GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 13, 2023

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

RE: License #: AS800413641
Investigation #: 2023A1031025
North Lake Home

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 (616) 356-0183.

Sincerely,
Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800413641
Investigation #:	2023A1031025
Complaint Receipt Date:	03/23/2023
Investigation Initiation Date:	03/27/2023
Report Due Date:	05/22/2023
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277 Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2100
Administrator/ Licensee Designee:	Amber Hernandez-Bunce
Name of Facility:	North Lake Home
Facility Address:	12201 56th Street Grand Junction, MI 49056
Facility Telephone #:	(269) 762-2969
Original Issuance Date:	01/31/2023
License Status:	TEMPORARY
Effective Date:	01/31/2023
Expiration Date:	07/30/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was given another resident's medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/23/2023	Special Investigation Intake 2023A1031025
03/23/2023	Contact - Document Received Incident Report Received
03/27/2023	Special Investigation Initiated - Letter Email exchange with ORR Candice Kinzler and LD Amber Hernandez-Bunce.
03/27/2023	Contact - Documents requested.
03/27/2023	Contact - Telephone interview with ORR Candice Kinzler.
03/29/2023	Inspection Completed On-site
03/29/2023	Contact - Face to Face Interviews with Kendrell Dorrington and Resident A.
03/29/2023	Contact - Document Received and Reviewed.
03/30/2023	Contact – Telephone Interview with Robert Cox.
04/13/2023	Exit Conference held with Licensee Designee Amber Hernandez-Bunce.

ALLEGATION:

Resident A was given another resident's medications.

INVESTIGATION:

On 3/23/23, I received an incident report from the home that was completed by direct care worker (DCW) Robert Cox on 3/22/23. The incident report documented that Resident A received another residents medication at 8pm. The report indicates Mr. Cox contacted the crisis department and they informed him to contact 911. Mr. Cox was informed that Resident A would need to be transported to the emergency room to be seen by a physician. EMT's arrived at the home and transported Resident A via ambulance. Mr. Cox was contacted by the Director of Medical on 3/23/23 and it was requested that he go to the office, and he was spoken to about the incident. Mr. Cox is scheduled to attend medication training on 3/24/23 and is not allowed to pass medications until further notice.

On 3/28/23, I received an *After Visit Summary* for Resident A from his hospital visit. The summary stated Resident A was seen for an accidental drug overdose. Resident A received lab testing and his vitals were monitored. Resident A was discharged from the hospital and has a follow-up appointment on 5/3/23.

On 3/29/23, I interviewed the home manager Kendrell Dorrington in the home. Mr. Dorrington reported Resident A went to the hospital due to receiving the wrong medications. Mr. Dorrington reported DCW Robert Cox gave him another residents medication and Resident A was transported to the hospital by ambulance. Mr. Dorrington reported he went to the hospital with Resident A, and he did not show any negative side effects from the medications. Mr. Dorrington reported the hospital completed lab testing and released him since he appeared to be fine.

On 3/29/23, I interviewed Resident A in the home. Resident A reported he took the wrong medications and went to the hospital. Resident A did not further engage in the interview process.

On 3/30/23, I interviewed DCW Robert Cox via telephone. Mr. Cox reported he made a mistake and passed another resident's medications to Resident A. Mr. Cox reported he was preparing three resident's medications at one time. Mr. Cox reported he got distracted and mixed up the medication cups which resulted in Resident A receiving another residents medications. Mr. Cox reported Resident B informed him that he was receiving the wrong medication which made him realize Resident A received the wrong medications. Mr. Cox reported he instantly called the crisis team and was directed to call 911. Mr. Cox reported he contacted 911 and Resident A was transported to the hospital. Mr. Cox reported management pulled him from passing medications. Mr. Cox reported he works the night shift and day shift staff stays and passes medications for the evening.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A did not receive his medications pursuant to label instructions as he received another resident's medications. Mr. Cox reported he mistakenly gave Resident A another residents medication. Resident A reported he was given the wrong medications and was taken to the hospital. The presetting of resident medications is not consistent with safe administration practices.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/29/23, I reviewed Mr. Cox initial medication training. Mr. Cox completed medication training and a written test on 10/12/22.

Mr. Cox reported he completed his initial medication training class and test. Mr. Cox reported he felt the initial training was adequate. Mr. Cox reported he worked in another home through Cornerstone prior to being transferred to North Lake Home. Mr. Cox reported he shadowed other staff and management pass medications while working at the other home. Mr. Cox reported he worked evening shifts and medications were prepared for him to administer to the residents. Mr. Cox reported he did not previously prepare medications or utilize the medication administration record system (MAR) independently prior to working at North Lake. Mr. Cox reported he was given the opportunity to be shadowed by experienced staff to ensure he was administering medications appropriately. Mr. Cox reported he attended a medication training on 3/24/23 following the incident. Mr. Cox reported he is scheduled to take another medication training in two weeks and is not able to pass medications until that is completed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all the following provisions:

	(a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Mr. Cox was not thoroughly trained to properly handle and administer medications to residents in the home. Although Mr. Cox completed a formal medication class, he did not receive adequate hands-on training which contributed to a medication error. Mr. Cox reported the formal class was informative but hands-on training to learn how to properly use the MAR system and pass medications would have been beneficial prior to passing medications independently. The presetting of resident medications is not consistent with safe administration practices.
CONCLUSION:	**VIOLATION ESTABLISHED**

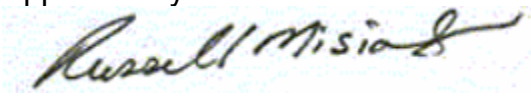
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

3/30/2023

Kristy Duda — Date
Licensing Consultant

Approved By:



4/11/23

Russell B. Misiak — Date
Area Manager