GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 3, 2023

Amber Bunce
Cornerstone II Inc
P. O. Box 277
Bloomingdale, MI 49026

RE: License #: AS800306200
Investigation #: 2023A1032040
Cornerstone

Dear Amber Bunce:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, 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

License #:	AS800306200
Investigation #:	2023A1032040
Complaint Receipt Date:	06/08/2023
Investigation Initiation Date:	06/12/2023
Report Due Date:	08/07/2023
Licensee Name:	Cornerstone II Inc
Licensee Address:	44409 Baseline Rd., Bloomingdale, MI 49026
Licensee Telephone #:	(269) 668-7070
Administrator:	Karmen Ball
Licensee Designee:	Amber Bunce
Name of Facility:	Cornerstone
Facility Address:	22858 West M-43,Kalamazoo, MI 49009-9208
Facility Telephone #:	(269) 668-3175
Original Issuance Date:	04/07/2010
License Status:	REGULAR
Effective Date:	10/21/2022
Expiration Date:	10/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Employees ignored Resident A, leaving him in his room for days at a time.	No
Employees did not alert EMS when Resident A was in distress and routinely made medication errors.	No
Employees did not provide Resident A with proper food and water.	No
Additional Findings	No

III. METHODOLOGY

06/08/2023	Special Investigation Intake 2023A1032040
06/12/2023	Special Investigation Initiated - On Site
06/22/2023	Contact - Telephone call made Interview with Case management of Michigan case manager Mark Magin
07/12/2023	Contact - Document Received I received a copy of Resident A's Medication Administration Record
08/02/2023	Inspection Completed On-site Interview with Resident A and Resident B
08/03/2023	Exit Conference With licensee designee Amber Bunce

ALLEGATION:

Employees ignored Resident A, leaving him in his room for days at a time.

INVESTIGATION:

On 6/12/23, I interviewed home manager Jalen Johnson in the home. Mr. Johnson denied that Resident A was left in his room for four days. He stated that he will often engage Resident A to make proper health choices, such as smoke cessation, and to follow treatment plans set forth by his various health care professionals. Mr. Johnson stated that the residents have opportunities to go to outside and enjoy the outdoors.

On 6/22/23, I interviewed the complainant, via telephone. The complainant added that Resident A was sent to The VA Hospital in Battle Creek for inpatient treatment.

On 6/22/23, I interviewed Mark Magin, from Case Management of Michigan, via telephone. Mr. Magin stated that he is Resident A's case manager. Mr. Magin reported that he last saw Resident A in the home on June 8, 2023. Mr. Magin stated that he does not have any concerns about Resident A's care in the home as it related to food and water intake, medication management and general care. He stated that he will be making a recommendation for him to return there once discharged from the VA Hospital in Battle Creek.

On 8/2/23, I interviewed Resident A in the home. Resident A denied being left alone in his room for multiple days. Resident A acknowledged that Mr. Johnson in particular, does a good job and tries to engage him in healthier choices, such as smoke cessation.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Employees at the home appear to have engaged Resident A and offered advice to improve Resident A 's self esteem and normalization and did not leave him secluded in a room for four days.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees did not alert EMS when Resident A was in distress and routinely made medication errors.

INVESTIGATION:

On 6/12/23, Mr. Johnson stated that when he reported for work on June 7, 2023, he received a report that overnight, Resident A had complained of a stomachache. Mr. Johnson advised that per protocol, he took Resident A's vitals, which were within normal range. He mentioned that he explained to Resident A that a home care nurse would also be checking in at 3PM that day. Mr. Johnson reported that the home nurse from Mary-Freebed had followed up with a visit that day and noted that Resident A was not in distress. Mr. Johnson continued, that on June 8, 2023, he showed up to work to complete some paperwork, and noticed that there was a change in Resident A's routine, where he would usually be outside smoking. He stated that he checked in on Resident A who still complained of pain, and he called for an ambulance. He further stated that Resident A did not ask him to call an ambulance. He reported that Resident A was checked out at Bronson-Methodist Hospital in Kalamazoo but remains there for a psychiatric evaluation, after making suicidal statements. He reported that Resident A had a urinary tract infection.

On 7/12/23, I reviewed Resident A's Medication Administration Record. There did not appear to be any inconsistencies that would reflect Resident A receiving the wrong medication.

On 8/2/23, Resident A denied that he was given the wrong medication on a routine basis. He stated that upon reflection, the employees, and Mr. Johnson in particular, took appropriate steps to assess him and to call EMS when he was in distress.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	An examination of Resident A's Medication Administration Record reflected compliance with doctor's orders. Resident A denied that the employees did not follow protocol and alert EMS for assistance. Mr. Johnson detailed steps he took when it was noted that Resident A was in decline medically. The home had established a protocol where resident needs were communicated among shifts.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees did not provide Resident A with proper food and water.

INVESTIGATION:

On 6/12/23, Home Manager Jalen Johnson denied that Resident A was not provided adequate food and water. He stated that water and snacks are made available to residents throughout the day.

While I conducted an inspection, I observed employees preparing hamburgers for lunch.

On 8/2/23, Resident A denied that he was provided inadequate quantities of food and water. Resident B stated that breakfast is typically served around 8:30AM and 9AM, and lunch is served between 12PM and 12:30PM

I interviewed Resident B in the home. Resident B stated that she has been in the home for nine years. Resident B was asked about the quality of the food provided and she expressed satisfaction.

While conducting the onsite inspection, I observed fish sticks being prepared for lunch.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Resident A denied that he was not provided adequate food and water. On two separate occasions, I observed food service being conducted. Resident A seemed to have accurate knowledge of mealtimes. Resident B expressed satisfaction with meal quality.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change to the status of this license.

8/3/23

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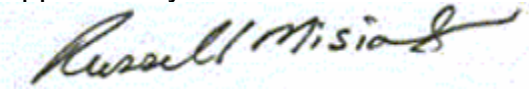
Dwight Forde Date
Licensing Consultant

Approved By:



8/9/23

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Russell B. Misiak Date
Area Manager