GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2026

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

RE: License #: AS370084056
Investigation #: 2026A0577043
Lynnwood 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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,

Bridget Vermeesch

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370084056
Investigation #:	2026A0577043
Complaint Receipt Date:	05/19/2026
Investigation Initiation Date:	05/20/2026
Report Due Date:	07/18/2026
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Kaila Morris
Licensee Designee:	James Boyd
Name of Facility:	Lynnwood Home
Facility Address:	1801 S. Lynnwood Mount Pleasant, MI 48858
Facility Telephone #:	(989) 772-8133
Original Issuance Date:	04/12/1999
License **Status:**	REGULAR
Effective Date:	10/31/2025
Expiration Date:	10/30/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A fell off of van lift due to lift not being utilized properly by direct care staff.	Yes
Resident B was not seat belted into his wheelchair and fell out during a fire drill.	Yes

III. METHODOLOGY

05/19/2026	Special Investigation Intake, 2026A0577043
05/20/2026	Special Investigation Initiated – Letter, Melissa Leach, ORR-CMHCM
05/20/2026	Referral - Recipient Rights
05/20/2026	APS Referral
05/20/2026	Contact - Document Received IR received via email from M Leach, ORR-CMHCM.
05/20/2026	Contact - Document Received IR received from M Leach, re Resident A.
05/20/2026	Contact - Telephone call made, M. Leach, ORR-CMHCM.
05/25/2026	Contact - Document Received Physicians orders for assistive devices.
05/25/2026	Contact - Document Sent, Kaila Morris, Regional Manager.
05/25/2026	Contact - Document Sent Naudia Potts, HM.
05/26/2026	Contact - Document Sent, Email to Naudia Potts, HM.
06/03/2026	Inspection Completed On-site
06/15/2026	Contact-Telephone Call Made, Interview with DCS.
06/16/2026	Exit Conference with licensee designee Jim Boyd.

ALLEGATION:

- **Resident A fell off of van lift due to lift not being utilized properly by direct care staff.**
- **Resident B was not seat belted into his wheelchair and fell out during a fire drill.**

INVESTIGATION:

On May 19, 2026, a complaint was received reporting on 05/15/2026 Katherine Kinder, direct care staff, (DCS) failed to utilize the "van lift" appropriately when assisting Resident A out of the van which led to Resident A falling backwards off the van lift. The complaint reported that a neighbor and DCS Makayla Smith assisted Ms. Kinder in lifting Resident A's wheelchair upright and proceeded to call 911 and the home manager. The complaint reported that Resident A was taken by ambulance to the hospital for an evaluation, no injuries were sustained but it was noted "minor bruising on [Resident A's] back."

On May 20, 2026, I interviewed Melissa Leach from the Office of Recipient Rights with Community Mental Health Central Michigan (ORR-CMHCM). Ms. Leach reported that, upon reviewing AFC Licensing Division Incident/Accident Reports (IRs) completed on May 15, 2026, concerns were noted regarding an incident in which Resident A fell from a van lift. Ms. Leach provided a copy of the IR, which stated that while assisting residents off the facility van after an outing, DCS Katherine Kinder attempted to unload Resident A, who uses a wheelchair lift. The IR documented the lift had not been fully raised, causing Resident A's wheelchair to tip backward. Ms. Kinder attempted to stabilize the chair, but both she and Resident A fell from the van. The IR indicated that the wheelchair handle prevented Resident A from striking his head, and he remained face up in the chair. A neighbor and another staff member assisted in returning the wheelchair to an upright position. Emergency services were contacted, and Resident A was transported to the hospital for evaluation. The IR documented that no visible injuries were observed at the scene, hospital scans revealed no injuries, and only minor bruising was considered possible.

Ms. Leach also reported that an IR completed on May 15, 2026, by DCS Janell Utlerback documented an incident that occurred during a fire drill. According to the IR, Ms. Utlerback had not fastened Resident B's wheelchair seatbelt. While attempting to pass a housemate standing in the doorway, she inadvertently pushed Resident B's wheelchair forward. Due to a slight slope in the sidewalk outside the door, the wheelchair rolled down the incline with Resident B in it and tipped over. The IR documented that no injuries were reported.

Ms. Leach reported that she interviewed DCS Katherine Kinder on May 18, 2026, and she acknowledged the incident happened without denial. Ms. Leach reported that Ms. Kinder reported that she thought she put the van lift up after removing another resident from the van, stating, "but I must have forgot, so when I pushed him out the back of the van he fell out of the van backwards." Ms. Leach reported that Ms. Kinder stated she

attempted to pull Resident A back into the van but was not strong enough and both Resident A and Ms. Kinder fell to the ground. Ms. Leach reported that Ms. Kinder stated Resident A wears a 4-point harness when in his wheelchair, along with having a head rest on his chair, so he did not fall out of the wheelchair nor did he hit his head, but the back of the wheelchair did "bounce" off the ground. Ms. Leach reported that Ms. Kinder was upset and had visible marks on her shins and wrists where she did everything she could to stop or brace Resident A's fall. Ms. Leach reported that Resident A was also seen by his neurologist as a follow up for his shunt on May 18, 2026, and there was no damage or concerns regarding Resident A's shunt from the fall.

On May 25, 2026, I contacted DCS Naudia Potts, whose role is home manager, and she provided me with copies of Resident A and Resident B's physician orders, *Assessment Plan for AFC Residents* and *Person Centered Plan*. Upon review of the requesting documents, I noted that Resident A is prescribed a manual wheelchair with a seatbelt, footbox, lateral left arm support, and butterfly chest harness used for his safety. These were ordered on December 04, 2024, by CMHCM Occupational Therapist. Resident A's *Assessment Plan for AFC Residents* and *Person Centered Plan* both documented that Resident A requires the use of a custom fitted Tilt N Space wheelchair with an attached seatbelt, a vest to assist with positioning while in the wheelchair, a foot box and arm strap for safety when being maneuvered. Resident B's documents verified that he is prescribed a wheelchair with seatbelt and body point security buckle. These assistive devices were ordered on June 11, 2025, by CMHCM Occupational Therapist. Resident B's *Assessment Plan for AFC Residents* and *Person Centered Plan* both documented that Resident B requires the use of a wheelchair and locking seatbelt for safety.

On May 25, 2026, I contacted administrator Kaila Morris who provided me with verification of DCS Katherine Kinder's Training Inservice Records for the van which documented Ms. Kinder completed an in-service video training on February 10, 2026. Ms. Kinder also completed the annual in-service training for all direct care staff which includes a full van/vehicle orientation, completion of checklist, and three training videos. This training was documented as completed on April 01, 2026.

On June 03, 2026, I completed an unannounced onsite investigation and observed Resident A in bed sleeping with no visible injuries. I also interviewed Resident B who reported that while completing a fire drill, DCS Janell Utlerback pushed Resident B's wheelchair out the side door to go to the back yard. Resident B reported DCS Utlerback forgot to buckle Resident B's wheelchair seatbelt and once out the facility door, there is a little slope, and Resident B's wheelchair rolled down the slope causing Resident B to fall out of his wheelchair due to not being buckled in. Resident B reported he had a small scratch on his knees, but no other injuries.

During the onsite investigation, I interviewed DCS Makayla Smith who reported that she was working with DCS Katherine Kinder on May 18, 2026, when Resident A fell off the van lift pulling DCS Kinder with him due to the lift not being hoisted. Ms. Smith reported that she had just unloaded another resident from the outing and went into the facility to

start passing medications to residents when she heard DCS Kinder yell for help. Ms. Smith stated she ran outside and found DCS Kinder and Resident A on the ground. Ms. Smith reported that a neighbor came running over to assist DCS Kinder and Ms. Smith with picking Resident A up from the ground. Ms. Smith reported Resident A has no injuries but medical attention was sought to assure Resident A's shunt was not damaged during the fall.

DCS Naudia Potts showed me the exit used during the fire drill on May 15, 2026. I noted that the sidewalk has a slight slope towards the backyard where Resident B's wheelchair rolled off after Resident B was placed on the sidewalk while DCS Utlerback went back into the facility to assist the next resident.

On June 15, 2026, I left a voicemail message with DCS Janell Utlerback, requesting a return call, with no return call.

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:	On May 15, 2026, DCS Katherine Kinder unloaded Resident A from the facility van without ensuring the van lift was fully raised. DCS Katherine Kinder did not follow proper safety procedures while exiting the van with a resident in a wheelchair which resulted in Resident A's wheelchair tipping backward and both Resident A and DCS Katherin Kinder fell from the van. Although Resident A's positioning equipment and harness prevented more serious injury, Resident A was evaluated by a medical professional to assure Resident A's shunt was not affected by the fall. Also on May 15, 2026, during a fire drill, DCS Janell Utlerback did not buckle Resident B's wheelchair safety belt prior to taking Resident B down a small slope. This resulted in Resident B falling out of his wheelchair onto the ground and sustaining small scrapes. Based on the documented facts, the licensee did not fully comply with the rule requiring supervision, protection, and personal care in accordance with the resident's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

Bridget Vermeesch

06/16/2026

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

06/17/2026

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Dawn N. Timm Date
Area Manager