GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

June 25, 2025

RE: License #: AS800413641
Investigation #: 2025A1031032
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) 356-0100.

Sincerely,

KDuda

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

License #:	AS800413641
Investigation #:	2025A1031032
Complaint Receipt Date:	04/30/2025
Investigation Initiation Date:	04/30/2025
Report Due Date:	06/29/2025
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277 Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2100
Licensee Designee/Administrator:	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:	REGULAR
Effective Date:	07/31/2023
Expiration Date:	07/30/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A had bruising caused by staff.	No
Additional Findings	Yes

III. METHODOLOGY

04/30/2025	Special Investigation Intake 2025A1031032
04/30/2025	APS Referral Received.
04/30/2025	Special Investigation Initiated - Letter Email sent to Candice Kinzler.
05/07/2025	Inspection Completed On-site
05/07/2025	Contact - Face to Face Interviews with Ashley Ruperd, Elizabeth Snyder, Resident A, Resident B, and Resident C.
06/11/2025	Contact – Telephone Interview with Candice Kinzler.
06/23/2025	Contact - Telephone Interview with Amber Hernandez-Bunce.
06/23/2025	Exit Conference held with Amber Hernandez-Bunce.

ALLEGATION:

Resident A had bruising caused by staff.

INVESTIGATION:

On 4/30/25, I sent an email to Van Buren recipient rights director Candice Kinzler informing her that I received allegations that staff caused bruising on Resident A. Ms. Kinzler reported she was not aware of the allegations and would be opening an investigation.

On 5/7/25, Ms. Kinzler and I conducted an unannounced visit to the facility. We interviewed direct care worker (DCW) Ashley Ruperd. Ms. Ruperd was informed of the allegations and reported she has never caused physical harm to Resident A. Ms. Ruperd reported Resident A will often get bruises on his shins due to how he walks with his walker. Ms. Ruperd reported Resident A leans while walking and will hit his

shins on the sides of his walker. Ms. Ruperd reported she has never observed other staff cause any harm to Resident A.

On 5/7/25, Ms. Kinzler and I interviewed the facility manager Elizabeth Snyder. Ms. Snyder reported that Resident A does get bruises on his legs and shins due to hitting them on his walker when he walks. Ms. Snyder reported she has not observed any staff cause physical harm to Resident A.

On 5/7/25, Ms. Kinzler and I attempted to interview Resident A. Resident A was not able to engage in the interview process due to being nonverbal. Resident A was able to shake is head up and down and make noises when questions were asked. Resident A was asked if anyone hurt him, and he was able to communicate “no” by moving his head. Resident A was observed to have a few very small bruises on his legs. Resident A was observed to walk with his walker, and he did bump his legs on his walker when walking around the facility.

On 5/7/25, Ms. Kinzler and I interviewed Resident B and Resident C individually. Resident B and C reported they have not observed staff physically harm Resident A.

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:	There was no evidence found to support that staff physically harmed Resident A. The bruising was consistent with the reports they made about Resident A hitting his legs on his walker and he was observed to hit his legs on his walker when walking around the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Ruperd reported she will often have to get “loud” with Resident A when he is making moaning and groaning noises as it annoys the other residents. Ms. Snyder reported she has to get loud because Resident A has a hard time hearing. Ms. Snyder reported there was another DCW named Tabitha that is no longer employed at the facility that would yell at the residents.

Ms. Snyder reported DCW Tabitha would yell at the residents and call them names. Ms. Snyder reported that she is no longer employed at the facility due to this behavior.

Resident B reported that most of the staff will yell at Resident A when he is “doing his moaning and groaning thing”. Resident B stated, “I should have recorded it because they yell all the time at him”. Resident B reported DCW Tabitha would yell at him the most, but other staff do to.

Resident C reported staff are always yelling at Resident A when he moans and groans. Resident C reported he does not understand why they yell at him because it is the only way he can ask for things since he cannot talk.

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:	Based on interviews with staff and residents, it has been determined that Resident A is not treated with dignity as staff will yell at him when he makes noises to express his personal needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Kinzler and I arrived at the facility around 12pm and we noticed Resident A asking for lunch. Ms. Ruperd reported that Ms. Snyder was picking up groceries and would be back shortly with lunch for the residents. I looked in the refrigerator and cabinets and there was minimal food available. I looked at the menu posted on the wall and inquired about what the residents ate for breakfast. Ms. Ruperd reported the residents had cereal and milk. Ms. Ruperd was asked if the residents received turkey bacon and toast as that is what was listed along with cereal on the menu. Ms. Ruperd reported the residents did not as the items were not available to provide to

them. Ms. Ruperd reported staff do not often follow the menu as the food items needed to cook the meals on the menu are not available.

Ms. Snyder arrived at the facility with groceries while we were at the facility. Ms. Snyder reported staff do not often follow the menu as the residents do not like what is on there or there are not ingredients available to make what is on the menu.

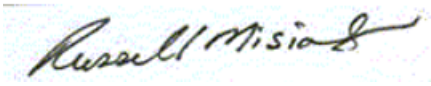
APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Although the facility had completed menus, there was not food available to make the meals outlined. Staff reported they do not follow the menu as residents do not like what is on the menu or there are not any ingredients in the home to make the meals.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference special investigation report #2023A1031054 and corrective action plan dated 9/5/23**

IV. RECOMMENDATION

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

Kristy Duda Date
Licensing Consultant

Approved By:



6/26/25

Russell B. Misiak Date
Area Manager