



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 2, 2025

Robert and Laura Hopkins
P O Box 728
Ewart, MI 496310728

RE: License #: AS670012822
Investigation #: 2025A0870020
Hopkins Whispering Pines

Dear Robert and Laura Hopkins:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On May 20, 2025, you submitted a request to have the license closed. I will consider your request to close the license as an acceptable written corrective action plan and will close this license effective on the date of this letter.

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,

A handwritten signature in blue ink, reading "Bruce A. Messer".

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS670012822
Investigation #:	2025A0870020
Complaint Receipt Date:	05/02/2025
Investigation Initiation Date:	05/02/2025
Report Due Date:	07/01/2025
Licensee Name:	Robert and Laura Hopkins
Licensee Address:	1375 Chaput Sears, MI 49679
Licensee Telephone #:	(231) 734-5936
Name of Facility:	Hopkins Whispering Pines
Facility Address:	7401 65th Avenue Ewart, MI 49631
Facility Telephone #:	(231) 734-9957
Original Issuance Date:	10/14/1985
License Status:	REGULAR
Effective Date:	07/19/2024
Expiration Date:	07/18/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was found with yeast infections in the folds of her body.	No
Resident A was found with bedbugs on her person.	Yes

III. METHODOLOGY

05/02/2025	Special Investigation Intake 2025A0870020
05/02/2025	Special Investigation Initiated - Telephone Telephone call to McBride #1 AFC staff member Arica Quesnel.
05/02/2025	APS Referral APS referral made to MDHHS APS CI.
05/07/2025	Contact - Telephone call made Telephone calls were made to Licensee Laura Hopkins and to the facility. no answer. Voicemail left.
05/12/2025	Contact - Telephone call made Telephone calls were made to Licensee Laura Hopkins and to the AFC facility. No answer. voicemail left.
05/13/2025	Inspection Completed On-site Facility appears vacant. I left a business card in the front door for Licensee Laura Hopkins to call me ASAP.
05/14/2025	Contact - Telephone call received Telephone interview with Licensee Laura Hopkins.
05/16/2025	Contact - Telephone call made Telephone interview with home manager Sally Hopkins.
05/20/2025	Contact - Telephone call made Interview with home manager Sally Hopkins.
05/20/2025	Contact - Telephone call made Interview with CMHCM caseworker Patricia Prince.
05/20/2025	Contact - Document Received

	Request to close the license, effective upon completion of this special investigation, was received from Licensee Laura Hopkins. Ms. Hopkins written requests to close the AFC license, in lieu of a corrective action plan, is approved.
05/22/2025	Exit Conference with Licensee Laura Hopkins.
05/22/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A was found with yeast infections in the folds of her body.

INVESTIGATION: On May 2, 2025, I conducted a telephone interview with Arica Quesnel. Ms. Quesnel stated she is a direct care worker employed at the McBride #1 AFC home. She stated she was instructed to pick up Resident A from the Hopkins Whispering Pines AFC home on May 1, 2025, and transport Resident A to the McBride #1 AFC home, where she will now be living. Ms. Quesnel stated that shortly after transporting Resident A to her new home, she assisted Resident A with a shower. She noted, while washing Resident A, that Resident A had “yeast infections in every fold of her body.” Ms. Quesnel stated the yeast was removed with soap and water. She stated the affected areas were treated by facility staff and no outside medical care was needed.

On May 7, 2025, and again on May 12, 2025, I made attempts to contact Licensee Laura Hopkins by telephone at her office and by calling the facility. I left voicemails at each number, on both days, requesting Ms. Hopkins return my call.

On May 13, 2025, I conducted an unannounced on-site special investigation at Hopkin’s Whispering Pines AFC home. I found the home to be vacant and it appeared that no one is residing in the facility at this time. I left my business card in the front door with a note requesting that Ms. Hopkins contact me ASAP.

On May 14, 2025, I received a call from Laura Hopkins. I informed her of the above stated allegations. Ms. Hopkins stated she had no idea of the “yeast infection” issue with Resident A and suggested I contact the home manager, Sally Hopkins, for specific details. Ms. Hopkins stated the Whispering Pines AFC is now vacant as all of the residents have been relocated. She stated she wishes to have the license closed.

On May 16, 2025, and again on May 20, 2025, I conducted telephone interviews with home manager Sally Hopkins. Ms. Hopkins stated that facility staff members treated Resident A’s yeast infections “constantly.” She noted that staff used a prescription antifungal cream and corn starch. Ms. Hopkins stated Resident A was

showered three times weekly, and “washed up” every morning. She stated she communicated these issues with Resident A’s caseworker Patricia Prince and physician, who had prescribed the antifungal cream used on Resident A.

On May 20, 2025, I conducted a telephone interview with Patricia Prince. Ms. Prince stated she is Resident A’s case manager through Community Mental Health for Central Michigan. She stated she was aware of the “yeast infection” issues with Resident A and this has been an ongoing issue for quite some time. Ms. Prince stated she conducted monthly in-home visits with Resident A and Resident A also saw her doctor every six months. She noted she was always under the impression that facility staff were properly showering and caring for Resident A. Ms. Prince noted that Resident A’s Individual Plan of Service does not have provide any specific instruction regarding this “yeast infection” issue. She further noted that Resident A does not have in-home nursing or receive services from the CMHCM nurse.

APPLICABLE RULE	
R 400.14314	Resident hygiene.
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	<p>Statements from facility manager Sally Hopkins note Resident A was bathed regularly and treated for the “yeast infections” with a prescription cream and corn starch.</p> <p>Resident A’s CMHCM case worker Patricia Prince notes she conducted monthly in home visits with Resident A and is under the impression that facility staff were properly caring, and showering Resident A. She also noted Resident A saw her doctor every six months.</p> <p>The Licensee did afford Resident A the opportunity to bath at least weekly and did so more often as necessary.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was found with bedbugs on her person.

INVESTIGATION: Ms. Quesnel stated that while she was at the Hopkins Whispering Pines AFC home, she noticed ant traps around the facility that were “covered in bed bugs.” She further stated that after she arrived with Resident A to

the McBride #1 AFC, she noted Resident A's wheelchair had bed bugs "which fell off" and that Resident A had multiple "bites" on her body.

Ms. Laura Hopkins stated she has been "dealing with the bed bugs, but it's a losing battle." She referred me to home manager Sally Hopkins for specific details on how the facility was treating the home for the bed bugs. Ms. Hopkins noted the facility is now vacant and she wishes to have the AFC license closed.

Ms. Sally Hopkins stated she had a professional exterminator conduct a full house treatment "about two years ago." She stated that she has since treated the home with a chemical spray and uses "spot treatments" weekly. Ms. Hopkins noted that she has also "thrown away furniture and clothing" which contained bugs.

Ms. Prince stated she has been aware of the bed bug issue in the facility, and it has been an ongoing issue "for a long time." She stated she feels the facility is not properly treating the home for the bedbugs and "it needs a professional treatment."

It is noted that this facility had previously been investigated for having bed bugs on October 15, 2024, Special Investigation number 2025A0870003. At that time, the facility was not cited for rule noncompliance, as Licensee Laura Hopkins indicated an intent to control the bed bug infestation by using "heater machines", having her maintenance staff removed baseboards and treat areas with chemical sprays. It is evident that this either did not occur or was ineffective. Ms. Hopkins has not further utilized professional pest control measures since that time.

APPLICABLE RULE	
R 400.14401	Environmental health.
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	The Licensee has failed to maintain a pest control program in a manner that continually protects the health of the residents.
CONCLUSION:	VIOLATION ESTABLISHED

On May 20, 2025, Licensee Laura Hopkins submitted a written request to have this AFC license closed effective immediately. She stated the facility is vacant with no residents in care. This was verified by an on-site visit on May 13, 2025. On May 22, 2025, I concluded this special investigation and provided Ms. Hopkins with an exit conference informing her of the above findings. I had previously informed her that no corrective action plan will be required, and the license will be closed, per her request. She had no additional questions or information to provide concerning this investigation.

IV. RECOMMENDATION

I recommend the license be closed per the Licensee's request.



May 28, 2025

Bruce A. Messer
Licensing Consultant

Date

Approved By:



June 2, 2025

Jerry Hendrick
Area Manager

Date