STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 18, 2023

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

RE: License #: AS800413641
Investigation #: 2023A1031057
North Lake Home

Dear Licensee Designee:

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 #:	2023A1031057
Complaint Receipt Date:	07/25/2023
Investigation Initiation Date:	07/28/2023
Report Due Date:	09/23/2023
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 had a black eye.	No
Resident A did not receive a prescribed medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/25/2023	Special Investigation Intake 2023A1031057
07/28/2023	Special Investigation Initiated – Telephone Interview with ORR Candice Kinzler.
07/31/2023	Inspection Completed On-site
07/31/2023	Contact - Face to Face Interviews with Epiphany Parker, Resident A, Resident B, Resident C, Resident D, and Resident E.
08/01/2023	Contact - Documents Requested.
08/02/2023	APS Referral Received.
08/02/2023	Contact - Documents Requested.
08/02/2023	Contact - Telephone Interview with Candice Kinzler.
08/03/2023	Inspection Completed On-site
08/03/2023	Contact - Face to Face Interview held with Tyler Moffatt.
08/03/2023	Contact - Telephone Interview with Amber Hernandez-Bunce.
08/15/2023	Contact – Email Exchange with Mike Hartman.
08/28/2023	Contact - Telephone Interview with Amber Hernandez-Bunce.
08/28/2023	Contact – Telephone Interview with Candice Kinzler.
09/11/2023	Contact - Telephone Interview with LaSamuella Simpson.

09/18/2023	Exit Conference held with Amber Hernandez-Bunce.

ALLEGATION:

Resident A had a black eye.

INVESTIGATION:

On 7/28/23, I interviewed Van Buren Recipient Rights Director Candice Kinzler via telephone. Ms. Kinzler reported that Resident A was observed to have a black eye and the cause of the black eye was unknown.

On 7/31/23, I interviewed direct care worker (DCW) Epiphany Parker in the home. Ms. Parker reported she was not working when Resident A was found to have a black eye. Ms. Parker reported she saw Resident A had a black eye but she was not aware of how it happened.

On 7/31/23, I attempted to interview Resident A in the home. Resident A is nonverbal and was not able to engage in the interview process. Resident A was not observed to have a black eye.

On 7/31/23, I interviewed Resident B, Resident C, Resident D, and Resident E in the home. The residents reported that Resident A did have a black eye but they did not know what happened. The residents were consistent in reporting that staff treat the residents in the home well and they have never witnessed staff be assaultive towards themselves or others. The residents reported they never witnessed staff assault Resident A.

On 8/1/23, I requested Resident A's hospital discharge paperwork from the home.

On 8/01/23, I reviewed the incident report completed by the home on 7/18/23. The incident report read "Paul likes to turn around in his sleep from side to side, he turned too close to the wall and hit his eye/eyebrow that resulted swelling then a black eye. Staff immediately sough medical treatment regarding the black eye."

On 8/2/23, I reviewed Resident A's medical records for his hospital visit due to having a black eye. Resident A was examined and there were no visualized acute fractures or skull injury. Resident A was found to have had a small supraorbital hematoma (swelling).

On 8/2/23, I interviewed Ms. Kinzler via telephone. Ms. Kinzler reported she was informed that DCW Tyler Moffatt was working when Resident A was found to have a black eye. Ms. Kinzler reported she was informed that Mr. Moffatt did not know how Resident A got the black eye and reported he may have hit his head on the wall when he was sleeping.

On 8/3/23, Ms. Kinzler and I interviewed Mr. Moffatt in the home. Mr. Moffatt reported he arrived at the home around 7pm that evening for his shift and was the only staff working. Mr. Moffatt reported Resident A did not have a black eye when he arrived at the home. Mr. Moffatt reported he gave Resident A his medications at 8pm and he was fine. Mr. Moffatt reported he checked in on Resident A again around 9-9:30pm and he noticed Resident A had a purple mark around his eye. Mr. Moffatt reported he was in the living room which is directly outside of Resident A's bedroom and did not hear any noises coming from his room that would have indicated a fall. Mr. Moffatt reported Resident A's roommate was sleeping when he went into check on Resident A. Mr. Moffatt reported that he did not harm Resident A. Mr. Moffatt reported he assumed that Resident A had hit his head on the wall when he was sleeping as he did not hear anything alarming coming from the bedroom. Mr. Moffatt reported Resident A may have also hit his eye on his walker when trying to get up, but this was only an assumption. Mr. Moffatt reported he attempted to ask Resident A what happened, but he was not able to explain to him what happened to his eye.

On 8/3/23, I interviewed Amber Hernandez-Bunce via telephone. Ms. Hernandez-Bunce reported she did not have any concerns regarding Mr. Moffatt and him mistreating the residents in the home. Ms. Hernandez-Bunce reported that it is believed that Resident A may have hit his head on the wall when he was sleeping which caused the bruising.

On 8/15/23, there was an email exchange with adult protective services (APS) worker Mike Hartman. Mr. Hartman reported that he did not find any evidence to support that Resident A was assaulted or abused by staff and closed his investigation.

On 8/28/23, I interviewed Ms. Kinzler via telephone. Ms. Kinzler reported she did not find any evidence to support that Resident A was assaulted or abused by staff in the home.

On 9/11/23, I interviewed the home manager LaSamuella Simpson via telephone. Ms. Simpson reported she was not working when the incident occurred but spoke with Mr. Moffatt about the incident the following day. Ms. Simpson reported Mr. Moffatt was consistent in reporting that he did not know how Resident A got the black eye. Ms. Simpson reported that she never had any concerns regarding Mr. Moffatt mistreating residents in the home.

On 9/12/23, I emailed Resident A's case manager Linda Davis through Van Buren County Community Mental Health. Ms. Davis reported she was initially concerned about Resident A's black eye and thought someone may have harmed him. Ms. Davis reported Resident A stated "I did this to myself" but was unable to put into words how he got his black eye. Ms. Davis reported Resident A will yell loudly "help, murder, police" if someone did something to him to hurt or frighten him as he demonstrated this at his previous placement when a roommate scared him. Ms.

Davis reported when she has visited the home, it was brought to her attention that the residents were all provided with water bottles that had a very large spout on the top. Ms. Davis reported it is suspected that Resident A may have fell into his water bottle causing the black eye. Ms. Davis reported Resident A like his home, and she has no reason to believe that he is not being treated well. Ms. Davis believes that staff try to make sure that Resident A has everything he needs each day. Ms. Davis reported she has made unannounced and announced visits to the home and she has no concerns with Resident A living in the home.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Although Resident A did have a visible black eye, there is no evidence found to support that Resident A's black eye was caused by a staff member. The home ensured that Resident A received medical treatment following the incident and Resident A did not have any significant injuries aside from bruising around his eye.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

LLEGATION:

Resident A did not receive a prescribed medication.

INVESTIGATION:

Ms. Kinzler reported she was informed that Resident A had not received his prescribed medication Methotrexate which he received on a weekly basis.

On 8/02/23, I reviewed Resident A's medication administration record (MAR) for June and July 2023. The MAR read that Resident A did not receive his Methotrexate on 6/27/23, 7/4/23, and 7/10/23.

Ms. Hernandez-Bunce acknowledged that Resident A did not receive the medication on these dated. Ms. Hernandez-Bunce reported there was a change in management and the previous manager was not aware that Resident A was required to compete lab work prior to getting the prescription refilled. Ms. Hernandez-Bunce reported she

was not aware of the issue until it was brought to her attention by Resident A's guardian. Ms. Hernandez-Bunce reported she addressed this immediately and Resident A has been receiving his prescribed medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Interviews and the review of documentation revealed that Resident A did not receive a prescribed medication pursuant to label instructions.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2023A1031025 dated 4/13/23 and CAP dated 5/8/23.**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Hernandez-Bunce reported that an incident report was not completed for Resident A when he received treatment at the hospital.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(3) An incident must be recorded on a department-approved form and kept in the home for a period of not less than 2 years.
ANALYSIS:	An incident report was not available for review for Resident A's hospital treatment for his black eye.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/18/23, I conducted an exit conference with Amber Hernandez-Bunce via telephone. Ms. Hernandez-Bunce reported she agreed with the findings regarding Resident A not receiving his medications. Ms. Hernandez-Bunce reported she was not aware that an additional incident report form needed to be completed for Resident A being hospitalized as she noted in a different incident report that medical treatment was sought.

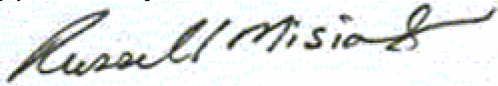
IV. RECOMMENDATION

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

9/12/23

Kristy Duda — Date
Licensing Consultant

Approved By:



9/14/23

Russell B. Misiak — Date
Area Manager