GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2026

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

RE: License #: AS370011271
Investigation #: 2026A1029056
Adams 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 licensee designee 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,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AS370011271
Investigation #:	2026A1029056
Complaint Receipt Date:	07/22/2026
Investigation Initiation Date:	07/22/2026
Report Due Date:	09/20/2026
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:	Adams Home
Facility Address:	208 S. Adams Street, Mount Pleasant, MI 48858
Facility Telephone #:	(989) 317-8717
Original Issuance Date:	03/11/1987
License Status:	REGULAR
Effective Date:	10/04/2025
Expiration Date:	10/03/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 07/13/2026 Resident A missed a scheduled appointment because direct care staff member Brian Recker refused to provide transportation.	Yes

III. METHODOLOGY

07/22/2026	Special Investigation Intake 2026A1029056
07/22/2026	Special Investigation Initiated – Letter Email to Sarah Watson
07/24/2026	Inspection Completed On-site – face to face with direct care staff members Milissa Torres, Brian Recker at Adams Home
08/06/2026	Contact - Telephone call made to licensee designee Jim Boyd
08/07/2026	APS Referral made to Centralized Intake
08/13/2026	Contact - Telephone call made to direct care staff member Jeff Crouch, CMH case manager Lorraine Crawford, Guardian A1, administrator Kaila Morris, licensee designee Jim Boyd and Kimberly Jones
08/18/2026	Exit Conference with licensee designee Jim Boyd

ALLEGATION: On 07/13/2026 Resident A missed a scheduled appointment because direct care staff member Brian Recker refused to provide transportation.

INVESTIGATION:

On 07/22/2026 a complaint was received via Bureau of Community and Health Systems online complaint system alleging that on 07/13/2026 Resident A missed a scheduled appointment because direct care staff member Brian Recker refused to provide transportation.

On 07/24/2026, I completed an unannounced on-site investigation at Adams Home and interviewed direct care staff member Milissa Torres. Ms. Torres stated she was working on 07/13/2026 and that when she arrived in the morning, direct care staff member Mr. Crouch informed her Resident A had an appointment that day and that direct care staff member Mr. Recker would be transporting him. Ms. Torres stated she could not

transport Resident A because he had previously been aggressive toward her during transportation. She reported there was ample time to make alternate arrangements, as she learned of the appointment at approximately 7:15 a.m. and the appointment was scheduled for around 2:00 p.m. Ms. Torres stated that Mr. Crouch was a newer manager and not trained to transport residents; however, she also noted that he had transported Resident A to other appointments in the past. Ms. Torres stated that when Mr. Recker said, “I’m not taking Resident A to his appointment and you can write me up if you need to,” Mr. Crouch did not respond. Ms. Torres believed the appointment was possibly for dental care in Midland but was not certain. She stated the doctor’s office later called to reschedule, and Resident A was technically a “no-show.” When asked why she did not call to reschedule, Ms. Torres stated she did not think of it until after the appointment time had passed and assumed Mr. Crouch would make the call.

On 07/24/2026, I also interviewed direct care staff member Brian Recker. Mr. Recker reported he was not willing to transport Resident A because Resident A becomes violent, and he did not feel safe transporting him alone. He stated there was no previously been a plan to send two direct care staff members to Resident A’s appointments, though this is now being discussed. Mr. Recker reported that Resident A has hit and kicked direct care staff members while in vehicles and that he did not want to travel down M-20 alone with Resident A, as Resident A would have the ability to hit or kick him while he was driving. Mr. Recker stated administrator Ms. Morris had mentioned possible sedation for appointments, though he did not believe sedation had ever been used. Mr. Recker reported he had worked at Adams Home for four years and expected that this incident would be reported to ORR and LARA, and he was comfortable with that because he believes alternative arrangements are needed for Resident A’s appointments. Mr. Recker stated that direct care staff member Ms. Jones previously took Resident A to an appointment where he grabbed her coat collar in the doctor’s office, forcing them to leave because the doctor wasn’t comfortable continuing the appointment due to his aggressive behaviors. Mr. Recker stated he did not know if home manager Mr. Crouch called to reschedule the missed appointment, but he and Mr. Crouch discussed the appointment at approximately 8:00 a.m. and the appointment was scheduled for 1:45 p.m., so there was sufficient time to call and reschedule.

During the on-site, I reviewed the following documentation for Resident A:

1. *Assessment Plan for AFC Residents* which states under Controls Aggressive Behavior: Manages his aggression well but needs help feeling safe.
2. Community Mental Health *Person Centered Plan* under transportation:
    a. Wheelchair with seat belt for safety and /or sedation not for restraint. Seat belt with shoulder / hip straps for safety reasons, use of wheelchair tie downs with shoulder, use of wheelchair on bus / van.
    b. [Resident A] is dependent on others for his safety needs. Has a history of inappropriate behavior at home and in the community he would require long term care facility placement without support.
    c. [Resident A] is diagnosed with intellectual disabilities severe, autism, obsessive compulsive and related disorder, major depressive disorder and panic attacks.

On 08/06/2026, I interviewed licensee designee Jim Boyd. Mr. Boyd stated that if a resident requires more than one direct care staff member to attend physician appointments, then this must be addressed in the resident's plan. He stated that direct care staff member Mr. Recker refused to complete his job duties and neglected Resident A's appointment. Mr. Boyd reported that after Resident A grabbed a staff member during an appointment in April 2026, no changes were made to require two direct care staff members for medical appointments. He stated he believes Resident A does require two direct care staff members for medical appointments and he plans to work with Community Mental Health to have this added to Resident A's *Person Centered Plan*. For upcoming appointments, he stated two direct care staff members will be scheduled. Mr. Boyd stated Resident A has been given a sedative prior to appointments in the past but he does not know if this is for every appointment. Mr. Boyd later emailed confirming the missed appointment was rescheduled for 08/18/2026 at 11:30 a.m.

On 08/13/2026, I interviewed direct care staff member whose current role is home manager, Jeff Crouch. Mr. Crouch stated he arrived for his shift with Ms. Torres and Mr. Recker and they identified that Resident A had an afternoon appointment in Midland. He reported telling Mr. Recker that he needed to transport Resident A because Mr. Crouch was not fully trained and Resident A could not be transported by a female direct care staff member due to past behaviors. Mr. Crouch stated that when informed of this, Mr. Recker said he would not take Resident A and that Mr. Crouch could write him up if needed, stating he "did not want to deal with [Resident A's] behaviors." Mr. Crouch stated Resident A has previously hit female direct care staff members while they were driving although, he has only been the home manager for a couple of months and has not personally experienced this. Mr. Crouch stated there needs to be at least two trained people for transport, and because he was not fully trained at that time, they did not have two available. Mr. Crouch stated Resident A takes Ativan before some appointments, particularly longer drives, but not for shorter appointments or local CMH visits. He was not aware whether a sedative had been prescribed for this particular appointment. Mr. Crouch stated staffing has now been adjusted to ensure two direct care staff members are available for medical appointments. He stated he was upset with Mr. Recker's attitude about not transporting Resident A due to his behaviors, rather than the need for two direct care staff members. Mr. Crouch stated Mr. Recker did not mention concerns about aggressive behaviors until a week later; had he communicated this earlier, another direct care staff member could have been called in. Mr. Crouch stated Resident A attended a CMH appointment on 08/12/2026 with one direct care staff member and there were no issues.

On 08/13/2026, I interviewed CMH case manager Lorraine Crawford. Ms. Crawford stated Resident A does not normally require two direct care staff members for transportation. Ms. Crawford stated Resident A missed a colonoscopy because hospital staff were uncomfortable with his behavior and canceled the procedure. Ms. Crawford stated she has never heard of Resident A assaulting direct care staff members during

transportation. She stated she does not know what occurred during the missed appointment addressed in this investigation.

On 08/13/2026, I interviewed Guardian A1. Guardian A1 stated she learned of the missed appointment because the provider's office contacted her to ask whether the appointment would be rescheduled. Guardian A1 stated Resident A's behavior depends on his mood and he often becomes nervous before medical appointments, which can affect how he responds. Guardian A1 reported his behavior also depends on his comfort level with the direct care staff members transporting him. She stated she does not believe it is a bad idea to require two direct care staff members, as there are no clear precursors before he lashes out and his reactions can happen quickly. Guardian A1 stated this is the first time she has ever heard of a direct care staff member refusing to transport him, and this is not a regular occurrence. She stated Resident A does not like van rides or going out, so they work with him by taking short drives to the store or getting a drink. Guardian A1 stated there have been doctor offices that refuse to treat him because he may slap providers. She stated that dental providers will give him medication to calm him before appointments to reduce his anxiety.

On 08/13/2026, I interviewed administrator Kaila Morris. Ms. Morris stated she was aware of the incident and agreed that communication could have been better from Mr. Recker. She stated that Mr. Recker apologized to Mr. Crouch for sounding rude when he said he did not want to deal with Resident A's behaviors. Ms. Morris stated that during a recent direct care staff member meeting, they discussed Resident A's transportation and she stated she felt that two direct care staff members are appropriate for transporting him. She stated there is nothing in Resident A's *Person Centered Plan* indicating he should receive a sedative except for dental appointments. Ms. Morris reported they are planning to revisit transportation guidelines in his *Person Centered Plan* and she would like it updated to reflect the need for two direct care staff members. She stated she often sends direct care staff member Ms. Jones on appointments with him and he has hit her in the past. She explained that Resident A sits in the front seat because he wants control of the radio, and if he sits in the back seat, he can reach forward and grab the driver. Ms. Morris stated they typically take their own vehicles on these visits. Ms. Morris stated that if two direct care staff members cannot attend an appointment, then Resident A may need to receive a sedative instead. She stated direct care staff use their personal vehicles to transport residents to appointments in case the facility bus is needed for outings. Ms. Morris acknowledged that using the van would be a safer option than having Resident A in the front seat of a vehicle when he is known to have these behaviors. Ms. Morris stated there is currently no transportation policy for Resident A, but she drafted one that will need to be reviewed by his primary care provider and psychiatrist in order to authorize sedative use when appropriate.

On 08/13/2026, I interviewed direct care staff member Kimberly Jones. Ms. Jones stated she was transporting Resident A to procedures and during the last one he was violent and choked her. She stated Resident A was scheduled for a colonoscopy in Midland, but due to his violent behavior toward her, medical staff instructed them to leave. Ms. Jones reported Mr. Crouch told her and Ms. Torres that neither should be

attending appointments alone with Resident A due to his behaviors and because they were not supposed to transport him without support. She stated she was alone during the last procedure. Ms. Jones stated she was off work during the July incident and when she returned, she learned that Mr. Recker refused to transport Resident A. She stated she understands that when a female direct care staff member is transporting Resident A, a male is supposed to accompany them; however, she does not know whether two males are required or only one, as this was not explained. Ms. Jones stated that during the last procedure, they only made it to the room where his blood pressure was to be checked. She attempted to hold his hand to calm him, and once the nurse stepped out, Resident A slid off the bed and slapped her twice. When the nurse returned, Resident A choked Ms. Jones, and the medical staff decided they would no longer treat him. Ms. Jones stated she was then instructed to drive Resident A home. Ms. Jones stated Resident A did not have any behavioral incidents during the drive, aside from adjusting the radio often. Ms. Jones stated approximately one year ago, Resident A attacked the former manager while they were traveling on the freeway, leaving her with two black eyes and broken glasses. She stated Resident A has never attacked male direct care staff members or registered nurses. Ms. Jones stated that when transporting Resident A to Midland or outside the immediate area, they use the van; however, for local trips, they use personal vehicles. She stated Resident A recently had to travel to Brighton and was given Ativan, and this occurred after the incident in which she was assaulted at the doctor's office. Ms. Jones stated there is no way to secure Resident A's wheelchair in personal vehicles, and she believes he should always be transported in the van. She stated Resident A has a dental appointment scheduled for 08/26/2026 and she and Ms. Torres will transport him together. She also stated Resident A has a dental appointment at the University of Michigan on 08/25/2026, which will require an overnight stay. For that appointment, the plan is for him to receive medication to sedate him during the drive.

On 08/18/2026, I completed an exit conference with licensee designee Jim Boyd. Mr. Boyd stated he will establish a protocol to ensure that transporting Resident A is safer for both Resident A and the direct care staff members involved. Mr. Boyd stated he will ensure that staff follow Resident A's *Person Centered Plan* and that Resident A is always transported using the van rather than personal vehicles.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Resident A was not consistently transported in accordance with instructions in his *Person Centered Plan*, as direct care staff members regularly used personal vehicles instead of the agency's van, which is necessary to ensure his safety and properly secure his wheelchair. Additionally, the administration of sedatives prior to appointments to reduce Resident A's anxiety and prevent aggressive behavior was not provided consistently. These deviations from established practices demonstrated that Resident A's transportation and preparatory needs were not fully aligned with the expectations of his *Person Centered Plan*.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.697	**Resident transportation.**
	(1) A licensee shall ensure the availability of transportation services as provided for in a resident care agreement. A licensee shall provide or arrange transportation for residents in a certified facility.
ANALYSIS:	Adams Home is a certified facility responsible for ensuring safe and appropriate transportation for residents; however, transportation services, including having two direct care staff members available to transport Resident A, were not available on 07/13/2026, resulting in Resident A missing his scheduled appointment.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_ _____08/19/2026_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

08/19/2026

_____

Dawn N. Timm
Area Manager

Date