GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2025

Karen Hoornstra
P.O. Box 362
Reese, MI 48757

RE: License #: AS730012944
Investigation #: 2025A0576047
Karens AFC Home

Dear Karen Hoornstra:

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.
- Be signed and dated.

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) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730012944
Investigation #:	2025A0576047
Complaint Receipt Date:	07/16/2025
Investigation Initiation Date:	07/21/2025
Report Due Date:	09/14/2025
Licensee Name:	Karen Hoornstra
Licensee Address:	10015 E Washington, Reese, MI 48757-0362
Licensee Telephone #:	(989) 753-1368
Administrator:	Theresa Lewis
Licensee Designee:	Karen Hoornstra
Name of Facility:	Karens AFC Home
Facility Address:	10015 E. Washington, Reese, MI 48757-0147
Facility Telephone #:	(989) 753-1368
Original Issuance Date:	10/01/1986
License Status:	REGULAR
Effective Date:	05/19/2024
Expiration Date:	05/18/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is being yelled at and made to clean up after the owner's dog.	No
Residents have food restrictions and cannot eat if they do not eat when meals are served.	No
Facility has bedbugs.	No
Additional Findings	Yes

III. METHODOLOGY

07/16/2025	Special Investigation Intake 2025A0576047
07/16/2025	APS Referral
07/21/2025	Special Investigation Initiated - Telephone Left message for Resident A
07/22/2025	Contact - Document Sent Sent email to Erica Partlow, Saginaw County Adult Protective Services (APS)
07/23/2025	Contact - Document Received Email received from Erica Partlow
07/25/2025	Contact - Face to Face Unsuccessful on-site inspection as there was no one home
07/25/2025	Contact - Telephone call made Interviewed Administrator, Theresa Lewis
07/29/2025	Inspection Completed On-site Interviewed Resident B and viewed Resident C
08/29/2025	Contact - Telephone call made Left message for Resident A to return call
09/12/2025	Contact - Telephone call made Interviewed Resident A
09/12/2025	Contact - Telephone call made Interviewed Guardian A1

ALLEGATION:

Resident A is being yelled at and made to clean up after the owner's dog.

INVESTIGATION:

On July 22, 2025, I sent an email to Erica Partlow, Saginaw County Adult Protective Services (APS) Investigator inquiring as to the status of her investigation involving Resident A. On July 23, 2025, Investigator Partlow advised she did not cite abuse or neglect of Resident A and her case has been closed.

On July 25, 2025, I conducted an on-site visit to the facility, however no one was at home. I telephoned the Administrator Theresa Lewis who confirmed they are not home and advised the allegations were not true. Resident A no longer lives at the facility and had been given a 30-day discharge notice to move from the home. Resident A often left her bedroom messy with old food under her bed and Resident A brought bed bugs into the home. Administrator Lewis did not yell at Resident A however she would try to redirect her when needed. Administrator Lewis is a loud talker however she is not disrespectful or trying to intimidate residents. Administrator Lewis reported that she did obtain a new puppy, and the puppy was being potty trained. There were times when the puppy had accidents in the home and Resident A was not made to clean up after the dog. There was one occasion when the puppy had an accident in the home and Resident A said she would clean it up. Administrator Lewis advised Resident A not to clean up the mess and that Administrator Lewis would do it, but Resident A cleaned chose to clean it. There were no other times that Resident A cleaned up after the dog.

On July 25, 2025, I viewed Resident C coming inside the home from outside. Resident C is verbal, however she speaks in another language and could not be understood. Resident C appeared well, clean, and in good spirits.

On July 25, 2025, I interviewed Resident B who reported he has lived at his home for 3 years. Resident B confirmed there is a dog at the home and the dog is fine. Resident B does not clean up after the dog, staff do. Resident B reported he is doing fine at his home and that he gets along well with the staff including Administrator Theresa Lewis. None of the staff are mean or disrespectful to Resident B and Resident B has not heard anyone yell at other residents who live at the home. Resident B feels safe at his home and has no concerns.

On September 12, 2025, I interviewed Resident A who reported she moved from the home on June 27, 2025. Resident A reported that Administrator, Theresa Lewis, would scream at her for everything and had a personal vendetta against her. Resident A would argue with Administrator Lewis and slam her door. Regarding the dog in the home, Resident A reported staff did not clean up after the dog had accidents and Resident A would always clean up after the dog had accidents in the home.

On September 12, 2025, I interviewed Resident A's guardian, Guardian A1 who denied any knowledge of the allegations. Staff would ask Resident A to complete basic things such as her laundry and Resident A would not. Guardian A1 had no knowledge of any issues with a dog at the facility and Guardian A1 had no concerns that Resident A was being mistreated during the time she lived at the facility.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A was being yelled at and made to clean up after the owner's dog. Upon conclusion of an unannounced on-site inspection to the home and investigative interviews there is not a preponderance of evidence to conclude a rule violation. Resident A was interviewed and reported that Administrator, Theresa Lewis often yelled at her and made her clean up after the dog that lives in the home. Administrator Lewis denied the allegations and advised Resident A cleaned up a mess the dog made after Resident A was directed not to. Administrator Lewis reported she does speak loudly however she did not yell at Resident A and was not mean or disrespectful toward her. Resident B was interviewed and had no concerns regarding staff or the dog. Resident A's guardian was interviewed and had no knowledge of the allegations. There is not a preponderance of evidence to conclude Resident A was not treated with dignity and respect and that her safety and protection was not adhered to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents have food restrictions and cannot eat if they do not eat when meals are served.

INVESTIGATION:

On July 22, 2025, I sent an email to Erica Partlow, Saginaw County Adult Protective Services (APS) Investigator inquiring as to the status of her investigation involving Resident A. On July 23, 2025, Investigator Partlow advised she found no evidence that Resident A was ever denied food or neglected.

On July 25, 2025, Administrator Theresa Lewis denied the allegations and stated Resident A liked to eat often and all the residents can have other meals if they do not like what is being served. Meals would be prepared, and Resident A would often call her sister to have food delivered to the home. According to Administrator Lewis, residents could save their meals to eat later if they wanted.

On July 29, 2025, I interviewed Resident B who reported he receives breakfast, lunch, and dinner at his home. Resident B gets plenty to eat and he can eat his meals later if he chooses. Resident B denied any concerns about the food he receives at his home.

On September 12, 2025, I interviewed Resident A who reported facility staff prepared breakfast, lunch, and dinner for the residents. There were times when Resident A wanted to eat lunch later at 2pm or 3pm and staff did not allow this.

On September 12, 2025, I interviewed Resident A and Resident C's guardian, Guardian AC1 regarding the allegations. Guardian AC1 denied any knowledge of the allegation and stated residents have the option of saving meals if they do not want to eat when the meal is served. Guardian AC1 denied Resident A was denied food and Resident A never reported to Guardian A1 that Resident A was not being provided meals. During the time Resident A lived at the home Resident A gained weight and was recently prescribed medication for weight reduction. Guardian A1 denied any concerns regarding resident meals.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	It was alleged that there are food restrictions and if residents do not eat when the meal is served they cannot eat. Upon conclusion of investigative interviews, there is not a preponderance of evidence to conclude a rule violation. Resident A was interviewed and stated that there were 3 meals provided daily. Resident A stated that she wanted to eat her lunch later than when it was served and she was not allowed.

ANALYSIS:	Administrator Theresa Lewis denied the allegation and stated residents could eat their meals when they wanted. Resident B was interviewed and confirmed he is provided with 3 meals per day. Resident B stated he could eat meals later if he wanted. Resident B denied any concerns about meals. Resident A and Resident C's guardian was interviewed and denied any concerns with meals provided by the home. There is not a preponderance of evidence to conclude the facility is not providing 3 meals per day to residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility has bedbugs.

INVESTIGATION:

On July 25, 2025, I interviewed Administrator Theresa Lewis regarding the allegation, and she reported there was a time when Resident A had bed bugs in her bedroom. Resident A would take donated clothing from the day program she attended and bring the clothing home. Unbeknownst to Resident A, the clothing would have bugs. The bedroom was treated, and the issue was resolved. Resident A moved from the home in June 2025, and there have been no issues with bed bugs at the facility.

On July 29, 2025, I conducted an unannounced on-site inspection at Karens AFC Home. I inspected the living room furniture, dining room furniture, and all resident bedroom furniture including resident beds. There was no evidence of bed bugs at the facility.

On July 29, 2025, I interviewed Resident B in his bedroom, and he denied any bug activity in his room. Resident B denied being bitten by any bugs at his home causing him to itch.

On September 12, 2025, I interviewed Resident A who reported she moved from Karens AFC Home on June 27, 2025. Resident A reported she had bed bugs on her bed and the facility was treated for bed bugs.

On September 12, 2025, I interviewed Resident A and Resident C's guardian, Guardian AC1 who denied any knowledge of the allegation. Guardian AC1 stated there may have been a bed bug issue in the past however it was treated.

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:	It was alleged that the facility has bed bugs. Upon conclusion of an unannounced on-site inspection and investigative interviews, there is not a preponderance of evidence to conclude a rule violation. I conducted an on-site inspection on July 29, 2025. I inspected the living room furniture, dining room furniture, and resident bedroom furniture including beds and there was no evidence of any bed bug activity. It was reported by Resident A and the Administrator Theresa Lewis that there had been bed bugs in the past at the facility, however the home was treated and the issue was resolved. There is not a preponderance of evidence to conclude the facility has any current pest issue requiring treatment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On July 29, 2025, I conducted an unannounced on-site inspection at Karens AFC Home. The carpet in the living room was dirty with lots of small pieces of debris throughout and needed vacuuming. I viewed Resident C's bedroom, and her floor was dirty with debris and needed to be vacuumed.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On July 29, 2025, I conducted an unannounced on-site inspection at Karens AFC Home. The carpet in the living room was dirty with lots of small pieces of debris throughout and

	needed vacuuming. I viewed Resident C's bedroom, and her floor was dirty with debris and needed to be vacuumed. There is a preponderance of evidence to conclude housekeeping standards did not present as clean and orderly.
CONCLUSION:	**VIOLATION ESTABLISHED**

On September 12, 2025, I conducted an exit conference with Licensee Karen Hoornstra and Administrator Theresa Lewis. I advised them of the findings of my investigation. I advised I would be requesting a corrective action plan for the cited rule violation.

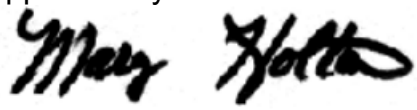
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

9/12/2025

Christina Garza Date
Licensing Consultant

Approved By:



9/16/2025

Mary E. Holton Date
Area Manager