not document any of their phone calls to the pharmacy to get a status update on the medication refill or to Resident A's doctor's office to get a new prescription for Levetiracetam for Resident A.

On 04/28/2026, I interviewed DCW Stephanie Gunter via phone. DCW Gunter stated that refilling medications was the responsibility of the previous manager/DCW Miranda Verdugo-Zunin. DCW Gunter reported that the manager was putting her responsibilities on others. DCW Gunter could not identify if she called the pharmacy to have Resident A's medication refilled. She stated that the pharmacy was also shut down for a short period of time. DCW Gunter reported that all workers were aware that Resident A was

out of her seizure medication. DCW Gunter stated that there is no documentation of any workers calling Resident A's pharmacy or doctor to have the medication refilled.
On 04/29/2026, I interviewed administrator Jenny Jacobs via phone. She confirmed that there is no documentation of direct care workers calling Resident A's pharmacy or doctor.

According to Resident A' s pharmacy, it was posted on their Facebook page that their system was down from March 4th-March 9th.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the interviews conducted and documentation reviewed, all direct care workers were aware that Resident A did not have her Levetiracetam 500mg available within the home to administer as prescribed. According to Resident A's medication administration record, she should have received this medication twice a day. Based upon Resident A's medication count and QuickMar she did not receive her Levetiracetam 500mg from March 8th at 8:38pm through March 14th at 9:52am. According to interviews and documentation, Resident A was taken by ambulance on 3/14/26 in the evening for a seizure. Resident A was hospitalized from 3/14/26-3/18/26. According to Resident A's hospital discharge summary her breakthrough seizure was likely due to missed medications and provoked by her PE. No documentation was available for review confirming that direct care workers attempted to call Resident A's pharmacy or doctor's office in attempt to get her Levetiracetam 500mg refilled. Due to direct care staff not following doctors orders and providing Resident A with her Levetiracetam 500mg from 3/8/26-3/14/26, which then resulted in Resident A having a seizure and needing to be hospitalized for four days, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.

04/30/2026

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Amanda Blasius — Date
Licensing Consultant

Approved By:

04/30/2026

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Dawn N. Timm — Date
Area Manager