GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 26, 2021

Amber Hernandez-Bunce
Cornerstone AFC, LLC
P.O. Box 277
Bloomingdale, MI 49026

RE: License #: AS120281503
Investigation #: 2021A0007021
Cornerstone AFC

Dear Ms. Hernandez-Bunce:

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 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.

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AS120281503
Investigation #:	2021A0007021
Complaint Receipt Date:	08/19/2021
Investigation Initiation Date:	08/20/2021
Report Due Date:	10/18/2021
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277 Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2011
Administrator:	Amber Hernandez-Bunce
Licensee Designee:	Amber Hernandez-Bunce
Name of Facility:	Cornerstone AFC
Facility Address:	633 N. Fall River Coldwater, MI 49036
Facility Telephone #:	(517) 278-7887
Original Issuance Date:	03/08/2006
License Status:	REGULAR
Effective Date:	10/01/2020
Expiration Date:	09/30/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Allegations that Ms. Thomas, Direct Care Staff, hit Resident A with the door. Ms. Thomas says that Resident A hit her with the door. Resident A does not have any marks or bruises.	No
Additional Findings	Yes

.

III. METHODOLOGY

08/19/2021	Special Investigation Intake - 2021A0007021
08/19/2021	Contact - Telephone call received - Interview with Ms. Bunce, Licensee Designee.
08/20/2021	Special Investigation Initiated - Letter
08/20/2021	APS Referral made.
09/15/2021	Inspection Completed On-site - Unannounced-Face to face contact with Staff A and Resident A.
10/11/2021	Contact - Telephone call made - Interview with Ms. Thomas, (Previous) Direct Care Staff.
10/11/2021	Contact - Telephone call made to the facility. Resident B was at work.
10/13/2021	Contact - Telephone call made to the facility. Interview with Ms. Hill, Home Manager, and Resident B.
10/13/2021	Contact - Telephone call made to Ms. Thomas, Follow up interview.
10/13/2021	Exit Conference conducted with Ms. Hernandez-Bunce, Licensee Designee.

ALLEGATION:

Allegations that Ms. Thomas, Direct Care Staff, hit Resident A with the door. Ms. Thomas says that Resident A hit her with the door. Resident A does not have any marks or bruises.

INVESTIGATION:

As a part of this investigation, I reviewed the incident report and noted the following: On August 19, 2021, Resident A got up that morning and she was "very aggressive verbally and physically." Resident A was yelling at staff (Ms. Thomas), and they tried to redirect her. The home manager was contacted by another resident, due to Resident A yelling. Staff went to assist a resident (Resident B) and was going into the resident's room. Resident A tried to go into Resident B's room without permission, while she (Resident B) was undressed. Staff told Resident A she would have to wait, outside her door, due to Resident B being in the bathroom and she didn't want her in her room. Resident A refused to listen to staff's redirection, and proceeded to aggressively push open the door, as staff was shutting the door. Resident A pushed staff with both hands into Resident B's animal cages and tried to hit staff but failed. Resident A elbowed staff in the side after failing to hit staff. After hurting staff, Resident A went into Resident B's room and sat in the chair and continued to be verbally aggressive. Staff asked Resident A to leave the room while Resident B undressed but she refused. Resident B asked Resident A to leave the room, but she refused. Law enforcement was contacted and once they arrived, they took over the situation. Case Management and Office of Recipient Rights were also notified of the incident.

On August 19, 2021, I spoke with Ms. Hernandez-Bunce, Licensee Designee. We discussed the incident. According to Ms. Hernandez-Bunce, the staff member is saying that Resident A hit her with the door and Resident A is saying the staff member hit her (Resident A) with the door; however, it's unknown, who hit who. Resident A does not have any marks or bruises.

On September 15, 2021, I conducted an unannounced on-site investigation and made face to face contact with Staff A and Resident A. I interviewed Resident A outside on the porch. When I attempted to bring up the topic, Resident A stated that Ms. Thomas was not working there anymore. Regarding the incident, Resident A informed me that Resident B was back in her room. Ms. Thomas was in the room too. Ms. Thomas slammed the bedroom door, hitting Resident A's right arm. Resident A and Ms. Thomas had a disagreement; Resident A told Ms. Thomas that she (Resident A) didn't push the door, Ms. Thomas pushed the door on her (Resident A). According to Resident A, Ms. Thomas said that "I assaulted her." Resident A went on to say, "I'm on the outside of the door and you're on the inside of the door."

According to Resident A, Resident B did not witness the incident, but she heard it. Resident A informed me that Resident B saw the bruise.

On October 11, 2021, I interviewed Ms. Thomas, (Previous) Direct Care Staff, via telephone. Ms. Thomas was cooperative with the interview. Ms. Thomas recalled on that particular day, (8/19/21), Resident A was being verbally and physically aggressive. Ms. Thomas stated that Resident A was getting into her face, pointing at her, and that she (Ms. Thomas) was not giving in to Resident A and walked away. Ms. Thomas stated that she went into Resident B's bedroom and "I shut the door behind me." Ms. Thomas was trying to tell Resident B that she did not have to be in the middle of this situation. According to Ms. Thomas, Resident B has a cell phone and Resident A does not. Resident A was trying to use Resident B's cellphone so that she could video others. Ms. Thomas stated that Resident A would violate other's rights and that's why she did not have a cellphone. Ms. Thomas stated that Resident A also wanted to video her on the couch with her feet up. Ms. Thomas stated that she had been accused of sleeping on the job, but there was no way she could sleep at work; there's just too much work to do. Ms. Thomas did admit that she works long hours, and her feet sometimes swell. She has put her feet up to help reduce the swelling.

Ms. Thomas went on to say that while she was trying to talk to Resident B, Resident A barged into the room. Resident B was upset. Ms. Thomas stated that Resident A pushed her into the guinea pig cage and was swinging her arms. Ms. Thomas stated that she was trying to shut the door and get space between she and Resident A. Ms. Thomas stated that Resident A said she (Ms. Thomas) hit her side with the doorknob or that she (Ms. Thomas) hit her, but "I didn't." Ms. Thomas also stated, "I'm not going to use CPI on a 67-year-old woman and run the risk of her getting bruised." Ms. Thomas stated that she jumped behind the door, trying to shut the door and Resident A pushed past her, pushing her into the cage. Then Resident A "started ripping into me." Resident B was in her own bathroom at that time.

I specifically asked Ms. Thomas if she hit Resident A. She stated that a no time did she hit her and stated, "you can ask all my residents."

I inquired about what happened after the police arrived. Ms. Thomas was not sure which police department responded but the police had to tell Resident A to "knock it off." I inquired if Resident A had any bruises or marks and Ms. Thomas stated that the police looked her over, they offered to take her in the ambulance, but Resident A declined.

Ms. Thomas informed me that Resident A has a history of going after others and she will pick on staff until they're out of the home. Resident A also picked with Resident C, who is no longer in the home.

Ms. Thomas informed me that she is a CENA, she has other medical licenses, and she wants to continue to work in a professional capacity. She stated that she was

put on leave after the incident for them to investigate. She was concerned as she did not want to lose her license for something she did not do. Ms. Thomas was adamant that she did not hit Resident A. Ms. Thomas was transferred to other home within the corporation.

On October 13, 2021, I interviewed Ms. Hill, Home Manager. Ms. Hill stated that she was not there when the incident occurred, but she was told about it. Ms. Thomas and Resident A had an argument and Ms. Thomas told Resident A that she did not need to go into Resident B's room. Resident B was using the bathroom. Resident A was trying to enter Resident B's room, while Ms. Thomas was closing the door. Resident A hit her elbow on the door. Resident A was being loud. Ms. Thomas was talking to Resident B, telling her she needed to speak up for herself, that she had rights and Resident A could not enter her room without permission. Resident B's animal cage got bent during the incident.

Resident A later stated that she was alright but that she would get a bruise from the incident.

Ms. Hill has never observed Ms. Thomas hit any of the residents.

I then interviewed Resident B. She informed me that she was in an area where she could talk, as there was no one around. She told me about her new guinea pigs and that she was taking care of them. I introduced the topic and asked about the incident that occurred when her pet cage got bent. Resident B stated that she was in the bathroom and did not see what happened. Resident B recalled that staff (Ms. Thomas) hit the cage, but she never saw Resident A in her room. Resident B stated that she heard arguing. Resident A stated that "[Ms. Thomas] kept telling [Resident A] not to come in my room because I was in the bathroom." Resident B again stated that she did not witness the incident, but she heard that Ms. Thomas hit Resident A with the door. I asked if she observed a bruise on Resident A and Resident B stated that she did not. During the interview, Resident B stated that Ms. Thomas had put a baby monitor in her room, and it made her uncomfortable. According to Resident B, Ms. Thomas told her (Resident B) that she could not hear her call for help, and she didn't want her to fall. Resident B stated that she would always have to go to Ms. Thomas if she needed help. Resident B informed me that the monitor was taken out of her room a long time ago.

On October 13, 2021, I conducted the exit conference with Ms. Hernandez-Bunce, Licensee Designee. We discussed the investigation. Ms. Hernandez-Bunce informed me that Resident A does have a history of targeting staff if she does not like them. Resident A has been issued a 30-day notice; however, case management has not found her another placement. We discussed how her behaviors could be addressed and Ms. Hernandez-Bunce stated that Resident A refuses to sign paperwork for any agreements. Resident A will not agree to receive services. Case management is trying to get her placed in a semi-independent setting. In addition, that Ms. Thomas

no longer works in this home. We discussed the conclusion of the investigation and Ms. Hernandez-Bunce concurred with my recommendations.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on the information gathered during this investigation and provided above, it's clear that there was an incident in which Ms. Thomas and Resident A were pushing the door. According to Ms. Thomas, Resident A was being verbally and physically aggressive. Ms. Thomas stated that Resident A was getting into her face, pointing at her, and that she (Ms. Thomas) was not giving in to Resident A and walked away. Ms. Thomas stated that she went into Resident B's bedroom and "I shut the door behind me." Ms. Thomas went on to say that while she was trying to talk to Resident B, Resident A barged into the room. Resident B was upset. Ms. Thomas stated that Resident A pushed her into the guinea pig cage and was swinging her arms. Ms. Thomas stated that she was trying to shut the door and get space between she and Resident A. Resident A informed me that Resident B was back in her room. Ms. Thomas was in the room too. Ms. Thomas slammed the bedroom door, hitting Resident A's right arm. Resident A and Ms. Thomas had a disagreement; Resident A told Ms. Thomas that she (Resident A) didn't push the door, Ms. Thomas pushed the door on her (Resident A). According to Resident A, Ms. Thomas said that "I assaulted her." Ms. Thomas denied hitting Resident A. Resident A stated she was hit and had a bruise; however, the bruise was not observed. Resident B did not witness the incident, as she was in the bathroom at that time. Essentially, it's Ms. Thomas' word against Resident A's word. Based on this information, it's concluded that there is not a preponderance of the evidence to support the allegations that Ms. Thomas hit Resident A with the door.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On October 13, 2021, during the interview with Resident B, she stated that Ms. Thomas had put a baby monitor in her room, and it made her uncomfortable. According to Resident B, Ms. Thomas told her (Resident B) that she could not hear her call for help, and she didn't want her to fall. Resident B stated that she would

always have to go to Ms. Thomas if she needed help. Resident B informed me that the monitor was taken out of her room a long time ago.

On October 13, 2021, I contacted Ms. Thomas as I had some follow up questions. I inquired about the baby monitor in Resident B's room, and Ms. Thomas informed me that Resident B was having pain in her neck and feet. In addition, her skin would also itch, and Resident B would scratch herself raw. Ms. Thomas explained that she had to do chores during the night, including laundry, restocking in the garage, and she could not monitor Resident B 24/7. Ms. Thomas told Resident B that she had a baby monitor that she could have. Ms. Thomas reported that she gave the monitor to Resident B. Ms. Thomas apologized if this was a violation of rights. Ms. Thomas stated that she didn't want Resident B screaming down the hall because that would upset Resident A. Ms. Thomas stated that the monitor is turned off when Resident A is up. Ms. Thomas recalled that on the date of the incident, the monitor was off and Resident B was screaming. Resident A will get upset if Resident B is screaming and she will curse at her. Ms. Thomas stated that Resident B never said she was uncomfortable with having the monitor in her room, otherwise she would have pitched it. I asked if management was aware of the monitor and Ms. Thomas stated they were. She stated the monitor was out in the open. I asked if there was anything in writing about the monitor and Ms. Thomas informed that she did not know. Ms. Thomas inquired if she was going to be fired and I explained the role of licensing to her.

During the exit conference with Ms. Hernandez-Bunce, she informed me that she was not aware that there was a baby monitor in the home. In addition, that she would talk to Ms. Hill regarding this matter. Ms. Hernandez-Bunce stated that baby monitors are not in their policy to utilize. She will follow-up with staff and address this matter. Ms. Hernandez-Bunce agreed to submit a written corrective action plan to address this violation.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

ANALYSIS:	A baby monitor was placed in Resident B's room. Resident B reported that this made her uncomfortable. According to Resident B, Ms. Thomas told her (Resident B) that she could not hear her call for help, and she didn't want her to fall. Ms. Thomas explained that she had to do chores during the night, including laundry, restocking in the garage, and she could not monitor Resident B 24/7. Ms. Thomas told Resident B that she had a baby monitor that she could have. Ms. Thomas reported that she gave the monitor to Resident B. Ms. Thomas apologized if this was a violation of rights. Ms. Thomas stated that Resident B never said she was uncomfortable with having the monitor in her room, otherwise she would have pitched it. Based on the information gathered during this investigation and provided above, it's concluded that Resident B was not treated with consideration for personal need of privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.

Mahtina Rubritius 10/14/2021

Mahtina Rubritius Date
Licensing Consultant

Approved By:

A. Hunter 10/26/2021

Ardra Hunter Date
Area Manager