GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 24, 2025

Cornerstone I, Inc.
P.O. Box 277
Bloomingdale, MI 49026

RE: License #: AM800267076
Investigation #: 2025A1031050
Cornerstone AFC

Dear Ms. Hernandez-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. 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,

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 #:** | AM800267076 |
| | |
| **Investigation #:** | 2025A1031050 |
| | |
| **Complaint Receipt Date:** | 09/10/2025 |
| | |
| **Investigation Initiation Date:** | 09/11/2025 |
| | |
| **Report Due Date:** | 11/09/2025 |
| | |
| **LicenseeName:** | Cornerstone I, Inc. |
| | |
| **Licensee Address:** | 98 45th St<br>Bloomingdale, MI 49026 |
| | |
| **Licensee Telephone #:** | (269) 521-4130 |
| | |
| **Licensee Designee/Administrator:** | Amber Hernandez-Bunce |
| | |
| **Name of Facility:** | Cornerstone AFC |
| | |
| **Facility Address:** | 59859 W M-43<br>Bangor, MI 49013 |
| | |
| **Facility Telephone #:** | (269) 427-8096 |
| | |
| **Original Issuance Date:** | 11/01/2004 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/31/2025 |
| | |
| **Expiration Date:** | 08/30/2027 |
| | |
| **Capacity:** | 10 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

| | |
|---|---|
| | TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff were verbally and physically abusive towards Resident A. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/10/2025 | Special Investigation Intake<br>2025A1031050 |
| 09/10/2025 | APS Referral |
| 09/11/2025 | Special Investigation Initiated - Letter<br>Email exchange with Mike Hartman. |
| 09/15/2025 | Inspection Completed On-site<br>Face to face interview with Jessie Green |
| 09/15/2025 | Inspection Completed-BCAL Sub. Compliance |
| 09/15/2025 | Contact – Telephone call made to Amber Hernandez-Bunce. |
| 09/26/2025 | Contact - Voicemail left with Resident A. |
| 10/16/2025 | Contact – Telephone Interview with Resident A. |
| 10/24/2025 | Exit Conference held with Amber Hernandez-Bunce. |

**ALLEGATION:**

**Staff were verbally and physically abusive towards Resident A.**

**INVESTIGATION:**

On 9/11/25, I exchanged emails with adult protective services (APS) Mike Hartman. Mr. Hartman reported he received a complaint that direct care worker (DCW) Jaron Burton had assaulted Resident A by running into him with his wheelchair when he fell out of it. Mr. Hartman reported he did not find any evidence to support the allegations. Resident A reported to Mr. Hartman that he had been acting out and he probably hurt himself when he went to the floor on his own. Mr. Hartman reported he conducted a joint investigation with the police, and they closed the case as “unfounded”.

On 9/15/25, I interviewed Mr. Burton at another facility. Mr. Burton reported he received a telephone call at approximately 1am from staff at the facility. Mr. Burton reported Resident A was exhibiting difficult behaviors and tried to break a tablet and threw oil and juice all over the facility. When Mr. Burton arrived to the facility, Resident A was stating that he was going to harm himself by rolling in his wheelchair in front of traffic. Mr. Burton attempted to redirect Resident A and then Resident A lifted himself up and threw himself out of his wheelchair. Resident A pulled himself into his bedroom by pulling on the door frame. Resident A was yelling and banging on his door asking someone to kill him because he wanted to die. Mr. Burton reported he sat in the living room which was near his bedroom to monitor him. Resident A initially refused assistance to be picked up off the floor. Mr. Burton was later able to assist Resident A get into his bed after he de-escalated.

On 9/15/25, I conducted an unannounced visit to the facility and interviewed DCW Jessie Green. Ms. Green reported she was not working when the alleged incident occurred, and Resident A was not at the facility to be interviewed.

On 10/16/25, I interviewed Resident A via telephone. Resident A reported there was a misunderstanding about the incident. Resident A reported he was having a rough day and expressed suicidal ideations. Resident A told Mr. Burton that he was suicidal and was going to roll himself in his wheelchair into a main road to be hit by a vehicle. Resident A reported that Mr. Burton did his job and prevented him from harming himself. Resident A reported during the process he was upset and threw himself out of his wheelchair and onto the floor. Resident A initially refused assistance to be put back into his wheelchair. Resident A reported Mr. Burton staff treat him well and had no further concerns to share.

On 10/23/25, I reviewed the police report dated 9/5/25 and it read that the case was closed as unfounded.

| **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 interviews and the review of documentation, there was no evidence found to support that Resident A was physically or emotionally abused. Resident A admitted that he was upset and threw himself to the ground and Mr. Burton appropriately assisted him. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

On 9/15/25, I arrived at the facility and observed DCW Jessie Green sleeping on the front porch. Ms. Green was woken up and asked if there were any other staff working in the facility and she reported she was the only staff working.

On 9/15/25, I contacted licensee designee Amber Hernandez-Bunce and informed her that Ms. Green was sleeping upon my arrival at the facility. Ms. Hernandez-Bunce reported she would be sending another staff member to the facility to relieve Ms. Green.

**INVESTIGATION:**

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14206** | **Staffing requirements.** |
| | **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.** |
| **ANALYSIS:** | Ms. Green was observed to be sleeping on the front porch when I arrived at the facility. Ms. Green was the only staff working in the facility and did not provide appropriate supervision, personal care, or protection for the residents in the facility. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

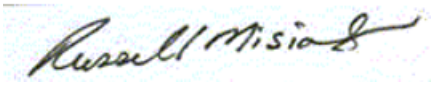
## IV. RECOMMENDATION

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

10/23/25

Kristy Duda — Date
Licensing Consultant

Approved By:



10/23/25

Russell B. Misiak — Date
Area Manager