



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

October 31, 2025

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

RE: License #: AS120281503  
Investigation #: 2025A1032048  
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 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.  
Grand Rapids, MI 49503

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

**I. IDENTIFYING INFORMATION**

|                                       |   |
|---------------------------------------|---|
| <b>License #:</b>                     | AS120281503   |
| <b>Investigation #:</b>               | 2025A1032048  |
| <b>Complaint Receipt Date:</b>        | 09/05/2025  |
| <b>Investigation Initiation Date:</b> | 09/09/2025  |
| <b>Report Due Date:</b>               | 11/04/2025  |
| <b>Licensee Name:</b>                 | Cornerstone AFC, LLC  |
| <b>Licensee Address:</b>              | P.O. Box 277, Bloomingdale, MI 49026  |
| <b>Licensee Telephone #:</b>          | (269) 628-2100  |
| <b>Administrator:</b>                 | Amber Bunce   |
| <b>Licensee Designee:</b>             | Amber Bunce   |
| <b>Name of Facility:</b>              | Cornerstone AFC   |
| <b>Facility Address:</b>              | 633 N. Fall River, Coldwater, MI 49036  |
| <b>Facility Telephone #:</b>          | (517) 278-7887  |
| <b>Original Issuance Date:</b>        | 03/08/2006  |
| <b>License Status:</b>                | REGULAR   |
| <b>Effective Date:</b>                | 10/01/2024  |
| <b>Expiration Date:</b>               | 09/30/2026  |
| <b>Capacity:</b>                      | 6   |
| <b>Program Type:</b>                  | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>TRAUMATICALLY BRAIN INJURED |

**II. ALLEGATION(S)**

|   | <b>Violation Established?</b> |
|---|-------------------------------|
| Resident A's treatment plan was not properly followed by staff. | Yes                           |
| Additional Findings   | No                            |

**III. METHODOLOGY**

|            |  |
|------------|--|
| 09/05/2025 | Special Investigation Intake<br>2025A1032048                           |
| 09/09/2025 | Special Investigation Initiated - On Site                              |
| 09/18/2025 | Contact - Telephone call made<br>Interview with employee Leslie Morley |
| 09/24/2025 | Contact - Telephone call made<br>LCMHA                                 |
| 10/30/2025 | Exit Conference  |

**ALLEGATION:**

**Resident A's treatment plan was not properly followed by staff.**

**INVESTIGATION:**

On 9/9/25, I interviewed employee Jaylynn Hecox in the facility. Ms. Hecox stated that she did not directly observe the events surrounding Resident A's substance use. She advised that Resident A went into a dispensary to purchase a dab pen and gummies. Ms. Hecox stated that Resident A had been to the hospital recently, for an apparent seizure.

I interviewed home manager Melissa Hall in the facility. Ms. Hall stated that Resident A left the van driven by employee Paige Hecox, despite being told no to go into the

store. Ms. Hall stated that she had concluded a conversation with Resident A's guardian, who advised that Resident A has faked medical emergencies in the past, such as seizures.

I interviewed Resident A in the facility. Resident A had been on the floor, insensate, when I arrived, but when she woke up, she inquired who I was, acknowledged that we met for a previous investigation, then left the living room.

I interviewed Resident B in the facility. Resident B stated that when they arrived at the dispensary, employee Paige Hecox repeatedly told Resident A that she was not supposed to go into the store without staff supervision.

I reviewed Resident A's assessment plan and IPOS. The IPOS reflected limited community access once Resident A had met certain behavioral goals, which she has yet to achieve. The plan detailed avoiding use of marijuana or its derivatives.

I reviewed Resident A's health care appraisal, and there is no documentation of a seizure disorder.

On 9/18/25, I interviewed employee Leslie Morley by telephone. Ms. Morley stated that employee Paige Hecox drove Residents A and B to the dispensary while she remained at the facility with the other residents. Ms. Morley advised that Resident A should not have gone, since the individual plan of service details staff supervision in the community. Ms. Morley surmised that since Ms. Hecox took them to the store, she could have gone in when Resident A left the vehicle. Ms. Morley added that there have been instances where residents' medications were not re-ordered in a timely fashion, resulting in gaps. When I asked what medications she was referring to, Ms. Morley stated that they were over the counter medications, not scheduled prescriptions needed for any chronic conditions. She advised that this happened months ago. She reported that Ms. Hecox's family interrupted business by being on the property and running around while she was working with a behavior specialist.

On 9/24/25, I interviewed Lenawee Community Mental Health Authority behavioral psychologist Dr. Charles Guccione by telephone. Dr. Guccione stated that he had authored Resident A's treatment plan to proscribing use of marijuana or its derivatives, because Resident A has such a strong physical reaction.

| <b>APPLICABLE RULE</b> |  |
|------------------------|--|
| <b>R 400.14303</b>     | <b>Resident care; licensee responsibilities.</b>   |
|                        | <b>(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.</b> |

|                    |  |
|--------------------|--|
| <b>ANALYSIS:</b>   | <p>After observing Resident A's treatment plan, it does not appear that the plan was followed by staff. Give Resident A's behavioral progress level, community access was limited, and contact with an establishment selling marijuana and its derivatives was not necessary and in contravention of the plan. Resident A could have remained at the facility with the other staff member while Resident B was taken to the dispensary.</p> <p>There were no current issues with medications at the facility that were identified by employee Leslie Morley.</p> |
| <b>CONCLUSION:</b> | <b>VIOLATION ESTABLISHED</b>   |

On 10/30/25, I conducted an exit conference with licensee designee Amber Bunce, by telephone, where I shared my findings. Ms. Bunce agreed to furnish the department with a corrective action plan to address the violation identified.

**IV. RECOMMENDATION**

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

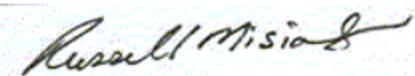


10/31/25

\_\_\_\_\_  
Dwight Forde  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:



11/4/25

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Russell B. Misiak  
Area Manager

\_\_\_\_\_  
Date