GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2026

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

RE: License #: AS150067537
Investigation #: 2026A0009011
Autumnvue Clf

Dear Ms. Daly:

Attached is the Special Investigation Report for the above-referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frame 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 (616) 356-0100.

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 #:	2026A0009011
Complaint Receipt Date:	01/14/2026
Investigation Initiation Date:	01/14/2026
Report Due Date:	02/13/2026
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, Designee
Name of Facility:	Autumnvue Clf
Facility Address:	109 Pine Street East Jordan, MI 49727
Facility Telephone #:	(231) 536-2455
License Status:	REGULAR
Effective Date:	03/20/2024
Expiration Date:	03/19/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL & AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has unexplained bruising to both her upper arms.	No

III. METHODOLOGY

01/14/2026	Special Investigation Intake 2026A0009011
01/14/2026	APS Referral
01/14/2026	Special Investigation Initiated – Telephone call received from adult protective services worker Lane Stopher
01/14/2026	Inspection Completed On-site Joint investigation with Lane Stopher, adult protective services, Chief Randy Kloss, East Jordan City Police and Laurie Griffee, Community Mental Health recipient rights, Interview with home manager Amber Foster, Resident A, Resident B and administrator Cassie Craft
01/14/2026	Contact – Telephone call made to direct care worker Samantha Evans
01/29/2026	Contact – Telephone call made to adult protective services worker Lane Stopher
02/04/2026	Exit conference with licensee designee Deb Daly

ALLEGATION: Resident A has unexplained bruising to both her upper arms.

INVESTIGATION: On January 14, 2026, I received a telephone call from adult protective services worker Lane Stopher. He reported that he had received a complaint that Resident A had been observed with unexplained bruising to her upper arms. He said that he was conducting a site visit at the Autumnvue CLF adult foster care home that morning and requested my assistance.

I conducted an on-site visit at the Autumnvue CLF adult foster care home on January 14, 2026. Lane Stopher, adult protective services, Chief Randy Kloss, East Jordan City Police and Laurie Griffee, Community Mental Health recipient rights were also on-hand to conduct their own investigation into the matter. Home manager Amber Foster was present and allowed us to speak with Resident A. I observed that Resident A used a wheelchair for mobility and had some limitations with speech. After some preliminary discussion, Resident A was asked about the

bruising on her arms. She lifted up both sleeves of her shirt to show us dark bruising in the fleshy part of both her inner, upper arms. Resident A was asked how she got those bruises. She indicated that Resident B had given those to her. Resident A said, “She pinched me” and “(Resident B) got me good”. She also said “I don’t like (Resident B)” and “She has bad behavior”. Resident A was insistent that Resident B had caused both bruises on each arm. She denied that there was any other reason for the bruising. Resident A denied that anyone else had hurt her at any time.

We then spoke with Resident B. She was able to demonstrate that she knew what telling the truth meant. Resident B was told that we had heard that she did something to Resident A. Resident B said that it was because Resident A “Keeps flipping me off!” She said they argue and that Resident A then “flips her off”. Resident B was told that we had heard that she hurt Resident A. Resident B started crying and admitted that she did but only because Resident A wouldn’t stop “flipping her off”. We asked how she hurt her. She said that she pinched her arms and indicated the inner part of each upper arm. Resident B said that she was sorry she did it and wouldn’t do it again. She said that she really liked living there and liked the staff. Resident B agreed not to do it again and to tell a staff person when Resident A did something she did not like. She was reminded that there are staff people there at all times when she needs assistance with anything.

Home manager Amber Foster said that Resident A and Resident B usually get along very well with each other but also sometimes “get into it”. Resident B has started to have significant issues with dementia and is “quicker to respond” than she ever was before. She is more sensitive to slights than she ever would have been. Ms. Foster provided me with two incident reports (BCHS-4607) dated January 7 and January 9, 2026. The first incident report indicated that Resident A was heard “cussing” at Resident B and that Resident B then “smacked” her near the shoulder. The second incident report indicated that bruising was observed on Resident A’s upper arm. When asked about it, Resident A at that time stated, “(Resident B) pinched me really hard.” Resident A denied that she was in pain at that time to the staff person who asked her about it.

I asked Chief Randy Kloss if there would be any further law enforcement action on the matter. He replied that there would not be due to both residents being vulnerable adults and both being at a comparable mental level of functioning.

I spoke with direct care worker Samantha Evans by telephone on January 14, 2026. She was the staff person had been present during the verbal and physical altercation between Resident A and Resident B. She said that she was sitting at the dining room table which allows one to see down the hallway where the resident rooms are located. Resident A and Resident B were arguing in the hallway. Resident A yelled something at Resident B. When Resident B walked by Resident A, she did something to her. Ms. Evans thought that she had hit her at that time because she did not clearly see what happened. She now knows that she had actually pinched Resident A, not hit her as indicated in the incident report. Nothing

else had happened at that time. She hadn't thought that she had hurt her in any significant way because it happened so fast. Ms. Evans said that she believes Resident A bruises easily. This is likely because of the medication she is administered. Resident A and Resident B usually get along fine but had been "bickering" some lately. She has not known them to hurt each other before. The staff do supervise the residents as closely as they can to ensure that they do not hurt each other. Ms. Evans also reported that she had only seen Resident B do something to Resident A "on one side". She did not think that she would have pinched both of her arms at that time. Ms. Evans said that Resident A had fallen out of her chair at one point and that the other bruise might have been from that. I stated that it did not seem like something that would have occurred from a fall. Ms. Evans said that possibly her arm had been bruised from her wheelchair.

I spoke again with adult protective services worker Lane Stopher by telephone on January 29, 2026. He stated he is not substantiating a case for neglect or abuse and planned on closing the adult protective services case.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A had dark, significant bruising on the inner part of both upper arms. She was clear that Resident B had done this to her. Resident B admitted that she had done this to Resident A. Resident A denied being hurt at the facility before. Resident B said that she was sorry she did it and would not do it again. Resident A and Resident B usually get along with each other. Resident B is starting to suffer from dementia and is not as tolerant as she might once have been. In consideration of the above information, it is determined that an occupant of the facility did mistreat a resident with physical harm and a deliberate infliction of pain in this one instance.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Deb Daly by telephone on February 04, 2026. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

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

02/04/2026

Adam Robarge — Date
Licensing Consultant

Approved By:

02/04/2026

Jerry Hendrick — Date
Area Manager