GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 21, 2023

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

RE: License #: AS800397501
Investigation #: 2023A1031014
52nd Street 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 #:	AS800397501
Investigation #:	2023A1031014
Complaint Receipt Date:	02/15/2023
Investigation Initiation Date:	02/15/2023
Report Due Date:	04/16/2023
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:	52nd Street Home
Facility Address:	31723 52nd Street Bangor, MI 49013
Facility Telephone #:	(269) 762-2969
Original Issuance Date:	02/12/2019
License Status:	REGULAR
Effective Date:	08/12/2021
Expiration Date:	08/11/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff left residents unsupervised.	Yes
Additional Findings	No

III. METHODOLOGY

02/15/2023	Special Investigation Intake 2023A1031014
02/15/2023	Special Investigation Initiated - Telephone interview completed with LD Amber Bunce.
02/15/2023	Contact - Documents requested and received.
03/03/2023	Contact - Voicemail left with DCW Marquis Merritt.
03/03/2023	Contact - Email sent to Karmen Ball.
03/15/2023	Contact - Voicemail left with DCW Marquis Merritt.
03/15/2023	Inspection Completed On-site
03/15/2023	Contact - Face to Face Interviews completed with DCW Kedyn Smith, Resident A, and Resident B.
03/15/2023	Contact - Telephone Interview held with licensee designee Amber Bunce-Hernandez.
03/21/2023	Contact - Telephone Interview held with DCW Marquis Merritt.
03/21/2023	Inspection Completed-BCAL Sub. Compliance
03/21/2023	Exit Conference held with LD Amber Bunce-Hernandez.

ALLEGATION:

Staff left residents unsupervised.

INVESTIGATION:

On 2/15/23, I received a telephone call from licensee designee Amber Bunce-Hernandez. Ms. Bunce-Hernandez reported direct care worker (DCW) Marquis Merritt left the residents in the home unsupervised for approximately five minutes. Ms. Bunce-Hernandez reported Mr. Merritt admitted to her that he did leave the residents alone. Ms. Bunce-Hernandez reported she had a conversation with Mr. Merritt regarding his actions and that it is not acceptable to leave residents unattended.

On 2/15/23, I reviewed the *Assessment Plan for AFC Residents* for all residents in the home. Multiple residents require ongoing supervision and redirection due to their identified needs.

On 3/15/23, I interviewed DCW Keydyn Smith in the home. Mr. Smith reported he did not have any information regarding the allegations due to being a newly hired staff.

On 3/15/23, I interviewed Resident A in the home. Resident A reported Resident C knocked on his door to tell him he was going to the store with staff. Resident A reported Resident B left the home with Mr. Merritt. Resident A reported he walked outside and noticed the vehicle gone and there were no staff in the home. Resident A reported this has not happened before but he was very upset that he was left alone.

On 3/15/23, I interviewed Resident B in the home. Resident B reported he was not aware of staff leaving the home during the night because he was sleeping. Resident B reported staff never leave residents alone.

On 3/21/23, I interviewed DCW Marquis Merritt via telephone. Mr. Merritt reported Resident C was begging him to go to the store and he decided to take him. Mr. Merritt reported he took Resident C to the store that was located approximately three minutes away from the home. Mr. Merritt reported the residents were left unsupervised as he was the only staff scheduled in the home. Mr. Merritt reported Ms. Bunce-Hernandez spoke to him about his actions and that he cannot leave residents unsupervised.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Interviews with the licensee designee, staff, and residents determined there was not sufficient direct care staff on duty to ensure the supervision, personal care, and protection of all residents in the home. Residents in the home have assessment plans that identify needs for supervision and behavioral redirection. Mr. Merritt admitted to leaving multiple residents unattended in the home when he took one resident to a local store. Mr. Merritt reported he was the only staff scheduled in the home. Mr. Merritt did not ensure the supervision, personal care, and protection of the other residents in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended no change to the status of the license.

3/21/23

Kristy Duda Date
Licensing Consultant

Approved By:

3/21/23

Russell B. Misiak Date
Area Manager