GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 14, 2021

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

RE: License #: AS280069661
Investigation #: 2021A0230041
Elmwood AFC

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.

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,

Rhonda Richards

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 #:	2021A0230041
Complaint Receipt Date:	09/27/2021
Investigation Initiation Date:	09/27/2021
Report Due Date:	11/26/2021
Licensee Name:	Summertree Residential Centers, Inc.
Licensee Address:	210 N Lake Street, Boyne City, MI 49712
Licensee Telephone #:	(231) 582-2225
Administrator:	Barb Rhody
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:	03/11/2021
Expiration Date:	03/10/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff member Trisha Roark walked off job on 09/25/2021 leaving residents unattended.	Yes

III. METHODOLOGY

09/27/2021	Special Investigation Intake 2021A0230041
09/27/2021	Special Investigation Initiated - On Site Interview with Staff member Terry Cieslik
09/28/2021	Contact - Telephone call received Administrator Barb Rhody
09/28/2021	Contact- Telephone call made Staff member Trish Roark
09/28/2021	Contact - Telephone call made Staff member Sue Randall
10/13/2021	Contact - Telephone call made Barb Rhody
10/14/2021	Exit Conference With Licensee Designee Deb Daly

ALLEGATION: Staff member Trisha Roark walked off job on 09/25/2021 leaving residents unattended.

INVESTIGATION: On 09/27/2021, I conducted an on-site inspection at the facility and interviewed staff member Terry Cieslik who stated to me that staff member Trish Roark had walked out on her shift two days ago and left staff member Sue Randall alone with five residents.

On 09/28/2021, I spoke with staff member Sue Randall who stated she had been working with Ms. Roark on 09/25/201 when she observed Ms. Roark go outside to use her phone. After about ten or so minutes went by Ms. Randall looked to see why Ms. Roark was still outside. At this time, she discovered Ms. Roark and her vehicle were gone. Ms. Randall quickly contacted management and an additional staff member arrived to work within 45 minutes. No residents were harmed or neglected during that time period.

On 09/28/2021, I spoke with facility Administrator Barb Rhody who confirmed the above to be accurate. She stated that although another staff member was called into work at the facility, the facility requires that the ratio be a minimum of two staff members to six residents at all times. She indicated that three of the five residents who were at the facility at the time when Ms. Roark walked out are wheelchair bound. Additionally, she stated that the Summertree company would be officially terminating Ms. Roark's employment.

On 09/28/2021, I spoke with staff member Trish Roark who acknowledged that she left the facility on 09/25/2021, leaving Ms. Randall alone with the five residents. She stated she "just couldn't take it anymore. I feel like everyone is so rude to me, and they do not even let me take care of people or do my job. I knew Sue was there, so I wasn't leaving the home with no staff at all."

On 10/13/2021, during a virtual call with Administrator Barb Rhody I reviewed the assessment plans for all five residents and observed that Resident A requires a two-person assist to transfer on and off the toilet according to her assessment plan.

On 10/14/2021, I conduced an exit conference with Licensee Designee Deb Daly and reviewed the findings of the investigation. She stated she had no additional questions and would provide a plan of correction.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	There was not sufficient staff on duty at all times to provide personal care as specified in Resident A's assessment plan. As I observed that she required a two-person assist with transferring on and off the toilet. After Ms. Roark left the facility there was only one staff on duty for the duration of approximately 45 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

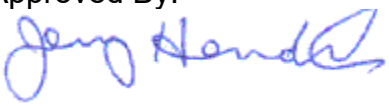
IV. RECOMMENDATION

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

10/14/2021

Rhonda Richards — Date
Licensing Consultant

Approved By:



10/14/2021

Jerry Hendrick — Date
Area Manager