GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 20, 2026

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

RE: License #: AS150067537
Investigation #: 2026A0009029
Autumnvue Clf

Dear Ms. Daly:

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. 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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS150067537
Investigation #:	2026A0009029
Complaint Receipt Date:	06/29/2026
Investigation Initiation Date:	06/30/2026
Report Due Date:	07/29/2026
Licensee Name:	Summertree Residential Centers, Inc.
Licensee Address:	210 N Lake Street Boyne City, MI 49712
Licensee Telephone #:	(231) 582-2225
Administrator:	Cassie Craft
Licensee Designee:	Deborah Daly
Name of Facility:	Autumnvue Clf
Facility Address:	109 Pine Street East Jordan, MI 49727
Facility Telephone #:	(231) 536-2455
Original Issuance Date:	10/01/1995
License Status:	REGULAR
Effective Date:	03/20/2026
Expiration Date:	03/19/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL & AGED

II. ALLEGATION(S)

	Violation Established?
Resident A requires two staff for transfers and this is not being provided.	No
On July 1, 2026, a second complaint alleged that Resident B also requires two staff for transfers and this is not being provided.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/29/2026	Special Investigation Intake 2026A0009029
06/29/2026	APS Referral
06/30/2026	Special investigation initiated: On-site Interviews with home manager Stephanie Straight and direct care workers Samanta Evans, Brecklyn Santos and Clarissa Skop Face to face with Resident A
07/07/2026	Contact – Telephone call received from adult protective services worker Lane Stopher
07/08/2026	Inspection Completed On-site Interviews with home manager Stephanie Straight and direct care workers Coleen Johnson and Tammy Oatly Face to face with Resident B
07/08/2026	Contact – Telephone call made to Deborah McPherson, Community Mental Health (CMH) caseworker
07/08/2026	Contact – Telephone call made to Megan Scott, CMH nurse
07/13/2026	Inspection Completed On-site Interviews with home manager Stephanie Straight and administrator Cassie Craft
07/14/2026	Contact – Telephone call made to adult protective services worker Lane Stopher
07/15/2026	Contact – Document (email with attachment) received from home manager Stephanie Straight

07/20/2026	Exit conference with licensee designee Deborah Daly

ALLEGATION: Resident A requires two staff for transfers and this is not being provided.

INVESTIGATION: I conducted an unannounced site visit at the Autumnvue Clf adult foster care home on June 30, 2026. I spoke with home manager Stephanie Straight at that time. Ms. Straight explained that Resident A is relatively new to the home. She arrived on April 9, 2026. She requires a lot of physical care. Ms. Straight said that she does require two staff for transfers. They always provide that. There are always at least two staff at the home due to the needs of the residents as well as a stipulation in their contract with Community Mental Health (CMH). Lately, they have had three staff on duty during waking hours. This is so two staff can be with Resident A and the third staff can attend to the other residents. I was provided with Resident A's assessment plan, health care appraisal and care agreement. Resident A's assessment plan indicates she requires "total assistance" with all care needs.

I interviewed three direct care workers, Samanta Evans, Brecklyn Santos and Clarissa Skop, separately on June 30, 2026. Each one confirmed that two staff always assist Resident A at all times during transfers. There were no exceptions. They also confirmed that there are always at least two staff working at the home even during the overnight hours. They often have three direct care workers during waking hours. During these times, two staff are with Resident A assisting her with her transfers and care needs and the third attends to other residents.

I interviewed direct workers Coleen Johnson and Tammy Oatly separately during my site visit on July 8, 2026. They also reported that Resident A always receives assistance from two direct care workers during all transfers.

I requested and reviewed the staff schedules for the Autumnvue Clf adult foster care home from April 9, 2026 to the present. The schedules showed that there were two or three direct care workers on duty in the home at all times during waking hours.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement.
ANALYSIS:	On June 30, 2026, I conducted an unannounced site visit at the Autumnvue Clf home. I interviewed four staff during my initial site visit and two more during my second site visit. They were

	each adamant that Resident A always has two staff assisting her with all transfers. They assured me that Resident A is being provided with that care. They all stated that there are always at least two direct care workers present in compliance with their contract with CMH. I reviewed the staff schedules which showed that there had always been at least two direct care workers, often three, on duty at all times. Information was not discovered through this investigation which would indicate that Resident A was not being provided with two staff assistance for all transfers.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On July 1, 2026, a second complaint alleged that Resident B also requires two staff for transfers and this is not being provided.

INVESTIGATION: I spoke with adult protective services worker Lane Stopher by telephone on July 7, 2026. He reported that he is investigating the matter of Resident B needing a "higher level of care" than is being provided at Autumnvue Clf home. It was reported that she currently needs two staff for all transfers. He is investigating the matter to determine what level of care is most appropriate.

I conducted another unannounced site visit at the Autumnvue Clf home on July 8. 2026. There were four staff present including home manager Stephanie Straight. I asked Ms. Straight about the complaint that Resident B is not always being assisted by two staff during all transfers. Ms. Straight said that Resident B does not always need two staff for all transfers. She explained that Resident B is able to physically assist herself during transfers when she is cooperative. At those times, she only requires the assistance of one staff. There are other times when Resident B refuses to assist herself with the transfers and requires two staff to assist her. There are always at least two direct care workers present, often three, in the home as we had discussed during my last visit. I requested and was provided with Resident B's assessment plan, health care appraisal, and resident care agreement at that time.

I also interviewed direct care workers Coleen Johnson and Tammy Oatly separately during my visit to the home on July 8, 2026. They both confirmed that Resident B will have one staff assisting her when she is cooperative and two staff assisting her when she is uncooperative.

I spoke with Resident B's CMH caseworker Deborah McPherson by telephone on July 8, 2026. She reported that Resident B's primary physician had recommended Resident B have two staff assisting with all transfers after Resident B suffered a fall on May 28, 2026. She recommended I speak with the CMH nurse who was directly involved with the physician and staff at the Autumnvue Clf home.

I then spoke with CMH nurse Megan Scott. Ms. Scott reported that the physician verbally told the staff who brought Resident B in for her medical appointment on Many 28, 2026, that Resident B would require two staff for all transfers going forward. Ms. Scott said that it was also in the doctor's notes from that visit that the doctor "Recommends staffing of 2:1 for toileting, hygiene, transfers and transportation (for Resident B)." Ms. Scott said that she had spoken directly to home manager Stephanie Straight and administrator Cassie Craft about the 2:1 ratio. She had notes where she spoke about this issue with them during a meeting on June 16, 2026. Ms. Scott said that she did not believe they are providing the 2:1 staff ratio that the doctor recommended and that she had discussed verbally with them.

I conducted another unannounced site visit at the Autumnvue Clf home on July 13, 2026. There were four staff present including home manager Stephanie Straight and administrator Cassie Craft. I spoke with Ms. Straight and Ms. Craft about the doctor's recommendation regarding Resident B needing two staff for transfers and other needs and the CMH nurse discussing it with them. They confirmed that the CMH nurse had spoken with them about it but denied that it had been their impression at that time that Resident B needed two staff every single time. I asked if they could show me the documentation from Resident B's medical appointment on May 28, 2026. It took some time for this to be found and Ms. Straight explained that she was new in her role as home manager and still hadn't found all the pertinent documentation. Ms. Straight was able to find the documentation and did find where it indicated from the doctor that Resident required two staff for transfers. Ms. Straight admitted that she hadn't known that was there. She maintained that she did not think this was absolutely necessary for Resident B since when she helps them, transfers can be done safely with one staff. I explained that the doctor's instructions and recommendations needed to be followed. I told her it was appropriate for them to give the doctor additional or more recent information that might change that recommendation or instruction but until that happened it needs to be followed.

I spoke with adult protective services worker Lane Stopher again on July 14, 2026. He spoke with Resident B's guardian who wants her to stay at the Autumnvue Clf home and who does not believe she needs a higher level of care. Mr. Stopher stated that he is continuing to address this issue but he does not feel Resident B's safety is at risk at the Autumnvue Clf home at this time.

I received an email with an attached document from home manager Stephanie Straight on July 15, 2026. The attached document was a Patient Plan for Resident B dated July 14, 2026. For Assessment Patient Plan it indicated, "*Transfer safety improved with correction of Hyponatremia; currently safe for one-person transfers when cooperative, two-person transfers required when uncooperative. Previous two-person transfer requirement stemmed from concerns about behaviors and falls on May 28, 2026.*"

APPLICABLE RULE	
R 400.689	**Resident health care.**

	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Resident B visited her physician on May 28, 2026. The physician recommended at that time that Resident B have a two-person assist for all transfers. This requirement was reiterated by the CMH nurse verbally to staff. The home continued to provide only a one-person assist even after the recommendation when they felt that Resident B was being cooperative and could help, herself, with the transfer. It was confirmed through this investigation that between May 28, 2026 and July 14, 2026, the licensee did not follow the physician's recommendation that Resident B have two-person staff assists for all transfers.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On July 8, 2026, I spoke with CMH caseworker Deborah McPherson and CMH nurse Megan Scott. They reported there had recently been several medication errors involving Resident A and Resident B at the Autumnvue Clf adult foster care home. Ms. Scott said that some of it was reportedly not the home's fault since they were not provided with Resident A's medication when she first arrived at the home. They did get new medication from the pharmacy as soon as they could after discovering this oversight. There were further medication administration errors that involved staff at the home, though.

On July 13, 2026, I asked home manager Stephanie Straight about medication errors involving Resident A and Resident B. She said that there had recently been medication errors involving Resident A and Resident B. She provided me with the Incident Reports (BCHS-4607) involving the medication errors. It was reported that Resident A accidentally received two extra Dicyclomine pills on May 31, 2026. Ms. Straight told me that the reason this happened was that there had been a medication change regarding the Dicyclomine and 2 pills were added to each packet. The staff who administered Resident A's medication on May 31 knew about the change and administered the two pills but didn't realize they had also been added to the packets as well. The appropriate medical professional and poison control had been contacted after the error and they monitored Resident A through the night. The other two errors involved Resident B, one on June 24, 2026 when she had been given two packets of medication, the a.m. packet and the p.m. packet, at the same time and on June 26, 2026, when Resident B had been given a pill that had been discontinued. Administrator Cassie Craft said that they were working with the staff

to make sure they were following the “5 R’s” of medication administration at all times.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	There were at least three recent medications errors involving Resident A and Resident B. One involved Resident A on May 31, 2026 and two involved Resident B on June 24 and June 26, 2026. It was confirmed through this investigation that medication was not given as prescribed in those instances.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 8, 2026, I spoke with CMH caseworker Deborah McPherson and CMH nurse Megan Scott. Ms. Scott reported that there were some significant discrepancies in Resident B’s weights as taken by staff at the Autumnvue Clf home. She believed that some of the staff were having trouble using the wheelchair scale. Ms. Scott had required that they take daily weight measurements for a while before the weight measurements had become more consistent again. She stated that she had also noticed that Resident B’s weight was not recorded on a regular basis before that as required.

On July 13, 2026, I asked home manager Stephanie Straight about Resident B’s weight record. She provided me with Resident B’s weight record from January 2025 to the present. I noted that there were missing weights in February, March, April, June and December of 2025 and January of 2026. Ms. Straight said that she believed that they had not had a wheelchair scale during those times and did not record her weight at those times. They now have a wheelchair scale.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident that includes the following: **(g) Admission and monthly weight record.**

ANALYSIS:	Resident B's weight was not measured and/or documentation was not able to be provided for her weight in February, March, April, June and December of 2025 and January of 2026. In consideration of the above information, it was determined that a monthly weight record was not completed and maintained consistently in 2025 and the beginning of 2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with licensee designee Deborah Daly by telephone on July 20, 2026. She was told of the findings of the investigation and given the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

07/20/2026

Adam Robarge Date
Licensing Consultant

Approved By:

07/20/2026

Jerry Hendrick Date
Area Manager