



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2025

Karmen Ball
Cornerstone II Inc
P. O. Box 277
Bloomington, MI 49026

RE: License #: AS120265532
Investigation #: 2025A1032049
Cornerstone II AFC

Dear Karmen Ball:

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 plan.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How 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) 356-0100.

Sincerely,

A handwritten signature in black ink, appearing to read "Dwight Forde".

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 #:	AS120265532
Investigation #:	2025A1032049
Complaint Receipt Date:	09/15/2025
Investigation Initiation Date:	09/16/2025
Report Due Date:	11/14/2025
Licensee Name:	Cornerstone II Inc
Licensee Address:	44409 Baseline Rd., Bloomingdale, MI 49026
Licensee Telephone #:	(269) 668-7070
Administrator:	Karmen Ball
Licensee Designee:	Karmen Ball
Name of Facility:	Cornerstone II AFC
Facility Address:	157 W. Garfield Road, Coldwater, MI 49036
Facility Telephone #:	(517) 278-0313
Original Issuance Date:	08/20/2004
License Status:	REGULAR
Effective Date:	05/08/2025
Expiration Date:	05/07/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
An employee was high while on shift.	No
A medication error led to Resident A needing to go to the hospital.	Yes
Additional Findings	No

III. METHODOLOGY

09/15/2025	Special Investigation Intake 2025A1032049
09/16/2025	Special Investigation Initiated - On Site
10/28/2025	Contact - Telephone call made Interview with employee Crystal Rose
10/29/2025	Contact - Telephone call made Interview with employee Ty Donald
10/29/2025	Contact - Telephone call made Interview with Van Buren Recipient Rights Officer Candice Kinzler
10/30/2025	Exit Conference With licensee designee Karmen Ball

ALLEGATION:

An employee was high while on shift.

INVESTIGATION:

On 9/16/25, I interviewed home manager Derek Bultler in the facility. Mr. Butler stated that employee Crystal Jennings was on shift and had given Resident A the wrong medication. He stated that he received a call from the hospital that she seemed intoxicated and presented with a faint odor of marijuana. He denied observing Ms. Jennings to be intoxicated when he relieved her at the hospital, where he then transported Resident A to the facility. Mr. Butler commented that the

residents all smoke, and that the smell can be quite pervasive. He denied that the residents smoke in the home. He acknowledged, and I observed during the onsite inspection, that there was an odor of marijuana present.

I interviewed Resident A in the facility. Resident A recalled having to go to the hospital recently after being reminded. I asked if he had ever observed employee Crystal Jennings to be intoxicated, and he denied ever seeing her drunk or in an altered state.

On 10/28/25, I interviewed employee Crystal Jennings by telephone. Ms. Jennings denied smoking marijuana or consuming alcohol while on shift.

On 10/29/25, I interviewed employee Ty Donald by telephone. Mr. Donald denied observing Ms. Jennings consume marijuana or alcohol during their shift.

On 10/29/25, I spoke with Van Buren Recipient Rights officer Candice Kinzler by telephone. Ms. Kinzler stated that her office did not open or substantiate a case against Ms. Jennings for abuse/neglect concerns.

APPLICABLE RULE	
R 400.14204	Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.
	(1) A licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household shall be in such physical and mental health so as not to negatively affect either the health of the resident or the quality of his or her care.
ANALYSIS:	The employees and resident interviewed denied seeing Ms. Jennings consume alcohol or smoke marijuana during her shift, therefore there is insufficient evidence to establish a violation that direct care staff were not in good physical or mental health to carry out duties.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

A medication error led to Resident A needing to go to the hospital.

INVESTIGATION:

On 9/16/25, Mr. Butler advised that on the day in question, Ms. Jennings had a shift partner named Ty, who was fairly new to the facility. He expressed a concern that the medications were pre-set, and had explained to Ms. Jennings that this was not allowed in AFC facilities.

On 10/28/25, Ms. Jennings stated that on the day in question, she was training another new employee and had been showing him how to dispose of medications that were refused. She advised that she left the medication room with a cup and Resident A was outside the room. She acknowledged being somewhat distracted in the moment and accidentally gave Resident A the wrong medication. She advised that once she realized her error, she followed protocol. Ms. Jennings stated that since then, she has been re-trained on passing medication.

On 10/29/25, Mr. Donald advised that on the day in question, he was working with Ms. Jennings, who was showing him how to properly dispose of rejected medication. He stated that she left the medication room and accidentally gave Resident A the wrong medication. He stated that Ms. Jennings followed protocol by notifying the licensee designee and the home manager, as well as transporting Resident A to the hospital to be evaluated.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Medications were not given pursuant to label instructions since Resident A was given the wrong medications. Ms. Jennings reported being somewhat distracted at the time. Positives include the fact that the error was reported, Resident A was evaluated at the hospital and Ms. Jennings was re-trained.
CONCLUSION:	VIOLATION ESTABLISHED

On 10/30/25, I conducted an exit conference with licensee designee Karmen Ball by telephone. Ms. Ball acknowledged that a violation occurred and agreed to furnish the department with an acceptable corrective action plan.

IV. RECOMMENDATION

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

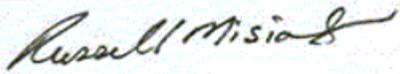


10/31/25

Dwight Forde
Licensing Consultant

Date

Approved By:



11/4/25

Russell B. Misiak
Area Manager

Date