GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 12, 2026

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

RE: License #: AS400069154
Investigation #: 2026A0009030
North Birch

Dear Mr. Boyd:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frame 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS400069154
Investigation #:	2026A0009030
Complaint Receipt Date:	07/23/2026
Investigation Initiation Date:	07/23/2026
Report Due Date:	08/22/2026
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Sherry Kidd
Licensee Designee:	James Boyd
Name of Facility:	North Birch
Facility Address:	2200 N Birch Kalkaska, MI 49646
Facility Telephone #:	(231) 258-5105
Original Issuance Date:	01/25/1996
License Status:	REGULAR
Effective Date:	02/23/2026
Expiration Date:	02/22/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A fell out of his wheelchair in the facility's van and was injured as a result.	Yes

III. METHODOLOGY

07/23/2026	Special Investigation Intake 2026A0009030
07/23/2026	Special Investigation Initiated – Telephone call received from administrator Sherry Kidd
07/28/2026	Inspection Completed On-site Interview with direct care worker Quartney Lester
08/10/2026	Contact – Telephone call made to home manager Kelly Happel
08/10/2026	Contact – Document (email) received from home manager Kelly Happel
08/11/2026	Contact – Telephone call made to Resident A's Guardian
08/11/2026	Contact – Telephone call made to licensee designee Sherry Kidd
08/12/2026	Exit conference with administrator Sherry Kidd

ALLEGATION: Resident A fell out of his wheelchair in the facility's van and was injured as a result.

INVESTIGATION: I received a telephone call from administrator Sherry Kidd on July 23, 2026. She reported that Resident A had fallen out of his wheelchair in the facility's van and was injured. He was taken to the hospital and it was determined that he had suffered a broken femur bone. She said that the incident report detailing the event mentioned that Resident A's seat belt had come undone but not how it came undone as they were pulling out of the driveway. She was still looking into how this might have happened but wanted me to know about it.

I conducted an unannounced site visit at the North Birch adult foster care home on July 28, 2026. I spoke with direct care worker Quartney Lester at that time. She said that she had been the one who was driving when Resident A fell out of his wheelchair. She said that she acts as assistant home manager at the facility and provides most of the transportation for residents. Ms. Lester said that as she was leaving that day, home manager Kelly Happel came out and told her that Resident A

should have his medication before they left. Ms. Lester went in to prepare his medication at that time and brought it out to him. Ms. Happel stayed with Resident A as he was in the van until she came back. Ms. Lester stated that Resident A did not want to take his medication and became agitated. They were trying to gently encourage him to take it, but he was swearing at them and refusing. He did finally take it, and she proceeded to take him to his appointment. Resident A still had a partially filled cup of water in his hand. He swore at her and then threw the cup towards the front of the van. Immediately after he threw the cup, he fell out of his wheelchair. I asked to see the van and she took me and showed me the inside of the van. She showed me the four "tie-downs" that anchor his wheelchair into place. She assured me that she had those in place and correctly attached to his wheelchair. He also has a seatbelt on his wheelchair which keeps him in place in the chair. This was also on him when they started out and properly fastened. After he fell, she asked him how he had fallen out of his wheelchair. She saw that his seatbelt had been unfastened. He told her that he had been "adjusting himself", which was all she got out of him at that time because he was yelling at her. Ms. Lester said that his wheelchair seatbelt was fastened correctly when they started moving. She said the only explanation is that he unbuckled the belt himself. She stated he does know how and does unfasten the belt himself.

I spoke with home manager Kelly Happel by telephone on August 10, 2026. She said that she was present at the home when Resident A fell out of his wheelchair. She had gone out to Ms. Lester and Resident A as they were leaving to tell them that it was probably a good idea for Resident A to get his medication before leaving for his appointment. Ms. Lester went into the home to prepare his medication and she stayed with Resident A. She saw that all four of the anchor straps were attached to his wheelchair and that his wheelchair seatbelt was fastened. Resident A was initially refusing to take his medication when Ms. Lester came back and became upset. Ms. Happel said that his seatbelt should not have come undone by itself if it had been properly fastened. She said they do sometimes use a seat belt alarm with him but it was not in use at that time. Ms. Happel said she did not believe they had to always use the seat belt alarm with him but that she would check his medical records and Community Mental Health (CMH) plans to see if that was the case. She stated Resident A has not returned home yet. He is currently in the hospital and will be going to a nursing home after that. She said this is due to other medical issues unrelated to the fall.

Ms. Happel sent me an email later in the day to tell me that she had checked Resident A's medical records and CMH plans and there is nothing in those documents saying that they must use a seat belt alarm with Resident A at all times.

I spoke with Resident A's guardian by telephone on August 11, 2026. She said that she wasn't sure how Resident A had fallen out of his wheelchair but did know that he had been injured as a result. I told her that I was told that the only explanation was that he unfastened the seatbelt himself. She said that was quite possible. She had been quite concerned when hearing about the incident, but the facility has always

been “really good” with Resident A in her experience. Resident A’s guardian said that she had talked to Resident A in person after the incident and no “red flags” had come up. He was adamant that nothing bad had happened with staff saying “No, no, nothing bad”. Resident A was vague about what had happened and this could be because he had undone the seatbelt himself and didn’t want to talk about it.

I spoke with administrator Sherry Kidd by telephone on August 11, 2026 and asked her about the incident with Resident A. She said that she had determined that Resident A had not had the shoulder harness seatbelt attached when he fell out of his wheelchair. Ms. Kidd explained that this is a belt which is used in addition to the four tie-down straps and the wheelchair seatbelt. The shoulder harness seatbelt is attached to the van and comes across the resident and attaches to the floor of the van. This information was not initially shared with me, but she had subsequently talked to home manager Kelly Happel about it and Ms. Happel had talked to Ms. Lester about it. Ms. Lester reportedly admitted that the shoulder belt had not been used at the time of the incident. Resident A would not have been able to fall out of his wheelchair if the shoulder belt was properly used and secured. Ms. Kidd said that she is already preparing to increase training on facility van use and include a visual guide in each van to ensure that all the safety steps and devices are used correctly every time a resident is transported.

Ms. Kidd also sent me, via email, their *Van Lift Use Guide*. In the section, Restraint System it directed staff to, “*Extend the shoulder belt over the rider’s shoulder and across the upper torso. Connect to lap belt and secure to tiedown*”.

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:	Resident A fell out of wheelchair onto the floor of the facility’s van as they were pulling out of the driveway. The direct care worker who was caring for him at that time stated that the four tiedowns were secured as well as his lap seatbelt. As she was pulling out of the driveway, Resident A threw a plastic cup at her and fell out of his chair at that time. The direct care worker said that she believed he must have unfastened his lap seatbelt himself after they started moving. The administrator, Sherry Kidd, reported that information had come to her attention that Resident A had not been properly secured with the shoulder harness strap that is to be used during every transport. This is used in addition to the tiedowns and lap seatbelt. The direct care worker who transported Resident A admitted that it was not secured. Ms. Kidd stated

	that the direct care worker was trained on how to properly secure a resident in the van. It was confirmed through this investigation that Resident A was not protected and safe when he was driven without all the proper straps needed for transport.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted by telephone with administrator Sherry Kidd by telephone on August 12, 2026. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

08/12/2026

Adam Robarge — Date
Licensing Consultant

Approved By:

08/12/2026

Jerry Hendrick — Date
Area Manager