GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 20, 2025

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

RE: License #: AS120281503
Investigation #: 2025A1032013
Cornerstone AFC

Dear Amber 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.

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,

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

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

I. IDENTIFYING INFORMATION

License #:	AS120281503
Investigation #:	2025A1032013
Complaint Receipt Date:	01/27/2025
Investigation Initiation Date:	01/29/2025
Report Due Date:	03/28/2025
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277, Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2100
Administrator:	Amber Bunce
Licensee Designee:	Amber 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:	10/01/2024
Expiration Date:	09/30/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
An employee disrespected a resident.	Yes
An employee's omission resulted in serious harm to a resident's health.	Yes
Additional Findings	No

III. METHODOLOGY

01/27/2025	Special Investigation Intake 2025A1032013
01/29/2025	Special Investigation Initiated - On Site
02/03/2025	Contact - Document Sent Email sent requesting Resident A's IPOS and assessment plan.
02/11/2025	Contact - Document Received
02/20/2025	Contact - Telephone call made Left voicemail for employee Deanna Remsing
03/04/2025	Inspection Completed On-site Interview with Resident B
03/07/2025	Contact - Telephone call received Interview with Van Buren County Recipient Rights Officer Candice Kinzler
03/20/2025	Exit Conference

ALLEGATION:

An employee disrespected a resident.

INVESTIGATION:

On 1/19/25, I interviewed Home Manager Melissa Hill in the facility. Ms. Hill was unaware of any instance where employee Deanna Remsing was disrespectful of Resident A, by cursing at her.

I reviewed an incident report written by Ms. Remsing, where she referred to the build up to an elopement as “The door game.” Ms. Hill stated that Resident A suffers from a mental condition where she has delusions, and that one of the delusions was that her children were outside. The incident report references some aggression on Resident A’s part.

On 2/20/25, I left a voicemail for employee Deanna Remsing, stating the investigative purpose of my call. To date, I have not received a return call.

On 3/4/25, I interviewed Resident B in the facility. Resident B stated that she recalled employee Deanna Remsing referring to Resident A as being lazy. Resident B stated that she chided Ms. Remsing for making the comment, and Ms. Remsing told her to shut up.

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:	After interviewing Resident B and reviewing some of the verbiage in the incident report authored by Ms. Remsing, I concluded that there may have been cracks in Ms. Remsing’s professional demeanor, resulting in a lack of dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

An employee's omission resulted in serious harm to a resident's health.

INVESTIGATION:

On 1/19/25, Ms. Hill discussed Resident A trying to leave through the front door of the facility but was barred from by a resident who had locked the door. Resident A subsequently left through the side door. Ms. Hill stated that Resident A has a shuffling gait and was not able to move very quickly. She advised that while restraint was not warranted, the staff member could have blocked Resident A from leaving, or guided her back to the facility once she left.

Ms. Hill stated that there is another resident who is on a restricted movement plan outlined in an Individual Plan of Service. She advised that the facility will be adding another person to the night shift as a result of Resident A's elopement.

I reviewed the incident report authored by Ms. Remsing. The report reflects Ms. Remsing's efforts to redirect Resident A, some aggression on the resident's part, and a call for assistance from another employee. The report notes that Resident A left the home barefoot and states that Ms. Remsing was unable to get her to come back in. Resident A was eventually found by staff, and checked out by emergency medical services (EMS). Subsequent to these events, Resident A was taken to a nursing home. Her health worsened after the exposure to snow and frigid temperatures.

On 2/11/25, I reviewed Resident A's assessment plan. There was no indication on the plan that Resident A was an elopement risk.

On 2/20/25, I left a voicemail for employee Deanna Remsing, stating the investigative purpose of my call. No return call has been received as of the date of this report.

On 3/4/25, Resident B stated that she recalled telling employee Deanna Remsing that Resident A had left the facility by pointing out that the side door was open. I asked Resident B if she recalled what happened next, but she was unable to do so. She remembered that Ms. Remsing was on the phone at the time that Resident A left the facility. Ms. Remsing was reportedly sitting at a desk in the living room, near the hallway that lead to the side door. Based on the floor plan, Resident A would have walked past Ms. Remsing on her way out the side door.

Ms. Hill advised that Resident A was still at a nursing home, with an unclear discharge plan.

On 3/7/25, I interviewed Van Buren County Recipient Rights officer Candice Kinzler by telephone. Ms. Kinzler shared that she had spoken with employee Deanna Remsing, who had reported to her that at the time of the incident, all residents were asleep, which appears to contradict a statement from home manager Melissa Hill.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my interviews with Ms. Hill and Resident B, it appears that Resident A likely walked past Ms. Remsing on the way out the side door of the facility, while Ms. Remsing was on a phone call. While Ms. Remsing details efforts to redirect Resident A, enough attention to supervising Resident's movements was not applied. Resident A's difficulty walking suggests that she did not have the speed to leave the facility without being barred.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/30/25, I shared my findings with licensee designee Amber Bunce. I provided Ms. Bunce with an opportunity to provide evidence of facility compliance.

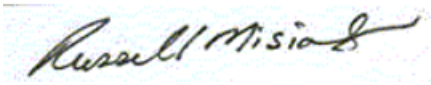
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

3/20/25

Dwight Forde — Date
Licensing Consultant

Approved By:



3/21/25

Russell B. Misiak — Date
Area Manager