GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2021

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

RE: License #: AS800309333
Investigation #: 2021A0578050
Cornerstone House

Dear Ms. Ball:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800309333
Investigation #:	2021A0578050
Complaint Receipt Date:	08/23/2021
Investigation Initiation Date:	08/24/2021
Report Due Date:	10/22/2021
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 House
Facility Address:	22722 M-43 Kalamazoo, MI 49009
Facility Telephone #:	(269) 668-7419
Original Issuance Date:	10/11/2010
License Status:	REGULAR
Effective Date:	04/24/2021
Expiration Date:	04/23/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was able to elope from the facility without staff noticing. Resident A does not have independent access within the community.	No

III. METHODOLOGY

08/23/2021	Special Investigation Intake 2021A0578050
08/23/2021	Contact-Document Reviewed *-AFC Licensing Division Incident / Accident Report*, dated 08/21/2021.
08/24/2021	Contact-Telephone -Resident A returned to the facility.
08/24/2021	Special Investigation Initiated – On Site -Interview with Resident A.
08/24/2021	Contact-Document Reviewed -*Health Care Appraisal* for Resident A, dated 07/24/2021.
08/24/2021	Contact-Document Reviewed -Cornerstone *Referral Packet and Intake Form* for Resident A, dated February 2021.
09/27/2021	Contact-Telephone -Interview with the licensee, Ms. Karmen Ball.
09/27/2021	Contact Document Reviewed. - *Individual Plan of Service* for Resident A, dated 08/13/2021.
10/06/2021	Contact-Document Requested -Kalamazoo County Sheriff's Department, No records available.
10/07/2021	Contact-Telephone -Interview with direct care staff Tammy Willis, unsuccessful.
10/07/2021	Contact-Telephone- Interview with Tammy Hutari of Pathways Community Mental Health.
10/08/2021	Contact-Telephone- Interview with direct care staff Tammy Willis.

10/08/2021	Contact-Document Requested- Van Buren County Sheriff's Department *Incident Report* #03842-21.
10/08/2021	Contact-Document Requested- Kalamazoo Department of Public Safety Records, No records available.
10/12/2021	Exit Conference- With the licensee designee, Ms. Karmen Ball.
10/12/2021	APS Referral Completed.

ALLEGATION:
Resident A was able to elope from the facility without staff noticing. Resident A does not have independent access within the community.

INVESTIGATION:
On 08/23/2021, I received this intake form AFC licensing consultant Cathy Cushman based on an AFC Licensing Division Incident / Accident Report provided by licensee designee Karmen Ball. Ms. Cushman reported Resident A eloped from the facility without direct care staff noticing. Ms. Cushman added that when direct care staff went into Resident A's bedroom, direct care staff discovered pillows under Resident A's blankets. Ms. Cushman clarified Resident A does not have independent access within the community.

On 08/23/2021, I reviewed the *AFC Licensing Division Incident / Accident Report* related to the allegations, dated 08/21/2021 and completed by direct care staff Tammy Willis. Ms. Willis documented on this *AFC Licensing Division Incident/ Accident Report* that on 08/21/2021, when checking on Resident A, she found stuffed pillows under Resident A's blanket and determined Resident A had eloped. Ms. Willis documented notifying the manager, case manager, the Cornerstone crisis team, guardian, and law enforcement.

On 08/23/2021, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 08/05/2021. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A is allowed to move independently in the community.

On 08/23/2021, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 08/19/2021. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A should have staff support in the community due to Resident A being a "flight risk" and vulnerable to others.

On 08/24/2021, AFC licensing consultant Cathy Cushman reported Resident A was found and returned to the facility.

On 08/24/2021, I completed an unannounced investigation on-site at this facility and interviewed Resident A regarding the allegations. Resident A acknowledged living at

this facility for only a few days before the alleged incident occurred. Resident A reported that she had been struggling with anxiety and meeting new people and missed her children. Resident A reported she decided to go “somewhere” with an individual she thought she could trust and thought that since she was allowed to go with her guardian in the community, a visit with this individual was allowed as well. Resident A reported she met this individual on an internet dating site and agreed to go to a hotel with this person. Resident A acknowledged not communicating her outing in the community with direct care staff because Resident A anticipated direct care staff at this facility would not allow it. Resident A acknowledged arranging her pillows to look like she was in bed and left the facility by going out the front door when direct care staff were not immediately present.

Resident A reported her community outing did not go well and refused to provide any additional information regarding her elopement and denied having any type of injuries or the need to provide any type of additional information to law enforcement. Resident A reported attempting to return to the facility the following day but was unfamiliar with the address or the community. Resident A reported she called her case manager and the facility several times without being able to make contact before reaching her case manager through her guardian and returning to the facility. Resident A expressed remorse and stated she was from a remote northern city and was overwhelmed by the area and would never engage in such behavior again. Resident A denied having any additional concerns. I observed Resident A with no visible marks or bruises or injuries.

While at the facility, I interviewed direct care staff member Jewel Archer regarding the allegations. Ms. Archer reported serving as the home manager for this facility. Ms. Archer reported being aware of the allegations based on an *AFC Licensing Division Incident / Accident Report* completed by direct care staff Tammy Willis. Ms. Archer reported that Ms. Willis typically works the evening and overnight shift.

While at the facility I reviewed the *Health Care Appraisal* for Resident A, dated 07/24/2021. The *Health Care Appraisal* for Resident A identified Resident A’s diagnosis as Major Depressive Disorder, Post Traumatic Stress Disorder and Opioid Use Disorder.

While at the facility, I reviewed a Cornerstone *Referral Packet and Intake Form* for Resident A, dated February 2021. The *Referral Packet and Intake Form* for Resident A documented that Resident A requires “line of sight” supervision at all times while in the community. The *Referral Packet and Intake Form* documented that Resident A’s supervision requirements regarding community access may be amended after placement.

On 09/27/2021, I interviewed the licensee designee Ms. Karmen Ball regarding the allegations. Ms. Ball acknowledged that on the weekend shortly after being admitted to the facility, Resident A asked for her medications early and placed her blankets and pillows under her bedsheets before eloping from the facility. Ms. Ball reported

the Cornerstone crisis team went out and looked for Resident A with no success. Ms. Ball reported that Resident A contacted her guardian and informed him she was at a local hotel. Ms. Ball reported the guardian then paid for Resident A to stay another night at the hotel before the facility was contacted the next day by Resident A's case manager, who arranged for Resident A to be returned to the facility. Ms. Ball denied having any type of issues with telephone service at this facility but acknowledged that several of the residents may be using the phone to talk to relatives or friends. Ms. Ball reported Resident A denied any type of injuries and refused to have any type of physical and described Resident A as "startled" by the new community this facility is located in.

Ms. Ball acknowledged that a *Referral Packet and Intake Form* was completed with Resident A in February 2021 which identified Resident A as "line of sight" supervision. Ms. Ball clarified the treatment team for Resident A acknowledged that Resident A had a history of elopement but wanted to give Resident A an opportunity for the least restrictive environment before giving Resident A any type of restrictions. Ms. Ball reported as a result, Resident A was given independent community access once she arrived at this facility, as agreed upon by the guardian and case manager Cheri Lane and previous case manager Katy Ballard. Ms. Ball reported that all staff were given an initial in-service regarding Resident A and although independent, encouraged staff to complete 15-minute checks with Resident A. Ms. Ball clarified Resident A's independent community access was changed to "supervised by staff" after receiving the *Individual Plan of Service* from Pathways Community Mental Health which identified Resident A as a "flight risk." Ms. Ball clarified that after the incident of elopement, staff now document 15-minute checks with Resident A.

On 09/27/2021, I reviewed the Pathways Community Mental Health *Individual Plan of Service* for Resident A, dated 08/13/2021. The *Individual Plan of Service* for Resident A identified that Resident A would need staff assistance to know what leisure choices and activities are safe to attend in the local community. The *Individual Plan of Service* identified that staff would need to monitor due to Resident A's "flight risk" and vulnerability to others.

On 10/07/2021, I interviewed Tammy Hutari of Pathways Community Mental Health. Ms. Hutari reported Cheri Lare and Kathleen Ballard were on extended medical leave but serve as their direct supervisor. Ms. Hutari acknowledged that when Resident A was first admitted to this facility the guardian and case manager agreed to independent community outings for Resident A based on Resident A progressively doing better independently. Ms. Hutari clarified this incident of elopement was something different than what was agreed upon and something Resident A decided to do on her own. Ms. Hutari added the treatment team for Resident A agreed that Resident A should continue to reside at this facility after the incident of elopement but clarified that Resident A could have visitors to the facility and staff supervision while out in the community. Ms. Hutari reported Ms. Kathleen Ballard is generally cautious and if something did not seem right at this facility, she

would have Resident A moved to another placement. Ms. Hutari denied having any additional concerns.

On 10/08/2021, I interviewed direct care staff Tammy Willis regarding the allegations. Ms. Willis reported that prior to her elopement, Resident A only requested her medications a little earlier than their scheduled time at 8PM and was advised that she would have to wait until that time. Ms. Willis reported she then went to the lower level of the facility to use the staff bathroom and when she returned to the main floor approximately five to ten minutes later to observe Resident A, one of Resident A's roommates indicated Resident A was "gone". Ms. Willis reported that she went to Resident A's bedroom and found that her pillows were covered in blankets to look like a person. Ms. Willis reported that she then contacted law enforcement and management for this facility. Ms. Willis reported the Cornerstone Crisis Team then began to look for Resident A in the area. Ms. Willis identified Van Buren County Sheriff's Department as the responding law enforcement agency.

On 10/08/2021, I reviewed *Incident Report* #03842-21 provided by the Van Buren County Sheriff's Office. *Incident Report* #03842-21 identified Deputy Chris Orr as the responding officer. Deputy Chris Orr documented on *Incident Report* #03842-21 making contact with direct care staff Tammy Willis who had informed him that Resident A had left the facility on foot around 8PM. Deputy Chris Orr documented on *Incident Report* #03842-21 being unable to find Resident A.

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:	Licensee designee Ms. Karmen Ball acknowledged Resident A eloped from this facility despite being monitored every 15 minutes by staff. Ms. Ball denied Resident A required "line of sight" supervision and clarified that Resident A's treatment team agreed that upon Resident A's admission independent community outings would be permitted. Ms. Ball acknowledged the level of supervision Resident A required was changed after receiving Resident A's *Individual Plan of Service* to reflect staff supervision while in the community. I reviewed the *Assessment Plan for AFC Residents* for Resident A which documented that Resident A required staff supervision while in the community due to being a "flight risk" and vulnerable to others but also allowed Resident A independent access to the community. In an interview, Resident A confirmed waiting to elope from this facility until staff were not immediately present and using her pillows and blankets to hide her elopement. In an interview, direct care staff Tammy Willis confirmed Resident A eloped from the facility but the elopement was quickly discovered. Ms. Willis reported notifying law enforcement, case management, guardian, and the licensee of the elopement, and coordinating attempts to locate Resident A. Resident A was returned to the facility on 08/24/2021 and denied having any injuries and was observed with no visible marks or bruises. As such there is not enough evidence the licensee did attend to Resident A's personal need for protection and safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend that the current license status continue.

10/12/2021

Eli DeLeon Date
Licensing Consultant

Approved By:

10/12/2021

Dawn N. Timm Date
Area Manager