STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2026

Linda Kramer Vargas
707 Clinton Ave.
Grand Haven, MI 49417

RE: License #:	AS700418868
Investigation #:	2026A0356037
	Spring Lake AFC

Dear Ms. Kramer Vargas:

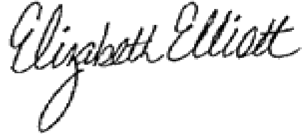
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700418868
Investigation #:	2026A0356037
Complaint Receipt Date:	04/22/2026
Investigation Initiation Date:	04/24/2026
Report Due Date:	06/21/2026
Licensee Name:	Linda Kramer Vargas
Licensee Address:	707 Clinton Ave. Grand Haven, MI 49417
Licensee Telephone #:	(616) 218-0921
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Spring Lake AFC
Facility Address:	17340 Oak Street Spring Lake, MI 49456
Facility Telephone #:	(616) 218-0921
Original Issuance Date:	01/24/2025
License Status:	REGULAR
Effective Date:	07/24/2025
Expiration Date:	07/23/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was given an improper 24-hour discharge.	Yes

III. METHODOLOGY

04/22/2026	Special Investigation Intake 2026A0356037
04/24/2026	APS Referral
04/24/2026	Special Investigation Initiated - Telephone Libby Huizenga, Lakeside Club House Day program.
04/24/2026	Contact-Document Received 2 more complaints came in, allegations similar.
05/05/2026	Contact - Telephone call made Resident A via telephone, left message. No return call.
05/14/2026	Inspection Completed On-site
05/14/2026	Contact - Face to Face Linda Kramer, licensee, Misael Vargas, husband, Resident's B&C.
05/14/2026	Contact - Document Received 24-hour discharge, medication pick up form.
06/15/2026	Contact - Telephone call made Resident A via telephone, left message. No return call.
06/15/2026	Contact - Telephone call made Libby Huizenga and Javier Valdez, Lakeside club house.
06/15/2026	Contact - Telephone call made Leah Osterhaven, Ottawa County Community Mental Health.
06/16/2026	Contact - Telephone call made Nicole Boyer, Ottawa County CMH.
06/17/2026	Contact-Telephone call received. N. Boyer, case manager, CMH.
06/17/2026	Exit Conference-Linda Kramer Vargas, Licensee.

ALLEGATION: Resident A was given an improper 24-hour discharge.

INVESTIGATION: On 04/22/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported on 04/21/2026, Resident A was being bullied by fellow residents and staff about the scars Resident A has. This led to yelling between Resident A and the Licensee, Linda Vargas. The complainant reported that Ms. Kramer Vargas told Resident A if she did not stop yelling, she was going to call the police and in response, Resident A stated, "if you call the police, I will call animal control on you because you abuse your animals." The complainant reported in response to this, Linda told Resident A that she was being removed from the facility immediately. Resident A called Javier Valdez, an employee at Lakeside Club House, to come and get her (Resident A). When Mr. Valdez arrived, he spoke to Ms. Vargas' husband, Misael Vargas. Mr Vargas told Mr. Valdez that a 24-hour discharge occurs when there is physical assault. Mr. Valdez asked if Resident A got physical with anyone and Mr. Vargas responded by stating, "no, she did not, but her words about the animal abuse was assault in his eyes and no one can talk to his wife that way." The incident occurred around 5:30p.m. The staff began immediately moving Resident A's belongings outside of her room. The complainant reported Mr. Valdez assisted Resident A with getting her belongings out of the house. The complainant reported that Resident A called the CMH after hour line and they (CMH) called the house and spoke to someone at the home. The person at the home told the CMH on call worker they were issuing Resident A 24-hour discharge notice and moving all of her personal belongings outside and Resident A could come back tomorrow and get her belongings but that they needed to be removed immediately.

On 04/24/2026, I received another LARA-BCHS online complaints. The unknown complainant reported that Resident A was kicked out of the home immediately and was not given a 30-day notice.

On 04/24/2026, I received another LARA-BCHS online complaint. The second unknown complainant reported that staff were bullying Resident A over self-harm scars. When Resident A expressed how she felt about it, Ms. Kramer Vargas started intimidating Resident A with her tone of voice and Ms. Vargas was approaching Resident A. The complainant reported that Ms. Vargas followed this with the threat of kicking Resident A out and proceeding to do so. Resident A was given 24 hours to leave and was not allowed to pack her belongings. They said they would throw it outside and call Resident A to come pick it up. The complainant reported they did allow Resident A to grab some things but are still withholding her clothing. The complainant reported that Resident A knows they hit their dogs with fly zappers, that Ms. Kramer Vargas admitted it and stated it is only done on the floor to zap and scare the dogs and then said they only hit them when the fly zapper is off. The complainant reported they threatened Resident A with police if she did not move out in the next 20 minutes and she was not allowed to grab any belongings as they no longer want contact with her. When Resident A was being picked up, Mr. Vargas

approached the driver and lied about Resident A and then back tracked when questioned by the driver. All of this was witnessed by the complainant.

On 04/24/2026, I interviewed Libby Huizenga, Lakeside Clubhouse supervisor, via telephone. Ms. Huizenga stated that Resident A contacted them and reported she was being kicked out of the home. Ms. Huizenga stated Resident A reported that other residents and Ms. Kramer Vargas were talking to Resident A about her self-harm scars. Ms. Huizenga stated Ms. Kramer Vargas threatened to call the police on Resident A and Resident A responded by saying if you call the police on me, I'll report the animal abuse and Ms. Kramer Vargas kicked Resident A out of the home. Ms. Huizenga stated she called the home and was told Resident A was given a 24-hour discharge notice so Mr. Valdez, from the Clubhouse, went to the home to pick Resident A up. Ms. Huizenga stated when Mr. Valdez went to the home, Mr. and Ms. Kramer Vargas said Resident A did not physically assault anyone, but only with her words about the animals. Ms. Huizenga stated Mr. Valdez witnessed the Varga's removing Resident A's belongings from the house.

On 05/05/2026, I attempted to contact Resident A via telephone and left a voicemail message. I did not receive a return call.

On 05/14/2026, I conducted an unannounced inspection at the home and interviewed Ms. Vargas. Ms. Kramer Vargas stated Resident A did not want to live in her home. She threatened to cut herself, cut her stitches open, bled all over and often complained about living at this home. Ms. Kramer Vargas stated prior to Resident A moving into this home, she did not have any idea that Resident A had a history of cutting herself. Ms. Kramer Vargas stated she had offered to take Resident A to the hospital. Resident A refused and said she was going to run into the street. She screamed and then Javier Valdez, Resident A's friend, showed up to pick Resident A up. Ms. Kramer Vargas stated none of the other residents nor herself bullied Resident A or made fun of her scars. Ms. Kramer Vargas stated Resident A lived in the home for less than 2 months. She did not have a guardian and Ms. Vargas confirmed that she issued Resident A a 24-hour discharge notice on 04/21/2026 and did not send the notice to Ottawa County Community Mental Health (CMH).

Ms. Kramer Vargas stated on 04/21/2026, Resident A's friend (Mr. Valdez) came to pick Resident A up. Mr. Vargas gave Mr. Valdez Resident A's medications. Mr. Valdez signed that he received Resident A's medications and they arranged for Resident A to come back to pick up her belongings later. Ms. Kramer Vargas stated they did not move Resident A's belongings out of the home because the incident occurred at Ms. Vargas' other AFC home called Ivy's Nest in Grand Haven and Resident A resided in the Spring Lake home. Ms. Kramer Vargas stated after Resident A left with Mr. Valdez, she (Ms. Vargas) messaged Resident A and told her that she could pick up her belongings at the Spring Lake home later.

Ms. Kramer Vargas stated later on 04/21/2026, she met Resident A and Mr. Valdez

so Resident A could gather her belongings. Ms. Kramer Vargas stated that Mr. Vargas told her that Resident A had left items behind that she would want so Ms. Kramer Vargas called Ottawa County CMH. They told Ms. Kramer Vargas to bring the items to CMH and drop them off there, which they did. Ms. Kramer Vargas stated she issued the 24-hour discharge notice to Resident A and confirmed that she did not send a written notice of the discharge to Ottawa CMH.

On 05/14/2026, I reviewed the discharge notice dated 04/21/2026, written and signed by Ms. Vargas. The discharge notice stated the following, *'To (Resident A), This is a 24-hour notice as of 6:30p.m. on 04/21/2026. You have 24 hours to gather your things and leave Spring Lake AFC. You attempted suicide at program that required an ambulance. You are trying to commit suicide now at our Ivy Nest home by running into traffic. You are refusing help. You called for someone to pick you up and refused to stay the rest of the day. While waiting outside for her ride, (Resident A) was opening up her stitches. (Resident A) agreed she wouldn't touch or open up her cuts while at Spring Lake AFC or Ivy Nest.'*

On 05/14/2026, I interviewed Resident B & C at the home. Resident B & C stated Resident A was going to call the police because she did not like the way "we use the fly zappers to the dogs." Resident B stated she is "deathly afraid" of police and did not want Resident A to call the police. Resident B & C stated Resident A would "bully us" and say things like, "stop looking at me." Resident B stated Resident A had "fresh cuts" on her hands, that was "scary to us" and she had stitches on her hands. Resident B had scars all over and it was scary. Resident B stated Resident A said the other residents were bullying her but that was not right, she (Resident A) was bullying us. Resident B stated when Resident A left the facility, she said she was going to jump off a bridge. Resident B & C stated things are better and calmer since Resident A is no longer there.

On 06/15/2026, I attempted to contact Resident A via telephone and left a voicemail message. I did not receive a return call.

On 06/15/2026, I interviewed Ms. Huizenga via telephone. Ms. Huizenga stated Resident A is currently in long term hospitalization and has not been available for an interview since discharge from this home. Ms. Huizenga clarified that Resident A did not attempt self-harm at the clubhouse requiring an ambulance as documented in the 24-hour discharge notice.

On 06/15/2026, I interviewed Leah Osterhaven, Ottawa County Community Mental Health, Supervisor of Residential Services via telephone. Ms. Osterhaven stated they were not notified of the 24-hour discharge notice issued to Resident A on 04/21/2026 by Ms. Kramer Vargas. Ms. Osterhaven stated the 24-hour discharge notice was not issued appropriately. Resident A did not have a safe place to discharge to, and no one from the home, including the licensee, Ms. Kramer Vargas called CMH to assist with Resident A's reported behaviors that were bad enough to

warrant issuing a 24-hour discharge. Ms. Osterhaven stated Resident A continues long-term psychiatric hospitalization and is unavailable to be interviewed.

On 06/17/2026, I interviewed Javier Valdez via telephone. Mr. Valdez stated when he arrived at the facility, Resident A had already been "kicked out" and was sitting on the curb with a bag of her personal belongings. Mr. Valdez stated he planned to take Resident A to the Holland Mission and along the way, he received a telephone call from Ms. Kramer Vargas that they could gather Resident A's belongings from the home, so Mr. Valdez turned around and went to the home. Mr. Valdez stated he and Resident A met Mr. Vargas at the home and got her medications, which he signed for, and Resident A gathered as many of her belongings as she could and left the rest. Mr. Valdez stated Mr. Vargas stated they do not allow residents to remain living in the home who threaten his wife, Ms. Kramer Vargas. Mr. Valdez stated he questioned what the threat was that Resident A made to Ms. Kramer Vargas and Mr. Vargas stated Resident A threatened to call authorities on Ms. Kramer Vargas due to the alleged mistreatment of the dogs. Mr. Vargas stated they took this as a threat and therefore, the 24-hour discharge was issued. Mr. Vargas stated on their way back to Holland, Resident A got a telephone call from the Vargas' stating that Resident A did not take all of her belongings and Resident A instructed them to throw the rest of her belongings away because she did not want to return to the home to get them. Mr. Valdez stated the police were never called or involved in this and they found a family friend of Resident A's that was willing to take her in. Mr. Valdez stated Resident A went there for approximately a week, then she went to the Holland Mission and then to the hospital where she currently remains.

Mr. Valdez stated on the way to drop Resident A off at the family friend's house in Grand Rapids, Resident A played a recording she had on her phone that was taken just prior to the 24-hour discharge being issued. Mr. Valdez stated he heard Resident A saying, "you're bullying me" and a lady's voice that sounded like Ms. Kramer Vargas yelling back at Resident A. The woman's voice stated people can see your scars, they are not nice to look at and it bothers people to look at them. Resident A then said she was going to call the authorities about the treatment of the dogs and then Ms. Kramer Vargas said, "then you can find another place to live."

On 06/17/2026, I interviewed Nicole Boyer, Ottawa County CMH supports coordinator via telephone. Ms. Boyer stated she was not notified of the 24-hour discharge in writing but did have a verbal conversation via telephone with Ms. Kramer Vargas on or around 04/21/2026-04/22/2026, that they discharged Resident A on a 24-hour basis. Ms. Boyer stated Vargas' dropped off the remainder of Resident A's belongings at her (Ms. Boyer's) office.

On 06/17/2026, I conducted an exit conference with Ms. Kramer Vargas via telephone. Ms. Kramer Vargas stated she was not aware of all the steps to this rule and did not understand that if a resident was harmful to themselves or others, a 24-hour discharge in the way she issued it was not in accordance with licensing rules.

Ms. Kramer Vargas stated she will familiarize herself with this rule and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(6) A licensee shall take all the following steps before discharging a resident under subrule (5) of this rule: (a) A licensee shall notify the resident, resident's designated representative, responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge in writing and include all the following: (i) Reason for discharge including the specific nature of the risk. (ii) Alternatives to discharge that have been attempted by the facility. (iii) Location where the resident will be discharged, if known. (b) A licensee shall notify adult protective services in the department of health and human services not less than 24 hours before discharge if the resident does not have a resident's designated representative or responsible agency. (c) A resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located. (d) If the department finds that a resident was improperly discharged, the resident has the right to return to the first available bed in the facility.
ANALYSIS:	The complainant reported that Resident A was issued an improper 24-hour discharge. My investigative findings show that Ms. Kramer Vargas failed to issue Resident A's 24-hour discharge notice according to Rule 400.687(6) and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/17/2026

Elizabeth Elliott, Licensing Consultant Date

Approved By:

06/17/2026

Jerry Hendrick, Area Manager Date