GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 20, 2023

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

RE: License #: AS800413641
Investigation #: 2023A1031015
North Lake Home

Dear Ms. Bunce-Hernandez:

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) 356-0183.

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 #:	AS800413641
Investigation #:	2023A1031015
Complaint Receipt Date:	02/20/2023
Investigation Initiation Date:	02/21/2023
Report Due Date:	04/21/2023
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277 Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2011
Administrator:	Amber Bunce-Hernandez
Licensee Designee:	Amber Bunce-Hernandez
Name of Facility:	North Lake Home
Facility Address:	12201 56th Street Grand Junction, MI 49056
Facility Telephone #:	(269) 762-2969
Original Issuance Date:	01/31/2023
License Status:	TEMPORARY
Effective Date:	01/31/2023
Expiration Date:	07/30/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A had access to the medication cabinet and took the wrong medications.	Yes
Additional Findings	No

III. METHODOLOGY

02/20/2023	Special Investigation Intake 2023A1031015
02/21/2023	Special Investigation Initiated - Documents requested from the licensee designee.
02/21/2023	Contact - Incident Report Received and Reviewed.
02/22/2023	Contact - Telephone interview completed with Amber Bunce.
02/24/2023	Contact - Email exchange with APS worker Mike Hartman.
02/24/2023	APS Referral
03/03/2023	Contact - Voicemail and text message sent to DCW Jennifer Gilliland.
03/08/2023	Inspection Completed On-site
03/08/2023	Inspection Completed-BCAL Sub. Compliance
03/08/2023	Contact - Face to Face interviews completed with DCW Kendrell Dorrington and Resident B.
03/08/2023	Voicemail left with DCW Jennifer Gilliland.
03/09/2023	Contact - Police report received and reviewed.
03/15/2023	Exit conference held with licensee designee Amber Bunce-Hernandez.

ALLEGATION:

Resident A had access to the medication cabinet and took the wrong medications.

INVESTIGATION:

On 2/21/23, I received an incident report from the home dated 2/19/23 that was completed by the licensee designee, Amber Bunce-Hernandez. The incident report stated Resident A "helped himself to his own medications in the medication cabinet". The incident report stated staff contacted EMS due to Resident A taking his 4pm medications at 12pm. The incident reported indicated the licensee reminded staff to ensure that medication cabinet remains locked, and keys are not accessible.

On 2/22/23, I received a telephone call from Ms. Bunce-Hernandez. Ms. Bunce-Hernandez reported Resident A had access to the medication cabinet and took his 4pm medications at 12pm. Ms. Bunce-Hernandez reported Resident A was taken to the hospital to be evaluated. Ms. Bunce-Hernandez reported direct care worker (DCW) Jennifer Gilliland reported keys to the medication cabinet were placed on a hook in the main office area. Ms. Bunce-Hernandez reported this area is accessible to the residents in the home. Ms. Bunce-Hernandez reported she went to the home and addressed the issue with all staff. Ms. Bunce-Hernandez reported Ms. Gilliland will be retaking medication training. Ms. Bunce-Hernandez reported Ms. Gilliland informed her she was assisting another resident when Resident A accessed the medication cabinet. Ms. Bunce-Hernandez reported company policy indicates keys to the medication cabinet are to be kept in the staff's possession at all times.

On 2/24/23, there was an email exchange with APS worker Mike Hartman. Mr. Hartman reported he was not able to interview Resident A as he was not compliant during the interview process. Mr. Hartman reported Ms. Gilliland informed him she was in a bedroom with another resident assisting them when Resident A accessed the medication cabinet. Ms. Gilliland informed him that she saw Resident A in the medication cabinet when she walked out of the bedroom. Ms. Gilliland reported she saw Resident A putting medications in his mouth and she then contacted emergency services. Ms. Gilliland informed Mr. Hartman that the keys to the medication cabinet were on the managers desk on a hook. Ms. Gilliland informed Mr. Hartman that she knows given her experience keys are supposed to be in the staff's possession. Mr. Hartman reported there was sufficient evidence to support neglect by an AFC member as they did not ensure keys were on AFC at all times which allowed Resident A to obtain the keys and access the medication cabinet to consume medications.

On 3/3/23 and 3/8/23, I left voicemails and text messages for Ms. Gilliland.

On 3/8/23, I completed an onsite visit to the home. The medication cabinet was viewed to be locked and there were not any keys accessible to residents. Resident A was not able to be interviewed due to receiving inpatient treatment in Indiana.

On 3/8/23, I interviewed DCW Kendrell Dorrington in the home. Mr. Dorrington reported he was not working when the incident occurred. Mr. Dorrington reported Ms. Gilliland did inform him of the incident and stated she was outside cleaning the van when Resident A took the keys and accessed the medication cabinet. Mr. Dorrington reported Ms. Bunce-Hernandez had a meeting with staff to discuss the policy regarding medications. Mr. Dorrington reported it is expected for staff to always keep keys on them. Mr. Dorrington reported keys were previously placed on a hook in the main office area.

On 3/8/23, I interviewed Resident B in the home. Resident B reported Ms. Gilliland was outside cleaning the van when he witnessed Resident A access the medication cabinet. Resident B reported he saw Resident B take medications out of the cabinet and consume them. Resident B reported the medication cabinet was left open and Ms. Gilliland has left it open on multiple occasions.

On 3/9/23, I received and reviewed the police report completed by Van Buren County Sheriff's Office. The report indicates the officer was dispatched to the home due to an AFC client possibly overdosing on medication. When the officer arrived, Resident A was with the EMS workers and getting secured for transport. MS. Gilliland was interviewed and reported keys were hanging on the wall near the medication cabinet. Ms. Gilliland reported she noticed Resident A in the medication cabinet and noticed he had taken medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Interviews completed with the licensee designee along with the review of supporting documentation determined the keys to the medication cabinet were accessible to residents which resulted in Resident A unlocking the cabinet.
CONCLUSION:	**VIOLATION ESTABLISHED**

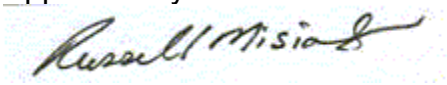
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

3/13/23

Kristy Duda Date
Licensing Consultant

Approved By:



3/20/23

Russell B. Misiak Date
Area Manager