GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 6, 2026

John Lewis
325 State Street
Harbor Beach, MI 48441

RE: License #: AL320297229
Investigation #: 2026A0623045
Karen's Place

Dear John Lewis:

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 July 23, 2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Cynthia Badour

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(517) 648-8877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL320297229
Investigation #:	2026A0623045
Complaint Receipt Date:	07/21/2026
Investigation Initiation Date:	07/23/2026
Report Due Date:	09/19/2026
Licensee Name:	John Lewis
Licensee Address:	325 State Street Harbor Beach, MI 48441
Licensee Telephone #:	(810) 767-6768
Administrator:	John Lewis
Licensee Designee:	N/A
Name of Facility:	Karen's Place
Facility Address:	325 State St. Harbor Beach, MI 48441
Facility Telephone #:	(989) 479-3465
Original Issuance Date:	10/23/2012
License Status:	REGULAR
Effective Date:	08/12/2024
Expiration Date:	08/11/2026
Capacity:	13
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 07/17/2026, Resident A eloped from the facility, and the home did not notify the police.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/21/2026	Special Investigation Intake 2026A0623045
07/23/2026	APS Referral I completed an APS referral.
07/23/2026	Special Investigation Initiated - On Site Observation and interviews.
07/23/2026	Contact – Document Received I received AFC documents.
07/23/2026	Inspection Completed-BCAL Sub. Compliance
07/23/2026	Exit Conference I conducted an exit conference with Licensee John Lewis.
07/23/2026	Corrective Action Plan Received
07/24/2026	Corrective Action Plan Approved
07/27/2026	Contact - Telephone call made I contacted case manager Emily Strozeski.
07/27/2026	Contact - Telephone call made I contacted ACT supervisor Beth Gonzalez.

ALLEGATION:

On 07/17/2026, Resident A eloped from the facility, and the home did not notify the police.

INVESTIGATION:

On 07/23/2026, An Adult Protective Service referral was completed. I shared information with APS. The referral was denied for APS investigation by Centralized Intake.

On 07/23/2026, I conducted an unannounced onsite inspection of the facility. I interviewed Licensee John Lewis, Staff Tina Frost, Resident A and Resident B individually.

On 07/23/2026, I interviewed Licensee John Lewis. Licensee Lewis stated that he had seen Resident A earlier in the evening when he said he was going out for a walk and seen later Resident A had not returned. Licensee Lewis stated that he didn't think much of it since Resident A is his own guardian. Licensee Lewis stated that he noted in the morning that Resident A hadn't returned so he called case manager Emily Strozeski and found that the police had picked him up and the case manager was bringing him back to the home. Licensee Lewis stated that he did not notify the police when he noticed that Resident A had not returned later in the evening and did not fill out an incident report.

On 07/23/2026, I interviewed Staff Tina Frost. Staff Frost stated that she had met Resident A earlier in the day. Staff Frost stated that she was unaware of Resident A leaving the home.

On 07/23/2026, I interviewed Resident A. Resident A stated that he is new at the home and likes it. Resident A stated that he is his own guardian. Resident A stated that he did tell John Lewis that he was going for a walk. Resident A stated that he feels safe at the home and likes it. Resident A stated that he likes to go out into the community.

On 07/23/2026, I interviewed Resident B. Resident B stated that she met Resident A when he moved in. Resident B stated that Resident A stays to himself, but he is okay. Resident B stated that if she wants to go out in the community, she tells staff and leaves and comes back. Resident B stated that she knows if she didn't come back the police would be called to look for her and she doesn't want that. Resident B stated that she doesn't remember Resident A leaving the home and was asleep when he was gone.

On 07/23/2026, I received and reviewed AFC documents. I reviewed Resident A's discharge summary from North Shores Center LLC in Oscoda (North Shores Center is a crisis residential unit that caters to short term comprehensive psychiatric services that include intensive psychotherapy and medication management). The discharge summary noted that Resident A was discharged on 07/16/2026 to Karen's Place. I reviewed Resident A's Resident Care Agreement, Weight Agreement and Assessment Plan. Resident A is scheduled on July 30, 2026, 10:30 am for an appointment with Dr. Meints

at Huron Behavioral Health. Resident A's assessment plan indicates he can go outside into the community unsupervised, and he does not have a history of elopement.

On 07/27/2026, I contacted case manager (CM) Emily Strozeski. CM Strozeski stated that Resident A was placed in the home on 7/16/2026 and he decided to go for a walk. CM Strozeski stated that Resident A appeared stable at the time and he is his own guardian and can access the community without supervision. CM Strozeski stated that she and other members of the ACT team checked daily on Resident A. CM Strozeski stated that Resident A was found by the police walking at night and was picked up by the police and they notified HBH/ACT which picked him up and took Resident A back to the AFC home

On 07/27/2026, I contacted Assertive Community Treatment (ACT) supervisor Beth Gonzalez. Beth Gonzalez stated that originally Resident A was from the Bad Axe area, and was placed in Iosco County, however he was not doing well there. Beth Gonzalez stated that the treatment team moved him closer to their service area to monitor him more closely. Beth Gonzalez stated that Karen's Place had an opening so Resident A was placed in the home. Beth Gonzalez stated that they will continue to monitor Resident A closely and decide if a different placement would be more suitable for his needs. Beth Gonzalez stated that she believes that Karen's Place can meet his needs at this time.

On 07/23/2026, I conducted an exit conference with Licensee John Lewis. I explained my investigation and findings. I explained the rule violations being cited. Licensee John Lewis stated that he was under the assumption that when a resident was their own guardian, he did not need to contact law enforcement even when he knew they were not in the facility late at night. Licensee Lewis stated that he understands once he accepts a resident into the home, no matter what their legal status, he and his staff are responsible A corrective action plan was completed onsite. Licensee John Lewis had no further questions at this time.

APPLICABLE RULE	
R 400.693	**Incident notification, incident records.**
	(2) If an elopement occurs, facility staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the initiation of the search, staff shall contact law enforcement.
ANALYSIS:	The allegation stated that on 07/17/2026, Resident A eloped from the facility, and the home did not notify the police.

	Interviews with the licensee, staff, residents, the case manager, and ACT supervisor confirmed that Resident A had left the facility overnight and was later located by police. The investigation determined that the licensee mistakenly believed that because Resident A was his own guardian, notification to law enforcement was not required. The investigation findings clarified that guardianship status does not exempt a licensee from ensuring resident safety or complying with incident reporting requirements. I conclude there is enough evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

The home did not complete an incident report of Resident A's elopement.

INVESTIGATION:

On 07/23/2026, I reviewed Resident A's file and there was no incident report for the elopement.

On 07/23/2026, I interviewed Licensee John Lewis. Licensee Lewis stated that he had seen Resident A earlier in the evening when he said he was going out for a walk and seen later Resident A had not returned. Licensee Lewis stated that he didn't think much of it since Resident A is his own guardian. Licensee Lewis stated that he noted in the morning that Resident A hadn't returned so he called case manager Emily Strozeski and found that the police had picked him up and the case manager was bringing him back to the home. Licensee Lewis stated that he did not notify the police when he noticed that Resident A had not returned later in the evening and did not fill out an incident report.

APPLICABLE RULE	
R 400.693	**Incident notification, incident records.**
	(3) An incident must be recorded on a department-approved form, or a facility form that contains the same information and retained in the facility for 2 years.

ANALYSIS:	An Incident Report was not completed for Resident A's elopement on 07/17/2026. During the interview with Licensee John Lewis, he admitted he did not complete an incident report on the elopement. I conclude there is enough evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

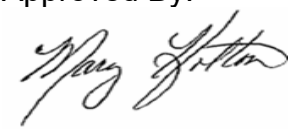
IV. RECOMMENDATION

An acceptable corrective action plan was received. I recommend no change in the status of this license.

08/06/2026

Cynthia Badour — Date
Licensing Consultant

Approved By:



08/06/2026

Mary E. Holton — Date
Area Manager