



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 14, 2026

Deborah Daly
Summertree Residential Centers, Inc.
210 N Lake Street
Boyne City, MI 49712

RE: License #: AS280069661
Investigation #: 2026A0230004
Elmwood AFC

Dear Ms. Daly:

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.
- 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

A handwritten signature in purple ink that reads "Rhonda Richards". The signature is written in a cursive style with a large initial "R".

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS280069661
Investigation #:	2026A0230004
Complaint Receipt Date:	11/19/2025
Investigation Initiation Date:	11/19/2025
Report Due Date:	01/18/2026
Licensee Name:	Summertree Residential Centers, Inc.
Licensee Address:	210 N Lake Street, Boyne City, MI 49712
Licensee Telephone #:	(231) 582-2225
Administrator:	Deborah Daly
Licensee Designee:	Deborah Daly
Name of Facility:	Elmwood AFC
Facility Address:	5861 Tilton Road, Traverse City, MI 49684
Facility Telephone #:	(231) 946-7939
Original Issuance Date:	02/21/1996
License Status:	REGULAR
Effective Date:	03/11/2025
Expiration Date:	03/10/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff member Liz Bohnhorst was observed sleeping on shift. Staff member Liz Bohnhorst caused Resident A and Resident B to fall while attempting to transfer them.	Yes

III. METHODOLOGY

11/19/2025	Special Investigation Intake 2026A0230004
11/19/2025	APS Referral
11/21/2025	Inspection Completed On-site Interview staff member Nikki Chesebro and observation of Resident A and Resident B
01/05/2026	Contact - Telephone call made Staff member Courtney Iden
01/05/2026	Contact - Telephone call made Staff member Cindy Powers
01/08/2026	Contact - Telephone call made Liz Bohnhorst
01/08/2026	Contact - Telephone call made Staff member Michelle Bell
01/12/2026	Inspection Completed On-site Staff member Courtney Iden
01/12/2026	Contact- Telephone call made Liz Bohnhorst
01/12/2026	Exit Conference Licensee Designee Deb Daly

ALLEGATION: Staff member Liz Bohnhorst was observed sleeping on shift. Staff member Liz Bohnhorst caused Resident A and Resident B to fall while attempting to transfer them.

INVESTIGATION: On 11/21/2026, I conducted an on-site investigation at the facility. Staff member Nikki Chesbro stated that Liz Bohnhorst’s employment had been terminated at the facility for falling asleep while working. She was not working

at the time when Resident A and Resident B were transferred by Ms. Bohnhorst but she was aware of the fact that both residents had fallen during a transfer. I observed both Resident A and Resident B but was unable to interview them due to cognitive limitations.

On 01/05/2026, I spoke with facility supervisor Courtney Iden who confirmed that Ms. Bohnhorst had been fired for sleeping and for not properly transferring Resident A and Resident B. This caused them to both fall .

On 01/05/2026, I interviewed staff member Cindy Powers who stated that she had worked a shift in November with Ms. Bohnhorst and observed her sleeping.

On 01/08/2026, I left a voicemail for Ms. Bohnhorst to contact me. I received no response.

On 01/08/2026, I spoke with staff member Michelle Bell who stated she had worked with Ms. Bohnhorst in mid-November. Ms. Bell told Ms. Bohnhorst to let her know when she was ready to get Resident A into bed so that she could assist in the process. Ms. Bell stated that she heard Ms. Bohnhorst call out and went into the room and found Ms. Bohnhorst underneath Resident A. She stated she had to pick Resident A up off Ms. Bohnhorst and get him into bed. Ms. Bell stated she did not know why Ms. Bohnhorst attempted to transfer Resident A by herself.

On 01/12/2026, I left a second voicemail for Ms. Bohnhorst and received no response.

On 01/12/2026, I conducted an on-site inspection at the facility and reviewed an incident report with supervisor Courtney Iden. The incident report was dated 11/16/2025 and indicated that Ms. Bohnhorst was found by staff member Lena Moscatiello on the floor with Resident B. Ms. Moscatiello stated Resident B was crying. Resident B's guardian was informed. Resident B was taken to Urgent Care and received X-Rays. A sprained right ankle was diagnosed.

Ms. Bohnhorst wrote a separate incident report indicating that she thought Resident B's wheelchair was locked but when she picked her up the chair started to slide backwards. Ms. Bohnhorst brought Resident A to her knees and called for help. Staff member Lena Moscatiello came in and assisted in getting Resident B up and to bed.

On 01/12/2026, I conducted an exit conference with Licensee Designee Deb Daly and reviewed the findings of the investigation. She confirmed that Ms. Bohnhorst's employment had been terminated due to the fact that she was not competent to meet the needs of the residents in the facility. The reasons she cited were sleeping while on duty and not properly being able to transfer residents.

APPLICABLE RULE	
R 400.629	Direct care staff; qualifications and training.

	<p>(4) Direct care staff shall possess all of the following qualifications before working independently:</p> <p>(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.</p>
ANALYSIS:	<p>Staff member Cindy Powers observed Ms. Bohnhorst sleeping while on duty at the facility.</p> <p>Staff member Michelle Bell requested Ms. Bohnhorst ask her to help when she was ready to transfer Resident A to his bed. Instead, Ms. Bohnhorst attempted to transfer Resident A by herself and ended up falling to the floor with him. Ms. Bell had to pick Resident A up off Ms. Bohnhorst as she was found lying underneath Resident A.</p> <p>I observed documentation in the form of two separate incident reports regarding an incident that occurred with Resident B on November 16th, 2025. One written by Ms. Bohnhorst indicates that she thought Resident B's wheelchair was locked and when she went to pick Resident B up her wheelchair slid backwards. Ms. Bohnhorst then had to lower Resident B to her knees and call for help. The other incident report written on 11/16/2025 was written by staff member Lena Moscatiello and confirmed that she had found Resident B on the floor with Ms. Bohnhorst needing help getting Resident B up off the floor.</p> <p>I left two separate voicemail messages for Ms. Bohnhorst to call me and she did not return the calls.</p> <p>As confirmed by Licensee Designee Deb Daly, staff member Liz Bohnhorst was not capable of meeting the physical, emotional, intellectual, and social needs of each resident.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Rhonda Richards

01/13/2026

Rhonda Richards
Licensing Consultant

Date

Approved By:



01/14/2026

Jerry Hendrick
Area Manager

Date