STATE OF MICHIGAN
DEPARTMENT OF
LIFELONG EDUCATION, ADVANCEMENT, AND POTENTIAL
LANSING

GRETCHEN WHITMER
GOVERNOR

BEVERLY WALKER-GRIFFEA
DIRECTOR

Heidi Przepiora
Camp Lu Lay Lea, Inc
92 Ohio Street
Lupton, MI 48635

2/23/2026

RE: License #: CR650418432
Investigation #: 2025C0434017
Camp Lu Lay Lea
92 Ohio Street
Lupton, MI 48635

Dear Heidi Przepiora

Attached is the Special Investigation Report for the above-mentioned 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.
- Signed and dated corrective action plan.

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.

A six month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify me in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 licensing unit at 833-665-8116.

Sincerely,



James Vanden Heuvel, Lead Licensing Consultant
Camp Licensing Unit
105 W. Allegan St. 2nd Floor
Lansing, MI 48909
enclosure

MICHIGAN DEPARTMENT OF
LIFELONG EDUCATION, ADVANCEMENT, AND POTENTIAL
CAMP LICENSING UNIT
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	CR650418432
Investigation #:	2025C0434017
Complaint Receipt Date:	07/13/2025
Investigation Initiation Date:	07/13/2025
Report Due Date:	09/13/2025
Licensee Name:	Camp Lu Lay Lea, Inc
Licensee Address:	92 Ohio St. Lupton, MI 48635
Licensee Telephone #:	989-714-7323
Administrator:	Heidi Przepiora
Name of Camp:	Camp Lu Lay Lea
Camp Address:	92 Ohio St. Lupton, MI 48635
Camp Telephone #:	989-714-7323
License Status:	Provisional
Effective Date:	01/14/2025
Expiration Date:	07/13/2025
Capacity:	86
Camp License Type:	Residential – Children's Camp

II. ALLEGATION(S)

	Violation Established?
The Zion cabin presented a fire, health, or safety hazard.	No
The camp operator did not evaluate staff before initial assignment.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

07/13/2025	Special Investigation Intake
07/13/2025	Special Investigation Initiated-Telephone
07/14/2025	Contact-Telephone Call Made with Camp Director
07/14/2025	Contact-Telephone Call Made with Ogemaw Sheriff Department
07/14/2025	Contact-Face to Face -Onsite
07/15/2025	Contact-Document Sent-Email to MIOSHA
07/17/2025	Contact-Document Sent-Requested Law Enforcement-FOIA
07/19/2025	Contact-Document Sent-CPS Centralized Intake
07/19/2025	Contact-Telephone Call Received-CPS/MIC
07/21/2025	Contact-Document Received-CPS/MIC
07/22/2025	Inspection Completed Onsite with CPS/MIC
08/12/2025	Contact-Telephone Call Made with CPS/MIC
08/15/2025	Contact-Face to Face with CPS/MIC
09/02/2025	Contact-Document Sent: Requested CPS/MIC report
09/08/2025	Contact-Telephone Call Made with CPS/MIC
09/15/2025	Contact-Document Received: CPS/MIC report
10/01/2025	Contact-Telephone Call Made
10/01/2025	Contact-Document Sent: Requested Law Enforcement-FOIA

10/22/2025	Contact-Document Received: Police Report
12/17/2025	Contact-Document Received: Medical Examiner Report
1/22/2026	Contact-Telephone Call Made
1/31/2026	Inspection Complete Sub Compliance
2/23/2026	Corrective Action Plan Requested and Due By 3/11/26
2/23/2026	Exit Conference with Hiedi Przepiora by telephone.

IV. INVESTIGATION AND FINDINGS

ALLEGATION:

The Zion cabin presented a fire, health, or safety hazard.

INVESTIGATION:

On 7/13/2025, the department received an online incident report submitted by the camp director, Heidi Przepiora reading a staff member passed away in their sleep in a camper cabin. In addition, to the submitted incident report, I received a phone call message from a camp board representative requesting a phone call.

I contacted camp board representative (CB1) by telephone. CB1 stated a minor staff member (MS1) was found in the camper cabin unresponsive on Saturday morning (7/12/2025) by staff members. He was transported by EMS and pronounced dead at the hospital. Saturday morning was closing day for session 3 and the camp subsequently cancelled the following session (7/13-7/19/2025). Campers and staff were receiving counseling and support services as needed. The Ogemaw County Sheriff's Department was conducting an investigation, and an autopsy would be performed to determine cause of death.

On 7/14/2025, I attempted contact by telephone with Ogemaw County Sheriff's Department (OCSD) to coordinate investigation. I left a message to contact me for coordination.

On 7/14/2025, I contacted camp director, Hiedi Przepiora by telephone. Ms. Przepiora was advised a special investigation was initiated and an onsite inspection was coordinated for the same day.

I interviewed Ms. Przepiora at the camp facility. Ms. Przepiora stated on 7/12/2025 in the morning she received a phone call from SM2 who was near the Zion Cabin

around 8:40am advising SM2 could not wake up MS1. She called 911 and activated an emergency response plan as she made her way to the cabin. Ms. Przepiora arrived at the “Zion” cabin to find MS1 on the floor with SM2 and SM3 performing CPR. She left and went to the front gate to direct the EMS to the scene. MS1 was treated and transported by EMS to a local hospital. MS1 was pronounced deceased on 7/12/2025 at the hospital.

Ms. Przepiora stated law enforcement officers conducted interviews onsite with campers and staff. It was a closing day for session three and campers were picked up at the regularly scheduled time. Ms. Przepiora described MS1 as a minor staff member working in the role of camp maintenance and program support. During session three (7/6-7/12/2025), MS1 was assigned to Zion cabin for nighttime sleeping support with the adult camp counselor, SM2. Ms. Przepiora stated there were no signs of foul play, and she did not know how MS1 died.

I toured the Zion Cabin. This cabin is a camper sleeping building located at the end of a cabin row. Zion cabin is the furthest structure from the office and main gate. The tour revealed Zion cabin to be a L- shaped rustic open construction cabin with wood 2x4 stud walls and cement floor. There were five bunks and two single twin beds placed on the interior of the perimeter of the cabin. Upon entering the cabin door, going clockwise, there was 1st bunk bed, then SM2’s twin bed, then MS1’s twin bed straight across from the cabin door, the egress window, then 2nd camper bunk bed, 3rd camper bunk bed, then 4th camper bunk bed, then 5th camper bunk bed just right of the main door. MS1’s twin bed was located center of the cabin. The walls had 4x8 sheet plywood covering the lower wall around the interior perimeter of the cabin. The cabin had an occupant load of 12. MS1’s bed was a wood construction twin with a standard mattress. Camper bunk beds were wood constructed with guard rails for upper bunks. There was string lights draped over the rafters. The cabin had a small table, two chairs, and a small two-shelf book stand located between SM2 and MS1’s beds. The cabin appeared generally clean and hazard free. There was some evidence of connected extension cords to power string lights and fans. Ms. Przepiora described MS1 was found lying parallel and adjacent to MS1’s bed on the floor. I observed this area to be generally in the middle of the camper cabin.

On 7/15/2025, I sent an email notice to the Michigan Department of Labor and Economic Opportunity (LEO) Michigan Occupational Safety and Health Administration (MIOSHA) worker advising I was conducting a concurrent investigation.

On 7/19/2025, I filed an online Centralized Intake report #159633526 due to a death of a minor child at a licensed camp facility. I received a follow up phone call from Centralized Intake asking to clarify information about the Centralized Intake report. I emailed a request to the Ogemaw County Sheriff’s Department for coordination.

On 7/21/2025, I received an email from CPS-MIC Intake Coordinator advising that CPS-MIC worker will be assigned the case for investigation. I had a follow up phone

call for coordination with CPS-MIC worker with a plan to conduct an onsite investigation on 7/22/2025.

On 7/22/2025, I conducted an onsite investigation along with CPS-MIC worker involving interviews and tour of the facility. I observed the Zion cabin with CPS-MIC worker. The cabin's condition remained generally the same from my inspection of the cabin on 7/14/2025. There were seven campers assigned to the cabin of Zion for week three. The camper ages ranged from eight to 11 years old. Each camper had an assigned bed and with two empty bunks. I observed no obvious health, safety, or fire hazards in the cabin.

I interviewed SM2 along with CPS-MIC worker about the conditions in the cabin the night of 7/11/2025 and morning 7/12/2025. SM2 stated the cabin was comfortable, windows were open, and some fans were on moving air. SM2 stated power cords were used to power cell phones, lights, and fans. SM2 did not know how MS1 died.

On 8/12/2025, I interviewed MS1's parents by telephone along with CPS-MIC worker. They reported MS1 started attending the camp as a camper for three or four years aging into a staff role at the camp. They reported that MS1 loved camp and looked forward to it every year. The parents did not express concerns about the camp facility or camp operator.

On 9/15/2025, I reviewed the Michigan Department of Health and Human Services (MDHHS) Children's Protective Services Investigation Report case number: 207923844. The report included investigation interviews, records reviewed, and conclusions. The report concluded "No Preponderance" of physical neglect.

On 10/22/2025, I reviewed a copy of the Ogemaw County Sheriff's Department report #2516502039. The report included officer investigation including child interviews, camp staff interviews, and photos. The status of the report noted "pending autopsy".

On 12/9/2025, I submitted a FOIA request to the Michigan Department of Labor and Economic (LEO) Occupational Safety and Health Administration (MIOSHA) requesting a copy of the investigation report for review. I received denial response due to investigation still being open.

On 12/17/2025, I reviewed the Ogemaw County, Office of the Medical Examiner report. The report declared the cause of death "based on autopsy, toxicology, and a thorough investigation of the circumstances, a cause of death cannot be determined. Manner of death: Indeterminate".

I reviewed the licensing record. The camp facility had an "A-Rated" Qualified Fire Inspection (QFI) dated 6/19/2025 reading substantial compliance with applicable rules. The QFI report read inspection of eight cabins used by campers for sleeping along with non-sleeping buildings. The camp facility had an "A-Rated" Environmental

Health Inspection (EHI) dated 6/25/2025 by the District Health Department No. 2 from Ogemaw County reading substantial compliance with applicable rules. The EHI report read the entire camp was inspected.

APPLICABLE RULE	
R 400.11149	**Site safety; emergency procedure; use of facilities; equipment; fire safety orientation.**
	(1) A camp shall ensure that the site and facilities of a camp do not present a fire, health, or safety hazard.
ANALYSIS:	Interviews and records reveal the cabin of Zion was an approved camper sleeping environment. It had acceptable rated QFI and EHI Inspections completed within the past year. This camper cabin environment could not be determined to be a cause to MS1's death.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The camp operator did not evaluate staff before initial assignment.

INVESTIGATION:

On 7/22/2025, I interviewed Staff Member 2 (SM2) along with CPS-MIC worker. SM2 was the Zion cabin counselor for week three. SM2 was staff member for over 11 years. He stated he did not attend staff training and did not get a staff manual. SM2 recalled the events leading to finding MS1 unresponsive in the morning on 7/12/2025. SM2 stated the evening closing night campfire finished around 8:15pm on 7/11/2025. The Zion cabin participated in a late night activity called "windego" in the woods after the campfire. MS1 was the "windego" which includes hiding in the woods, while cabin campers and SM2 would search. This activity ended around 11:45p. After which time, SM2 and MS1 went to the cabin to assist with lights out and bedtime. SM2 left the cabin around 12:30-12:45am, for shower and staff break, while MS1 stayed with the campers. SM2 stated that he heard that MS1 left the cabin around 1:00am and Staff Member 4 (SM4) watched the campers while SM2 and MS1 were on break. SM2 returned back to the cabin around 3:30am after taking medication for sleep. At that time, MS1 had not returned back to the cabin and SM4 was no longer in the cabin. SM2 recalled at some point in the night hearing either screaming or moaning but it wasn't enough to wake him up fully. In the morning around 8:30am, two staff members conducted wake-up for the cabin and sent campers to breakfast. Most all the campers were out of the cabin, when SM2 noticed MS1 laying on the floor on a blanket. SM2 found MS1 not breathing and did not have a pulse. SM2 went to get help and came back with SM3 to start CPR. SM2 continued with other staff to provide CPR until EMS took over care. SM2 reported MS1 was his "best friend" and had known MS1 for many years. SM2 stated MS1

using nicotine (vape), THC, and alcohol. SM2 denied MS1 consuming alcohol at camp but did have a vape and THC pen at the camp. SM2 denied knowing if MS1 used them a camp. SM2 denied knowing if MS1 took medications at the camp but noted that law enforcement found medications in MS1 fanny pack. After interviewing SM4, I reinterviewed SM2 about when SM2 returned on 7/12/2025. SM2 stated that SM4 was sleeping in the cabin and needed to be awakened. This was different than previously stated by SM2 and different that SM4's report.

I reviewed SM2 staff file. The file revealed no staff record on file within the document library titled "2025 staff records". SM2 did have an application submitted on 6/27/2025. The SM2 application did not include complete address including city, state, zip. The application did not include names of three references. The health information on SM2 records included a medication noted which corroborated SM2 statements about being on a medication that has sedative effects. The staff record revealed no criminal history check was completed. There was no record of evaluation conducted by camp director of determining suitability of SM2 of the role prior to initial assignment.

I interviewed Staff Member 4 (SM4) with CPS-MIC worker. SM4 defined the camp responsibilities as a "program staff person" and "floater role". SM4 stated he had spoken to several staff and was conducting his own investigation about what happened to MS1. SM4 reported MS1 used nicotine, weed, and alcohol. SM4 denied MS1 consumed alcohol at camp but did see MS1 take one hit on dab pen (cannabis) after the "windego" activity on 7/11/2025. SM4 reported leaving the Zion cabin around 3:00am with Minor Staff Member 3 (MS3). SM4 stated neither SM2 nor MS1 were in the cabin when SM4 and MS3 left Zion cabin. SM4 reported attended staff training during the week of 6/16-6/21/2025. SM4 denied receiving a staff handbook with job descriptions.

I reviewed SM4's employee file. The file included a job offer letter dated 5/29/2025. The staff record included only one reference dated 6/25/2025 which was completed by Staff Member 7 (SM7). SM4 application was dated 5/24/2025 and included name and street address but did not include city, state, and zip code. The record revealed that no criminal history check was completed. There was no record of evaluation conducted by camp director of determining suitability of SM4 of the role prior to initial assignment.

I searched for MS3's staff file. The search revealed a staff file including only a payroll and job letter. The file did not include three references. The staff application was submitted on 4/5/2025. The personal information on address did not include city, state, or zip. There is no record of evaluation conducted by camp director of determining suitability of MS3 of the role prior to initial assignment.

I interviewed health officer, Staff Member 10 (SM10) with CPS-Worker. SM10 stated MS1 did not have any medical history that she was aware of and no medications at the health lodge. SM10 reported MS1 would take over the counter medications of

Tylenol or Ibuprofen as needed for his knee but generally did not like taking medications. SM10 stated MS1 knee would bother him after running or pushing it too hard. SM10 denied MS1 taking any Tylenol or Ibuprofen during week three. SM10 denied knowing of any substance use by MS1 but noted that law enforcement did find a lockbox with marijuana and a vape in it that belonged to MS1.

I reviewed SM10's staff file. The file revealed an application was on file dated 1/14/2025. The 2025 staff file included central registry clearance dated 5/27/2025, one completed reference, and no criminal history check. There was no record of evaluation conducted by camp director of determining suitability of SM10 of the role prior to initial assignment.

I reviewed the Camp Lu Lay Lea policy manual section titled "Employment" on page six. The policy reads "*Employment. You have been selected as an employee to a called or appointed position with Camp Lu Lay Lea based on an available position, your experience, skills, references, personal interview, and your stated desire to do a good job*." Under section titled "1.10 Background Checks", the policy reads "*all employees are subject to reference and background checks as a condition of employment*." In Section 11 titled "Job Descriptions", under "11.1 General Items affecting all staff positions". The policy reads "*Qualifications: 1. good moral character and integrity, 2. good healthy and vitality, 3. emotional maturity*". The camp director job description reads the "*camp director is an employee of the Board of Trustees for camp Lu Lay Lead is responsible to the Board. His/her responsibilities include: "3. Properly administer the camp business and see that the camp complies with all regulations and laws and report to the Board any changes or deviations."; "6. Provide leadership, supervision, and guidance for the summer staff."; and "10. Hire a competent, qualified staff*" among several responsibilities. The Assistant Director job description includes the responsibility description reading "*Your main job is to supervise the staff and day to day operation of the camp*". The qualification for the role reads "*At least experience on season of supervisory and 1-2 administrative supervisory experience; ability to take responsibility for the administration of the camp in the absence of the director, responsible for the camp director's responsibilities and minimum age of 21 years old*." The job description does not include specific responsibilities for supervising staff including minor staff.

I reviewed the program director job description including the responsibility description on pg. 42 reading "*You supervise the program staff and counselors. It is your responsibility to make sure that camp's program is well planned, well organized, and well implemented*." The section titled "*Responsibilities*" details program responsibilities but does not detail specific responsibilities of supervision of counselors and staff. The responsibilities include responsible to the camp director and assistant camp director; to always keep in mind the camp is a children's camp and is operated for the children's benefit; consult with camp director relative to suggestions for improvement of activities and general camp experiences, supervise and carry out all program activities with the help of counselors and specialists when

necessary, and other specific responsibilities. The job description does not outline specific responsibilities for supervision of staff, including minor staff.

I reviewed staff member files. The documents were maintained in a google folder titled “staff 2025”. The records were titled by the staff member’s first name. There were 34 staff file folders. MS1 staff file was nested within Minor Staff Member 2 (MS2) staff file. The staff files included the following types of documents: payroll, job offer letter, references letters, and central registry check clearances. The staff member files folder revealed no records of criminal history checks being completed on staff members 18 or older. In addition, the staff files did not include three statements of positive reference for each person. Of the 34 records, 13 staff members had three statements of positive reference, and 11 staff records had no references included in the file. I reviewed a second document titled “*Camp Lu Lay Lead Application 2025 (Responses)*” described by Ms. Przepiora as the application submissions for the summer staff. The document included timestamped application submission, name of applicant, address, email, phone number, birthdate, age at beginning of 2025 season, and responses to application questions about interest, work history, self-attestation of conviction or abuse/neglect, camp experience/ history, training history, immunization, physical limitations, behavioral issues, allergies, special diets, other health concerns, medications, emergency contacts, reference names, for those under 18 years of age: parent authorization.

I reviewed assistant camp director, Staff Member 5 (SM5) employee file. The file included one reference and a central registry check. The employee file did not include a criminal history check. SM5’s application for the position described experience as a program director at the camp in 2024 and assistant program director in 2023. SM5 is listed as over 21 years of age. There was no record of evaluation conducted by camp director of determining suitability of SM5 of the role prior to initial assignment.

I reviewed MS1 staff records. The records revealed an online application including weeks of service, health and emergency information, reference names, attestations, and for minor staff under the age of 18 the application includes parent authorization. The parent authorization included four statements: “*1) to my knowledge all the information stated above is correct, 2) My child has permission to participate in all camp activities unless otherwise noted by me, 3) I hereby give permission for images of my child, captured through video, photo, and digital camera to be used solely for the purposes of Camp Lu Lay Lea promotional material and publications and waive any rights of compensation or ownership thereto. This permission includes images of my child in the weekly video that will be made and posted for campers to view. 4) In case of emergency, the health directors may give routine treatment, or a physician selected by the camp director may hospitalize or secure proper treatment, for said child, including injection, anesthesia, or surgery. The health history completed is correct to the best of my knowledge, and I understand it is requested for the benefit of my child. I have read and agree to the 4 statements above. typing your name and date serves as agreement.*” The form listed MS1’s

parent name and date of 1/21/2025. The health section of the application included a question about immunizations (measles, mumps, rubella, chicken pox, Rhematic Fever, Polio, and Unsure) with an answer noted as “unsure”. Additional questions on the form included: “*Do you have any physical limitations? If yes, please explain. If not, write N/A; Do you have any behavior issues, if yes, please explain, if not, write “N/A”, Do you have any allergies? If yes, please explain. If not, write “N/A”, Do you have a special diet? If yes, please explain, if not, write “N/A”, Do you have any other health considerations not previously listed? If yes, please explain. If not, write “N/A”. Please list any medication that you will be bringing to Camp Lu Lay La. Your list will be updated on the first day of work. If there are no medications at this time, please list N/A (Please know that medications will be locked up by the health directors and the camp director and dispensed by the health directors. All medications must be in their original over the counter or prescription bottle*.” For all the questions in the health section, the answer provided was “N/A”.

I reviewed camp counselor Staff Member 8 (SM8)’s application. SM8 completed an application on 7/10/2025. SM8 application did not include complete address including city, state, and zip. SM8 was listed as a current camp counselor on week 3 current staff roster. I reviewed the 2025 staff records and could not find an employee file for SM8 within the records. The record search revealed no criminal history check was completed. There was no record of evaluation conducted by camp director of determining suitability of SM8 for the role prior to initial assignment.

I reviewed SM3’s employee file. There was no record of a completed application or a staff file in the 2025 Staff records. SM3 was listed on the current camp staff roster as a “WF mentor and floater”. There was no criminal history check record available. There was no record of evaluation conducted by camp director of determining suitability of SM3 for the role prior to initial assignment.

I observed Ogemaw County Sheriff’s Department (OCSD) Body Cam footage from 7/11/2025. The body cam video showed the OCSD on the scene investigation footage, interviews, and searches. OCSD found two locked boxes contained in a staff sleeping area in building titled “Barnard”. The male staff sleeping quarters for SM7, SM14, SM15, and SM16. The sleeping quarters also contained some of MS1’s personal items. Staff advised that one of the lock boxes belonged to MS1 and the other lock box found in the same area in the staff sleeping quarters belonged to the program director, SM7. SM7 opened the personal black locked box on the video cam footage to reveal THC related products. SM7 was asked by OCSD if he knew the contents of the other locked box and if the contents were any stronger than THC. SM7 stated “no, no”.

I Interviewed co-program director, Staff Member 7 (SM7) by telephone. It should be noted that SM7 is related to the camp director. SM7 stated the role of the program director was to plan games, structure the camp program, and assign staff to cabins. The program director does not have hiring responsibilities but supports the camp director with supervision of staff and directly reports to the camp director. SM7

described the policy and procedures of the camp are covered during staff training week. SM7 advised there no curfew for staff members but campers are required to be in the cabin by 10:30pm on regular nights and on closing night it is 11:00pm. Counselors are given some personal time after lights out by having assigned 2nd staff members to cabins. SM7 stated campers must be supervised during nighttime. SM7 described the staff as a "big family" and staff hang-out in the dining hall or take showers during their time off. SM7 observed MS1 on the night of 7/11/2025 as "normal" at the closing night campfire. The camp program on closing nights included special activities like sparklers at the waterfront and "scary stories" which includes a walk in the woods called "windego". SM7 stated MS1, SM4, and Staff Member (SM9) were the individuals hiding in the woods for the activity.

I advised SM7 that I saw law enforcement body cam footage with SM7 admitting to having locked box with THC in possession at the camp. The locked box was observed in body cam footage being removed from a staff sleeping area where MS1 also had a locked box that was discovered. SM7 admitted to being the owner of one of the locked boxes and opened the box to allow law enforcement to see the contents. SM7 stated he was over 21 years old. He denied using marijuana at the camp and denied giving marijuana to MS1. SM7 was observed upon the opening of the locked box containing THC to the camp director, "News flash, I know, I know, I know". I asked SM7 about the policies of the camp and whether SM7 was aware of any policies about marijuana use. SM7 stated marijuana is not allowed to be used at the camp but he thought it could be possessed at the camp. I reviewed the policy in the 2025 Staff Manual with SM7 which reads on page 62 "*Drugs: Possession or use of illegal drugs of any kind while volunteering with Lu Lay Lea Ministries is not allowed and is grounds for immediate dismissal. Illegal use of any prescription, stimulant, or narcotic drugs while volunteering with Lu Lay Lea ministries is also grounds for immediate dismissal. This applies to all hours and all days, including times when the volunteer is not on duty. Smoking: Camp Lu Lay Lea is entirely smoke and tobacco use free. Volunteers who are smokers and tobacco users are to leave camp when they are off duty to smoke. The use of hookahs, chewing or other smokeless tobacco, cigars, e-cigarettes, or similar nicotine delivery devices are prohibited on camp or when representing the camp at events."* SM7 stated he was under the impression it could be possessed at the camp.

I reviewed SM7's employee file. There was a completed application on 1/2/2025. The file included three references and a central registry clearance. There was no record of criminal history check completed. There was no record of evaluation conducted by camp director of determining suitability of SM7 for the role prior to initial assignment.

I searched for SM9's employee file who was identified as one of the staff in the woods during the "windego" game. The employee file titled "Staff 2025" did not have a file for SM9. There was no record of staff application for SM9. SM9 was not listed on the current staff roster for week 3. There was no record of evaluation conducted

by camp director of determining suitability of SM9 for the role prior to initial assignment.

I reviewed assistant camp director, SM14's employee file. The record reveals SM14 is over 21 years of age. The 2025 Staff files contained a folder for SM14 including a central registry clearance completed 5/27/2025, one letter of reference for the role of assistant director, one letter of reference dated 12/21/2019, and letter of reference unknown date. SM14 noted only one reference name on application. There was no record of criminal history check completed. There was no record of evaluation conducted by camp director of determining suitability of SM14 for the role prior to initial assignment.

APPLICABLE RULE	
R400.11109	**Staff**
	(6) Before assignment, a camp shall evaluate all the following characteristics for each staff member in relation to the duties to be assigned: **(a) Character.** **(b) Emotional stability.** **(c) Health.** **(d) Ability.** **(e) Experience.** **(f) Education.**
ANALYSIS:	Interviews and records reveal the camp administration did not consistently meet the minimum requirements of evaluation for each staff member prior to initial assignment by not having references, interviews, or criminal background checks on file for the staff. The camp administration did not follow their own policy related to employment practices in determining suitability including application, references, interviews, and background checks. There were staff member(s) that had possession of vapes and marijuana at the camp in direct violation of written camp policy. SM7 had responsibilities of supervision of staff and was observed to have violated written policies about drug free environment.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

I observed OCSD body cam footage of interviews with campers assigned to the cabin of Zion. OCSD deputy interviewed campers on the 7/12/2025 privately to obtain statements from the campers who were in the cabin on 7/11-7/12/2025.

I observed Camper A's interview on OCSD body cam footage. Camper A stated during the night, MS1 was moving around in the cabin yelling "moo". He then fell straight down to the ground. Camper A stated SM2 was sleeping and didn't wake up. Camper A woke up around 8:00-8:30am and saw MS1 was "purple" laying on the ground.

I observed Camper B's interview on OCSD body cam footage. Camper B stated "I was reading my book. MS1 woke up and walked around with a chair in his hands, threw the chair at a bed, then laid back in bed for about 30 seconds, then MS1 fell off the bed, then MS1 was laying on his side running with a chair in hand. No adults in the cabin when it happened, SM2 came back to the cabin and Camper B told SM2 about the incident. Camper B asked MS1 if they were okay. MS1 did not respond. SM2 saw MS1 laying on the ground and then went to sleep". SM2 did not ask if MS1 was okay.

I observed Camper C's interview on OCSD body cam footage. Camper C stated he woke up in the night to see MS1 laying on the ground and shaking. MS1 was groaning and trying to reach for things. Camper C saw SM2 sleeping on his bed at the time. In the morning, Camper C saw MS1 laying on the ground with purple skin color.

I observed Camper D's interview on OCSD body cam footage. Camper D woke up during the night, MS1 was "sleepwalking" and "mooing". Camper D stated that SM2 was not in the cabin. Later, Camper D went to SM2 to ask if Camper D could use the bathroom but SM2 was not in the cabin.

I observed Camper E's interview on OCSD body cam footage. Camper E stated that MS1 threw a chair and then fell on the ground. SM1 was in the cabin sleeping when this occurred.

I observed Camper F's interview on OCSD body cam footage. Camper F stated MS1 was panting and shaking with his arms crossed. Camper F saw SM2 was sleeping when Camper F heard MS1 mooing during the night. Later, SM2 was awake when MS1 was panting and SM2 told the campers to leave.

I observed Camper G's interview on OCSD body cam footage. Camper G stated MS1 was mooing and threw a chair that hit Camper G. Camper G stated SM2 was in the cabin when this occurred. Camper G observed MS1 on the ground making some noises in the morning.

I interviewed SM4 about supervision in the cabin. SM4 reported that he left the cabin around 3:00am when MS3 woke him up. SM4 stated SM2 and MS1 were not in the cabin when he left.

I interviewed SM2 about supervision in the cabin. SM2 had left the cabin around 12:30pm and then returned to the cabin around 3:30am. SM2 had taken medication used for sleeping. SM2 recalled hearing some noises during the night that sounded like screaming or moaning. SM2 stated the noises weren't loud enough to "wake him up".

I reviewed the policy manual page 60 section titled "Lights Out". The policy reads "*Although this policy is primarily intended for seasonal staff, the concepts and guidelines of sufficient rest apply to volunteers, as well. Volunteers help seasonal staff and campers abide by and follow the camp policies regarding bedtimes, lights out, and general rest. The age group with which the volunteer is working or living determines lights out for staff and volunteers. Responsibilities for campers, safety, your own health, and the high standards of camping make it imperative that everyone get sufficient sleep. Tired people are not alert, mentally aware, others-sensitive, or enthusiastic about their work; rest and sleep are important to a staff and program under constant pressure and activity*."

On page 54 -55 of the policy manual within the section titled "Staff Ratio (Rule 11)" the policy reads "*The ratio of staff to campers will always be one adult staff member for every 10 campers or a fraction thereof beyond the first 10. Per the state of Michigan, a person legally becomes an adult at age 18."*

APPLICABLE RULE	
R 400.11111	**Number of staff.**
	(1) A camp shall develop and follow a written staffing plan for the camper population served. A camp shall ensure that the ratio is not less than as specified in subrule(2) of this rule.
FOR REFERENCE	**(2) A camp shall ensure that the ratio of adult staff members to campers at any one time is as follows:** **(b) For campers below the of 13, during their sleeping hours there shall be 1 adult staff member for every 14 campers or a fraction thereof beyond the first 14.**
ANALYSIS:	Interviews and records reveal the campers were left without an adult staff member who was coherent and able to respond to emergencies during the hours of 3:30am-8:30am on 7/12/2025. SM2 took medication that incapacitated the ability to be alerted and able to respond to a medical emergency within the cabin.

	In addition, interviews reveal that SM2 was not in the cabin from 12:30am to 3:30am and adult SM4 left the cabin at 3:00am without another adult in the cabin to supervise campers.
CONCLUSION:	**VIOLATION ESTABLISHED**

I observed OCSD body cam footage of a search in the Zion cabin of MS1 personal items. MS1 personal items were searched and included a fanny pack and phone. The unlocked fanny pack included a non-marked pill box with non-labeled medications.

I reviewed the health service policy with the policy manual on page 43 within the section titled “10.6 Storage and administration of prescription drugs and medications”. The policy reads “*All prescription drugs and medications, for both campers and staff, are kept in a locked Cabinet in the health center. The health director, assistant health director, and camp director are the only staff with keys to this cabinet. Campers and other staff are not allowed in the cabinet at any time.” The policy also reads “All administration of any drug or medication, any first aid treatment, and all visits whether treatment is given or not are noted in the health center’s bound log by the health director or the assistant health director.”*

APPLICABLE RULE	
R 400.11123	**Health facilities.**
	(3) A camp shall hold all prescription and nonprescription drugs and medications in secure locked storage unless medically contraindicated.
ANALYSIS:	Records reveal the MS1 had medications located in fanny packet within a camper occupied cabin.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the 2025 staff roster and observed SM11 listed as “WF Director” and SM3 as “WF mentor”. I reviewed the employee files for SM11 and SM3 for credentials. There were no credentials documented in the employee files. I requested SM11 and SM3 credentials from Ms. Przepiora and she provided an American Red Cross lifeguarding certification dated 6/2/2024 for SM3. SM11 did not have credentials in equivalent to lifeguarding or CPR for the professional rescuer. Ms. Przepiora provided a certification card for Staff Member 12 (SM12) who was on the 2025 staff roster as “assistant waterfront”. SM12 was issued a card by the American Lifeguard Association for “shallow water lifeguarding”, “CPR/AED for the Professional Rescuer”, and “community first aid”. This certification is not accepted by the department as equivalent to the Lifeguard and CPR requirements outlined in the administrative rules.

APPLICABLE RULE

R 400.11405	**Certified aquatic supervisor**
	(3) A certified aquatic supervisor shall be certified as specified in the high adventure statement for each aquatic activity. Certifications shall be 1 of the following: **(a) Equivalent to the lifeguard and CPR requirements in the American Red Cross manuals, numbers 655730 and 652161 respectively, which are adopted by reference in R 400.11103 for any of the following:** **(i) Lifeguard training.** **(ii) Swim instruction** **(iii) Instructor or instructor trainer.**
ANALYSIS:	Records reveal SM11 was assigned a position as a waterfront director without the appropriate credentials for the position. In addition, SM3 had appropriate lifeguard certification equivalent to American Red Cross but did not have any staff records on file with the camp. SM12 did not have equivalent lifeguard training certifications as required by administrative rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/23/2026, I conducted an exit conference with Ms. Przepiora and CB1 . I reviewed the findings of this report. Both Ms. Przepiora and CB1 had opportunities to ask questions and expressed understanding of the findings. They expressed that they will be reviewing their options about the 1st provisional and will submit the corrective action plan within the applicable timelines.

V. RECOMMENDATION

Upon submission of an acceptable written corrective action plan, I recommend a 1st provisional license.

James Vanden Heuvel, 02/23/2026
Lead Licensing Consultant Date

Approved By:

Deondra Ramsey, Manager 02/23/2026
Out-of-School Time Learning and Camp Licensing Date