



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

February 23, 2024

Cornerstone AFC, LLC  
P.O. Box 277  
Bloomington, MI 49026

RE: License #: AS800397501  
Investigation #: 2024A1031019  
52nd Street 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS800397501
<b>Investigation #:</b>	2024A1031019
<b>Complaint Receipt Date:</b>	01/02/2024
<b>Investigation Initiation Date:</b>	01/02/2024
<b>Report Due Date:</b>	03/02/2024
<b>Licensee Name:</b>	Cornerstone AFC, LLC
<b>Licensee Address:</b>	P.O. Box 277 Bloomingtondale, MI 49026
<b>Licensee Telephone #:</b>	(269) 628-2100
<b>Administrator:</b>	Tracie Hernandez, Designee
<b>Licensee Designee:</b>	Tracie Hernandez, Designee
<b>Name of Facility:</b>	52nd Street Home
<b>Facility Address:</b>	31723 52nd Street Bangor, MI 49013
<b>Facility Telephone #:</b>	(269) 762-2969
<b>Original Issuance Date:</b>	02/12/2019
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/12/2023
<b>Expiration Date:</b>	08/11/2025
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Staff smoked marijuana with residents.	Yes
Staff did not pass medications as prescribed.	Yes

## III. METHODOLOGY

01/02/2024	Special Investigation Intake 2024A1031019
01/02/2024	Special Investigation Initiated - Letter Email exchange and documents received from licensee designee.
01/02/2024	APS Referral
01/11/2024	Contact – Documents Requested, Received and Reviewed.
02/02/2024	Inspection Completed On-site
02/02/2024	Inspection Completed-BCAL Sub. Compliance
02/02/2024	Contact - Face to Face Interviews with Resident A, Resident B, Resident C, and Epiphany Parker.
02/07/2024	Exit Conference held with Amber Hernandez-Bunce.

### **ALLEGATION:**

**Staff smoked marijuana with residents.**

### **INVESTIGATION:**

On 1/2/24, I received an email from licensee designee Amber Hernandez-Bunce. Ms. Hernandez-Bunce reported direct care worker (DCW) Martel Jackson was accused of smoking marijuana with residents in the home but did not have any evidence to support the allegations.

On 2/2/24, I interviewed the home manager Epiphany Parker in the home. Ms. Parker reported residents in the home had informed her that Mr. Jackson had

provided them with marijuana. Ms. Parker reported she entered a company vehicle after Mr. Jackson had driven the vehicle and it smelled of marijuana.

On 2/2/24, I interviewed Resident A in the home. Resident A reported Mr. Jackson did not provide him with marijuana or smoke marijuana with him.

On 2/2/24, I interviewed Resident B in the home. Resident B reported Mr. Jackson did provide him with marijuana and they would smoke it together on the front porch of the home.

On 2/2/24, I interviewed Resident C in the home. Resident C reported Mr. Jackson sold him marijuana and they smoked it together by the firepit in the yard.

On 2/7/24, I conducted an exit conference with Ms. Hernandez-Bunce. She understood the reasoning behind the violation as residents in the home reported they did receive and smoke marijuana from Mr. Jackson. Ms. Hernandez-Bunce reported Mr. Jackson has been terminated from employment at the home.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on interviews with staff and residents, it has been determined that Mr. Jackson did not ensure the protection and safety of the residents. Residents reported Mr. Jackson provided them with marijuana at the home and then smoked the marijuana with them while he was working. The licensee designee has terminated Mr. Jackson's employment.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Staff did not pass medications as prescribed.**

**INVESTIGATION:**

On 1/2/24, I received an email from licensee designee Amber Hernandez-Bunce. Ms. Hernandez-Bunce reported direct care worker (DCW) Martel Jackson was terminated due to not passing residents their medications. Ms. Hernandez-Bunce

reported she had proof that he did not pass medications to the residents. Ms. Hernandez-Bunce provided incident reports for the individuals that did not receive their medications.

On 1/11/24, I reviewed the incident reports submitted. The incident reports read that five out of six residents did not receive their medications for consecutive days when Mr. Jackson was working. I reviewed the medication administration record (MAR) for each resident and there were multiple medications not passed. I reviewed the staff schedule to compare the dates and times medications were not passed and Mr. Jackson was scheduled for every shift.

Resident A reported Mr. Jackson would often give him his medications late and he would have to ask for Mr. Jackson to provide him with his medications.

Resident B and Resident C reported they could not remember if Mr. Jackson provided them with their medication or not.

Ms. Hernandez-Bunce reported Mr. Jackson was terminated immediately when the home manager informed her that Mr. Jackson had not passed them their medications.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(2) Medication shall be given, taken, or applied pursuant to label instructions.</b>
<b>ANALYSIS:</b>	Based on interviews and the review of documentation, it has been determined that Mr. Jackson did not provide the residents in the home with their prescribed medications pursuant to label instructions. The licensee designee has terminated Mr. Jackson's employment.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### **IV. RECOMMENDATION**

It is recommended that there be no change to the status of the license upon receipt of an acceptable corrective action plan.



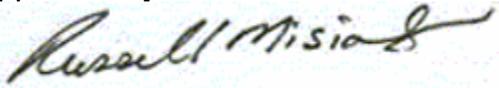
2/7/24

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Kristy Duda  
Licensing Consultant

Date

Approved By:



2/22/24

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Russell B. Misiak  
Area Manager

Date