GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 23, 2022

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

RE: License #: AS120281503
Investigation #: 2022A1030058
Cornerstone AFC

Dear Ms. 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 was required. On 9/7/22, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, 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 #:	AS120281503
Investigation #:	2022A1030058
Complaint Receipt Date:	08/29/2022
Investigation Initiation Date:	08/31/2022
Report Due Date:	10/28/2022
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277 Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2011
Administrator:	Amber Bunce
Licensee Designee:	Amber Bunce
Name of Facility:	Cornerstone AFC
Facility Address:	633 N. Fall River Coldwater, MI 49036
Facility Telephone #:	(517) 278-7887
Original Issuance Date:	03/08/2006
License Status:	REGULAR
Effective Date:	10/01/2020
Expiration Date:	09/30/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
A direct care staff member's personal medications were accessible to residents.	Yes
Additional Findings	No

III. METHODOLOGY

08/29/2022	Special Investigation Intake 2022A1030058
08/31/2022	Special Investigation Initiated - Telephone Interview with Amber Bunce
09/07/2022	Contact - Face to Face Interview with Resident A
09/07/2022	Contact - Face to Face Interview with Renee Remsing
09/07/2022	Exit Conference

ALLEGATION:

A direct care staff member's personal medications were accessible to residents.

INVESTIGATION:

On 8/31/22, I spoke with licensee Amber Bunce by phone. Ms. Bunce acknowledged the need for an investigation and scheduled face to face interviews on 9/7/22.

On 9/7/22, I interviewed Resident A at the home. Ms. Larson acknowledged she "accidentally" took the wrong purse because it "looked just like mine." Resident A reported the purse was sitting on the coffee table in the living room of the home where the residents sit and watch television. Resident A reported the purse belonged to direct care staff member (DCSM) Renee Remsing. Resident A denied taking anything out of the purse including medication or money. Resident A reported being taken to the emergency room for an examination and was "fine."

On 9/7/22, I interviewed DCSM Renee Remsing at the home. Ms. Remsing reported she was working on 8/27and put her purse in the “staff office” which is located in the corner of the living room. It should be noted that the “staff office” does not have any walls separating it from a common area in the home. Ms. Remsing reported she placed her purse on the filing cabinet and went to assist a consumer in another area of the home. Ms. Remsing reported she noticed her purse missing when she returned to the “staff office” and asked Resident A who was in her bedroom if the purse was in her bedroom. Ms. Remsing reported Resident A acknowledged she had her purse and gave it back to her.

Ms. Remsing reported she noted the contents of her wallet were out of the wallet and her candy and a small amount of money ($10.00) was missing. Ms. Remsing reported the next day she noticed the Cymbalta medication was missing from her purse. Ms. Remsing reported she contacted her supervisor and the staff on duty who noted Resident A appeared to be “acting differently.” Resident A was taken to the hospital for an examination due to possible overdose of mediation, however, was sent home with no treatment necessary. Ms. Remsing reported she and the other DCSM are now mandated to lock their personal items in the filing cabinet.

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 observations and interviews it was established Resident A had access to a direct care staff member’s personal medication as she left her purse in a common area in the home. The leaving of the purse with accessible medications unsecured placed the residents unnecessarily at risk of ingestion and subsequent poisoning.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/7/22, I shared the findings of the investigation with Licensee Designee, Amber Bunce. Ms. Bunce acknowledged and agreed with the findings and submitted a Corrective Action Plan on-site.

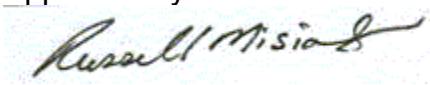
IV. RECOMMENDATION

Based on the submission of an acceptable corrective action plan, I recommend no change in the current license status.

9/7/22

Nile Khabeiry Date
Licensing Consultant

Approved By:



9/23/22

Russell B. Misiak Date
Area Manager