



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 17, 2025

Zoe Thorn  
4349 Sunnymeade Ave.  
Burton, MI 48519

RE: License #: AM250389333  
Investigation #: 2025A0580047  
Thorn Adult Foster Care

Dear Zoe Thorn:

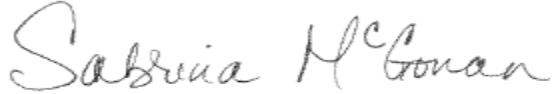
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 763-7960.

Sincerely,

A handwritten signature in cursive script that reads "Sabrina McGowan". The signature is written in black ink and is positioned below the word "Sincerely,".

Sabrina McGowan, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(810) 835-1019

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM250389333
<b>Investigation #:</b>	2025A0580047
<b>Complaint Receipt Date:</b>	08/28/2025
<b>Investigation Initiation Date:</b>	08/29/2025
<b>Report Due Date:</b>	10/27/2025
<b>Licensee Name:</b>	Zoe Thorn
<b>Licensee Address:</b>	4349 Sunnymeade Ave. Burton, MI 48519
<b>Licensee Telephone #:</b>	Zoe Thorn
<b>Administrator:</b>	Zoe Thorn
<b>Licensee Designee:</b>	N/A
<b>Name of Facility:</b>	Thorn Adult Foster Care
<b>Facility Address:</b>	4901 N Saginaw St FLINT, MI 48505
<b>Facility Telephone #:</b>	(810) 785-4234
<b>Original Issuance Date:</b>	10/13/2017
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/13/2024
<b>Expiration Date:</b>	04/12/2026
<b>Capacity:</b>	12
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Staff at the facility reportedly neglect and mistreat residents, calling them names.	No
Staff are not trained on proper medication passing.	No
Medication comes up missing on a regular basis.	No
Additional Findings	Yes

**III. METHODOLOGY**

08/28/2025	Special Investigation Intake 2025A0580047
08/29/2025	APS Referral Referred to APS.
08/29/2025	Special Investigation Initiated - Letter Allegations shared with APS.
09/04/2025	Inspection Completed On-site Unannounced onsite.
09/04/2025	Contact - Face to Face Interviews with Resident's A-G.
09/09/2025	Contact - Document Received Documents received.
09/12/2025	Contact - Telephone call received Spoke with Licensee Thorn.
09/12/2025	Contact - Document Received Email received.
09/12/2025	Exit Conference An exit conference was held with Licensee, Zoey Thorn.

**ALLEGATION:**

Staff at the facility reportedly neglect and mistreat residents, calling them names.

**INVESTIGATION:**

On 08/28/2025, I received a complaint via LARA-BCHS-Complaints. On 08/29/2025, I made a referral to Adult Protective Services (APS), sharing the allegations alleged in this complaint.

On 09/04/2025, I conducted an unannounced onsite inspection at Thorn AFC. Contact was made with direct staff, Alton Thorn III and Debbie Marlow. There are currently 11 residents in the home. Staff, Alton Thorn III and Debbie Marlow denied the allegations.

On 09/04/2025, I interviewed Residents A, B, C, D, E, F, and G. Each resident denied the allegations that they are called names or mistreated, adding that they are treated pretty fair in the home.

On 09/12/2025, I spoke with Licensee, Zoey Thorn. Licensee Thorn denied the allegations.

<b>APPLICABLE RULE</b>	
<b>R 400.14308</b>	<b>Resident behavior interventions prohibitions.</b>
	<b>(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.</b>
<b>ANALYSIS:</b>	<p>It was alleged that staff at the facility reportedly neglect and mistreat residents, calling them names.</p> <p>Direct staff, Alton Thorn III and Debbie Marlow denied the allegations. Licensee Zoe Thorn denied the allegations.</p> <p>Residents A, B, C, D, E, F, and G all denied the allegations that they are called names or mistreated, adding that they are treated pretty fair in the home.</p>

	Based upon my investigation, which consisted of interviews with facility staff members, residents, and Licensee Thorn, there is not enough evidence to substantiate the allegation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Staff are not trained on proper medication passing.**

**INVESTIGATION:**

On 09/04/2025, while onsite, staff, Alton Thorn III and Debbie Marlow denied the allegations that they are not trained to pass medication.

On 09/09/2025, I received an emailed copy of the medication training certification verifying medication training for all direct staff, Alton Thorn III, Alton Thorn IV, Zoe Thorn and Debbie Marlow.

On 09/12/2025, I spoke with Licensee Thorn who denied the allegations.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.</b>
<b>ANALYSIS:</b>	<p>It was alleged that staff are not trained on proper medication passing.</p> <p>Staff, Alton Thorn III and Debbie Marlow denied the allegations that they are not trained to pass medication. Licensee Thorn denied the allegations.</p> <p>Licensee Thorn provided copies of the medication training certification verifying medication training for all identified direct staff, Alton Thorn III, Alton Thorn IV, Zoe Thorn and Debbie Marlow.</p>

	Based upon my investigation, which consisted of interviews with facility staff members, residents, and Licensee Thorn, as well as a review of relevant facility documents pertinent to the allegation, there is not enough evidence to substantiate the allegation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Medication comes up missing on a regular basis.**

**INVESTIGATION:**

On 09/04/2025, while onsite, staff, Alton Thorn III and Debbie Marlow both denied the allegations that medication comes up missing. Medication is received from Union Pharmacy.

While onsite I overserved the medication for the residents. The medication is pre-packaged for each resident, separated by the morning, day and evening doses. The medication packaging is designed to be punched out of its packaging, dated for each day of the month. I randomly chose and reviewed the medication and medication logs for 2 residents, Resident A and Resident B. There were no missing medications. The medication logs reflect that both residents' medication has been administered accordingly.

On 09/04/2025, I interviewed Residents A, B, C, D, E, F, and G. Each resident stated that they receive all of their medication with no problems.

On 09/12/2025, Licensee Thorn denied the allegations.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.</b>

<b>ANALYSIS:</b>	<p>It was alleged that medication comes up missing on a regular basis.</p> <p>Direct staff, Alton Thorn III and Debbie Marlow denied the allegations. Licensee Zoe Thorn denied the allegations</p> <p>The medication and medication logs for 2 residents, Resident A and Resident B, were reviewed. There were no missing medications. The medication logs reflect that both residents' medication had been administered as prescribed.</p> <p>Residents A, B, C, D, E, F, and G. Each resident stated that they receive all of their medication with no problems.</p> <p>Based upon my investigation, which consisted of interviews with facility staff members, residents, Licensee Thorn, as well as a review of relevant facility documents pertinent to the allegation, there is not enough evidence to substantiate the allegation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 09/04/2025, while onsite I observed the medication, Lorazepam, 1mg medication for Resident B. This medication is not listed on his medication log. Staff Thorn stated that the medication for Resident B must have been discontinued, however, it had not been disposed of.

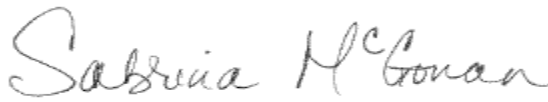
On 09/12/2025, I received an emailed copy of the pharmacy verification that the prescription for Resident was discontinued effective 05/22/2025.

On 09/12/2025, I conducted an exit conference with Licensee Thorn. Licensee Thorn stated that Resident A received a medication review on 05/21/2025. Licensee Thorn stated that medication was discontinued the following day, on 05/22/2025, however, she did not receive any verification until now, upon contacting the pharmacy during this investigation. Licensee Thorn was informed of the findings of this investigation.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.</b>
<b>ANALYSIS:</b>	<p>While onsite I observed the medication, Lorazepam, 1mg medication for Resident B. This medication is not listed on his medication log. Staff Thorn stated that the medication for Resident B must be discontinued, however, it had not been disposed of.</p> <p>On 09/12/2025, I received an emailed copy of the pharmacy verification that the prescription for Resident was discontinued effective 05/22/2025. Licensee Thorn stated that medication was discontinued the on 05/22/2025, however, she did not receive any verification until now. Based upon my investigation, which consisted of interviews with facility staff members, Licensee Thorn, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the allegation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon the receipt of an approved corrective action, no change to the status of the license is recommended.

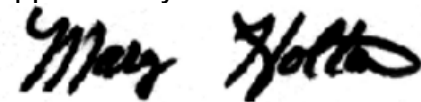


September 16, 2025

Sabrina McGowan  
Licensing Consultant

Date

Approved By:



September 17, 2025

Mary E. Holton  
Area Manager

Date