STATE OF MICHIGAN
DEPARTMENT OF LIFELONG EDUCATION, ADVANCEMENT, AND POTENTIAL
CHILD CARE LICENSING BUREAU

**In the matter of**

License #: DF700051588
SIR #: SI-00141127

Carolyn DeBoer

_____/

ORDER OF SUMMARY SUSPENSION
AND NOTICE OF INTENT TO REVOKE LICENSE

The Michigan Department of Lifelong Education, Advancement, and Potential, by Division Director Erika Bigelow and Bureau Director Courtney Adams, Child Care Licensing Bureau, hereafter referred to as "the Bureau," orders the summary suspension and provides notice of the intent to revoke the license of Licensee, Carolyn DeBoer, to operate a family child care home pursuant to the authority of the Child Care Organizations Act, 1973 PA 116, as amended, MCL 722.111 et seq., for the following reasons:

1. On or about December 12, 1993, Licensee was issued a license to operate a family child care home with a licensed capacity of six at 10109 Riley Street, Zeeland, Michigan 49464. On October 6, 2022, the Bureau granted Licensee a variance to increase her capacity to seven children and maintain a ratio of one child care staff member for every seven children as required under the rule.
2. Prior to the issuance of the license, and during subsequent modifications of the statutes and rules, Licensee received copies of the Child Care Organizations Act, the licensing rule book for family and group child care homes, and the Child

Protection Law. These rules and statutes are posted and available for download at www.michigan.gov/mileap.

3. Licensee failed to provide appropriate care and supervision of children at all times and is not conducive to the welfare of children, as demonstrated by the following:
    a. On July 22, 2025, Licensee was the only child care staff person present with the following children:
        i. Child A, age 11 years and unrelated to Licensee.
        ii. Child B, age 29 months and unrelated to Licensee.
        iii. Child C, age 5 months and unrelated to Licensee.
        iv. Child D, age 10 years and unrelated to Licensee.
        v. Child E, age 10 years and unrelated to Licensee.
        vi. Child F, age 8 years and unrelated to Licensee.
        vii. Child G, age 6 years and unrelated to Licensee.
        viii. Child H, age 5 years and unrelated to Licensee.
        ix. Child J, age 4 years and unrelated to Licensee.
        x. Child K, age 6 years and unrelated to Licensee.
        xi. Child L, age 9 years and unrelated to Licensee.
        xii. Child O, age 9 years and unrelated to Licensee.
    b. Child A has [redacted] three times since December 2024 due to this behavior.
    c. During the morning of July 22, 2025, Child A overheard Licensee talking about her to the older children who were present. Child A and Child D got

into an argument, and Licensee told Child D to go outside with her and the rest of the children. Licensee instructed Child A to remain in the home alone and read in Licensee's bedroom.

d. On July 22, 2025, at approximately 10:50 a.m., Child A went into the bathroom and [redacted]. The bathroom cabinet was unlocked, and the medication was on a lazy Susan turntable that was 5 feet, 3 inches from the floor.

e. On July 22, 2025, at or around 10:54 a.m., Child A called 911 and reported that she had [redacted]. Child A stated that she was having difficulty breathing.

f. On July 22, 2025, at 11:02 a.m., Ottawa County Sheriff Deputy Alex DeJong arrived at Licensee's address and observed Child A waiting in the garage. Child A informed Deputy DeJong that she [redacted]. [redacted]. Child A told Deputy DeJong that [redacted] because her friend recently stopped talking to her, and she felt bad about it. She acknowledged that [redacted]. Paramedics arrived on scene a short time after Deputy DeJong.

g. On July 22, 2025, while speaking with Child A in the garage, Deputy DeJong observed nine other children throughout the property without an adult present, and one of the children was in a car seat. After paramedics

arrived and approximately one minute after Deputy DeJong's arrival, Licensee emerged from the backyard and introduced herself to Deputy DeJong. Licensee was unaware that the police and paramedics were at the home until that moment. Deputy DeJong informed her what happened, and Licensee stated that Child A had [redacted] Licensee told Deputy DeJong that Child A thinks she is in charge at the child care and [redacted] when she doesn't get her way.

h. On July 22, 2025, while police and paramedics were still at the home, Licensee contacted Child A's mother who arrived at the home approximately 10 minutes later and transported Child A [redacted].

i. On July 23, 2025, Licensing Consultant Pamela Walker, accompanied by Licensing Consultant Andrea Hagen and Michigan Department of Health and Human Services Worker Ashley Feeback, conducted an on-site inspection at the child care home. The following unrelated children were present at the time of the inspection: Child B, Child C, Child D, Child E, Child F, Child G, Child H, Child J, Child K, Child L, and Child O.

j. Upon arrival on July 23, 2025, Pamela Walker and Andrea Hagen observed children moving freely between the backyard and the house. There were also children coming and going from the barn, which was not approved child care use space. A portion of the barn was equipped and being used as a children's play area. Child B was unattended and harnessed in stroller in the backyard while Licensee prepared lunch.

Licensee ultimately brought Child B inside but kept him harnessed in the stroller for the rest of the on-site inspection that lasted approximately one hour.

k. On July 23, 2025, during the on-site inspection, Pamela Walker interviewed Licensee who made the following statements:

   i. Licensee acknowledged that she was aware of Child A's [redacted] and knew that she needed to be supervised due to these behaviors.

   ii. Licensee acknowledged that Child A [redacted] was not out of the reach of children.

   iii. She described school-age children as "horrocious" and vowed to never care for school-age children again.

l. During the on-site inspection on July 23, 2025, Child C fell asleep in a car seat. Pamela Walker told Licensee that Child C needed to be moved to approved sleeping equipment. When Licensee did not move Child C, Pamela Walker made a second request for Licensee to move Child C to appropriate sleeping equipment, which she finally did. The following day, Pamela Walker observed Child C in a play yard with a blanket, which Licensee removed when Pamela Walker entered the room.

m. On July 24, 2025, Pamela Walker conducted a second on-site inspection at Licensee's home and again observed Child B harnessed in a stroller in

front of a television. Child B remained in the stroller in front of the television during the entire 50-minute inspection.

4. Licensee failed to ensure that all dangerous and hazardous materials and items are stored securely out of the reach of children. Specifically:
    a. On July 22, 2025, there was a bottle of acetaminophen tablets in an unlocked bathroom cabinet that was accessible to children. [redacted]
    b. On July 23, 2025, during the on-site inspection, Pamela Walker observed four loose pills on the kitchen countertop that were unsecured and accessible to children. Licensee later identified the pills as turmeric, fish oil, vitamin D, and iron. Pamela Walker instructed Licensee to secure the medication. That same day, Licensee signed a safety plan with Ashley Feeback indicating that she would store all medications in a locked container for the duration of the investigation.
    c. On July 23, 2025, Pamela Walker observed children playing in the barn. There were numerous dangerous and hazardous items that were accessible to children, including mineral spirits, bleach, ant and bug sprays, spray paint cans, hand rakes, and a bow saw. There were also stacked hay bales in the back of the barn, and two ducks with ducklings on the floor of the barn and accessible to the children.
    d. During the inspection on July 23, 2025, the cover to the hot tub was not secure, leaving it accessible to children. All four straps on the cover were

disengaged, allowing the cover to be easily opened. The hot tub was full of water and accessible to children in care.

e. On July 24, 2025, Pamela Walker conducted a second on-site inspection at Licensee's home and asked to see the bathroom cabinet [redacted]. The cabinet was unlocked even though she had agreed the previous day to store medications in a locked container. There were numerous medications, pain relievers, cough syrup, nasal spray, and eye drops in the cabinet, all accessible to children.

f. On July 24, 2025, during the second inspection, Pamela Walker observed children playing in the barn. There were still several dangerous and hazardous items that were accessible to children, including unobstructed stairs to the loft, rusted farm equipment in the loft, stacks of heavy feed bags, and a utility knife. There was an electrical cord near leaking water.

5. Licensee failed to have complete and accurate child information cards for all enrolled children. During the on-site inspections on July 23 and 24, 2025, Pamela Walker asked Licensee for the child information cards for the children in care. Licensee did not have cards for Child A, Child C, Child E, Child F, Child K, Child L, and Child N.

6. Licensee failed to provide accurate and truthful information to the Bureau during an investigation. Specifically:

a. On July 23, 2025, during the on-site inspection, Licensee initially told Pamela Walker that she had six unrelated children and three related children for a total of nine children in care. However, after further

questioning, Licensee later acknowledged that ten unrelated children and one related child was present.

b. On July 23, 2025, Licensee told Pamela Walker that Child L was related to her. When further pressed, Licensee admitted that Child L was not related to her by blood or law.

c. On July 23, 2025, Licensee told Pamela Walker that Child A's Mother had contacted her and apologized for Child A's behavior and the trouble she caused. However, Child A's Mother denied calling Licensee after the incident and did not apologize to her.

7. Licensee failed to ensure that the actual number of unrelated children in care does not exceed her licensed capacity of seven children. Specifically:

   a. On July 22, 2025, Licensee had 12 unrelated children in care, exceeding her licensed capacity by five children.

   b. On July 23, 2025, at the time of the on-site inspection, Licensee had 11 unrelated children in care, exceeding her licensed capacity by four children.

8. Licensee failed to maintain a ratio of one child care staff member for every seven unrelated children and all children less than 6 years of age. Specifically:

   a. On July 22, 2025, Licensee was the only child care staff person present with 12 unrelated children between the ages of 5 months and 11 years.

   b. On July 23, 2025, Licensee was the only child care staff member present for 11 unrelated children between the ages of 5 months and 10 years.

COUNT I

The conduct of Licensee, as set forth in paragraphs 3(a) through 3(m) above, evidences a willful and substantial violation of:

**R 400.1911**

(1) A licensee shall ensure appropriate care and supervision of children at all times.

COUNT II

The conduct of Licensee, as set forth in paragraphs 4(a) through 4(f) above, evidences a willful and substantial violation of:

**R 400.1932**

(2) All dangerous and hazardous materials or items must be stored securely and out of the reach of children.

COUNT III

The conduct of Licensee, as set forth in paragraphs 6(a) through 6(c) above, evidences a willful and substantial violation of:

**R 400.1903**

(4) The licensee shall cooperate with the department in connection with an inspection or investigation, as required in section 10(1) of the act, MCL 722.120(1). Cooperation includes, but is not limited to, all of the following:

(c) Provide accurate and truthful information to the department, and encourage witnesses to provide accurate and truthful information to the department.

COUNT IV

The conduct of Licensee, as set forth in paragraph 5 above, evidences a willful and substantial violation of:

**R 400.1907**

(1) Prior to a child's initial attendance, a licensee shall obtain the following documents:

(a) A completed child information card on a form provided by the department or a comparable substitute approved by the department.

COUNT V

The conduct of Licensee, as set forth in paragraphs 7(a) and 7(b) above, evidences a willful and substantial violation of:

**R 400.1908**

(1) The licensee shall ensure that the actual number of unrelated children in care at any 1 time does not exceed the number of children for which the child care home is licensed, not more than 6 children for a family child care home and not more than 12 children for a group child care home.

COUNT VI

The conduct of Licensee, as set forth in paragraphs 8(a) and 8(b) above, evidences a willful and substantial violation of:

**R 400.1910**

(1) The ratio of personnel to children present in the home at any 1 time must be not less than 1 member of the personnel to 6 children. The ratio must include all children in care who are not related to any personnel and any of the following children who are less than 6 years of age:

(a) Children of the licensee.
(b) Children of a child care staff member or child care assistant.
(c) Children related to any member of the household by blood, marriage, or adoption.

COUNT VII

The conduct of Licensee, as set forth in paragraph 3(l) above, evidences a willful and substantial violation of:

**R 400.1916**

(13) None of the following are approved sleeping equipment for children 24 months of age or younger:
(a) Infant car seats.

COUNT VIII

The conduct of Licensee, as set forth in paragraph 3(l) above, evidences a willful and substantial violation of:

**R 400.1916**

(8) Soft objects, bumper pads, stuffed toys, blankets, quilts or comforters, pillows, and other objects that could smother an infant must not be placed with, under, or within reach of a resting or sleeping infant.

COUNT IX

The conduct of Licensee, as set forth in paragraphs 3 through 8 above, evidences a willful and substantial violation of:

**R 400.1902**

(3) All persons, including minors, residing in the child care home shall meet all of the following requirements:

(c) Act in a manner that is conducive to the welfare of children.

**NOTE:**
**MCL 722.115m**

(13) As used in this section:

(b) "Conducive to the welfare of the children" means:

(*i*) The service and facility comply with this act and the administrative rules promulgated under this act.

(*ii*) The disposition, temperament, condition, and action of the applicant, licensee, licensee designee, program director, child care staff member, and member of the household promote the safety and well-being of the children served.

COUNT X

The conduct of Licensee, as set forth in paragraphs 3 through 8 above, provides grounds for revocation pursuant to:

**MCL 722.115m**

(2) If the department determines that a service, facility, applicant, licensee, child care staff member, or member of the household is not conducive to the welfare of the children, the department shall deny that application or revoke that licensee's license according to section 11.

DUE TO THE serious nature of the above violations and the potential risk it represents to vulnerable children in Licensee's care, emergency action is required.

Therefore, the provision of MCL 24.292 of the Administrative Procedures Act of 1969, as amended, is invoked. Licensee is hereby notified that the license to operate a family child care home is summarily suspended.

EFFECTIVE 6:00 p.m., on August 1, 2025, Licensee is ordered not to operate a family child care home at 10109 Riley Street, Zeeland, Michigan 49464, or at any other location or address. Licensee is not to receive children for care after that time or date. Licensee is responsible for informing parents or guardians of children in care that license has been suspended and that Licensee can no longer provide care.

HOWEVER, BECAUSE THE Department has summarily suspended Licensee's license, an administrative hearing will be promptly scheduled before an administrative law judge. Unless the Licensee waives their right to an administrative hearing, the Department will submit a request for hearing packet to the Michigan Office of Administrative Hearings and Rules (MOAHR) on Licensee's behalf. If Licensee has questions regarding the administrative hearing or no longer wishes to continue the appeal process, Licensee should contact MOAHR:

Michigan Office of Administrative Hearings and Rules
611 West Ottawa Street, 2nd Floor
P.O. Box 30639
Lansing, Michigan 48909-8139
Phone: 517-335-7519
FAX: 517-763-0155
MOAHR-BSD-Support@michigan.gov

MCL 24.272 of the Administrative Procedures Act of 1969 permits the Department to proceed with the administrative hearing even if Licensee does not appear. Licensee may be represented by an attorney at the administrative hearing.

DATED: 08/01/2025

Erika Bigelow, Division Director
Child Care Licensing Bureau

DATED: 08/01/2025

Courtney Adams, Bureau Director
Child Care Licensing Bureau

This is the last and final page of the ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT in the matter of Carolyn DeBoer, DF700051588, consisting of 14 pages, this page included.

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**STATE OF MICHIGAN**
**DEPARTMENT OF LIFETIME EDUCATION, ADVANCEMENT, AND POTENTIAL**
**CHILD CARE LICENSING BUREAU**

**In the matter of**

License #: DF700051588
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Carolyn DeBoer

_____/

**PROOF OF SERVICE**

The undersigned certifies that a copy of the Order of Summary Suspension and Notice of Intent was personally served upon the person below on ___/___/_____ at ___:___ a.m. or p.m.

Carolyn DeBoer
10109 Riley Street
Zeeland, Michigan 49464

Served by:

_____
Child Care Licensing Consultant
Child Care Licensing Bureau