GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 28, 2023

Amber Hernandez-Bunce
Cornerstone II Inc
P. O. Box 277
Bloomingdale, MI 49026

RE: License #: AS800306200
Investigation #: 2023A1031055
Cornerstone

Dear Amber Hernandez-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 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 #:	AS800306200
Investigation #:	2023A1031055
Complaint Receipt Date:	07/19/2023
Investigation Initiation Date:	07/19/2023
Report Due Date:	09/17/2023
Licensee Name:	Cornerstone II Inc
Licensee Address:	44409 Baseline Rd. Bloomingdale, MI 49026
Licensee Telephone #:	(269) 668-7070
Administrator/Licensee Designee:	Amber Hernandez-Bunce
Name of Facility:	Cornerstone
Facility Address:	22858 West M-43 Kalamazoo, MI 49009-9208
Facility Telephone #:	(269) 668-3175
Original Issuance Date:	04/07/2010
License Status:	REGULAR
Effective Date:	10/21/2022
Expiration Date:	10/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff hit Resident A on the arm.	No
Resident A fell in the shower.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/19/2023	Special Investigation Intake 2023A1031055
07/19/2023	APS Referral Received.
07/19/2023	Special Investigation Initiated - Letter Email Exchange with Mike Hartman.
07/31/2023	Inspection Completed On-site
07/31/2023	Contact - Face to Face Interview with Alexis Williams.
07/31/2023	Contact - Face to Face Interview with Resident B and Face to Face contact with Resident C and Resident D.
08/15/2023	Contact - Telephone Interview with Jaylen Johnson and Resident A.
08/15/2023	Contact - Incident Report and Hospital Discharge Paperwork Requested.
08/15/2023	Contact - Incident Report and Hospital Discharge Paperwork Requested.
08/17/2023	Contact - Telephone Interview with Amber Hernandez-Bunce.
08/22/2023	Contact - Hospital Discharge Paperwork Received.
08/22/2023	Contact - Incident Reports Requested.
08/28/2023	Exit Conference held with Amber Hernandez-Bunce.

ALLEGATION:

Staff hit Resident A on the arm.

INVESTIGATION:

On 7/19/23, there was an email exchange with adult protective services (APS) worker Mike Hartman. Mr. Hartman reported that based on his interviews, he did not find any evidence to support that Resident A was assaulted by staff and he closed the case. Resident A initially reported she was not assaulted by staff and then stated that staff pinched her arm. APS did observe a bruise on Resident A's arm, but he was informed that Resident A had recently fallen in the shower and outside where she could have injured herself.

On 7/31/23, I interviewed direct care worker (DCW) Alexis Williams in the home. Ms. Williams reported she never assaulted Resident A. Ms. Williams reported Resident A did bump into a chair and then Resident A immediately accused her of pinching her arm. Ms. Williams again denied pinching or hitting Resident A on the arm.

On 7/31/23, I interviewed Resident B in the home. Resident B reported she has never been mistreated by staff and never witnessed staff mistreat Resident B.

On 7/31/23, I was not able to interview Resident C and Resident D as they are nonverbal.

On 8/15/23, I interviewed the home manager Jalen Johnson via telephone. Mr. Johnson reported that Resident A had accused Ms. Williams of hitting her arm. Mr. Johnson reported he has never observed Ms. Williams to mistreat residents in the home. Mr. Johnson reported Resident A has a tendency to make false accusations when she is upset with staff.

On 8/15/23, I interviewed Resident A via telephone. Resident A reported Ms. Williams pinched her arm but could not remember any other details. Resident A reported there was no one else around to witness the incident.

On 8/17/23, I interviewed licensee designee Amber-Hernandez-Bunce via telephone. Ms. Hernandez-Bunce reported Ms. Williams had no history of mistreating residents in the home.

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:	There is not sufficient evidence to support that Resident A was assaulted by staff as there were no witnesses and there were conflicting reports made to APS by Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A fell in the shower.

INVESTIGATION:

On 7/31/23, I conducted an unannounced visit to the home. The two showers in the home did not have nonskid surfacing in the showers.

Ms. Williams reported she was aware that Resident A had injured her leg as she had a medical boot but was not sure where she had fallen.

Mr. Johnson reported Resident A reported she had fallen in the shower. Mr. Johnson reported Resident A did not break her leg. Mr. Johnson reported staff noticed that Resident A's ankle was swollen and took her to the hospital the following day for treatment. Mr. Johnson reported the hospital determined that Resident A had sprained her right ankle. Mr. Johnson reported Resident A received a medical boot for her ankle. Mr. Johnson reported the day after Resident A went to the hospital, she was walking in the yard and had fallen again due to stepping in a small hole. Mr. Johnson reported Resident A was taken back to the hospital for observation. Mr. Johnson reported there was no significant injuries and Resident A was sent home. Mr. Johnson reported incident reports were completed for the falls and he would submit the incident reports to licensing by 8/16/23.

Resident A reported she slipped and fell in the shower. Resident A reported she hurt her ankle because of the fall. Resident A reported she also fell in the yard when walking due to stepping in a hole. Resident A reported she received medical treatment after the incidents occurred.

Ms. Hernandez-Bunce reported Resident A did not break her leg. Ms. Hernandez-Bunce reported Resident A did fall and hurt herself and was taken to the hospital for treatment.

On 8/22/23, I reviewed Resident A's discharge summaries from the hospital. The discharge summary dated 7/10/23 read that Resident A had a sprained right ankle.

The hospital discharge summary dated 7/11/23 read that Resident A had an injury on her left ankle.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(11) Handrails and nonskid surfacing shall be installed in showers and bath areas.
ANALYSIS:	Resident A and staff reported Resident A slipped and fell in the shower. The home was observed to not have nonskid surfacing installed in both showers located in the home which could have prevented Resident A from falling in the shower and injuring herself.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/15/23 and 8/22/23, I requested the incident report for Resident A's falls and being seen at the hospital for treatment. Ms. Hernandez-Bunce reported an incident report was not completed for Resident A going to the hospital on 7/10/23 and 7/11/23. Ms. Hernandez-Bunce reported she requested for the home manager to complete an incident report for the hospitalizations. As of 8/28/23, the incident report for Resident A falling and injuring herself has not been received.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.**

ANALYSIS:	The home did not complete incident reports for Resident A when she was treated at the hospital for two falls causing injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(4) The department may review incident reports during a renewal inspection or special investigation. This does not prohibit the department from requesting an incident report if determined necessary by the department. If the department does request an incident report, the licensee shall provide the report in electronic form within 24 hours after the request. The department shall maintain and protect these documents in accordance with state and federal laws, including privacy laws.
ANALYSIS:	The incident reports that were reported to be completed by the home regarding Resident A falling and injuring herself were not provided to the department within 24 hours of the request.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/28/23, I shared the findings of this report with Ms. Hernandez-Bunce. She stated that she agreed with the findings regarding Resident A falling as there were not any nonskid strips in the showers. Ms. Hernandez-Bunce reported she agreed with the findings involving an incident report not being completed for hospitalization. Ms. Hernandez-Bunce reported staff did not complete the required incident reports. Ms. Hernandez-Bunce reported that the incident reports were not submitted to licensing within 24 hours of the request because they were not completed.

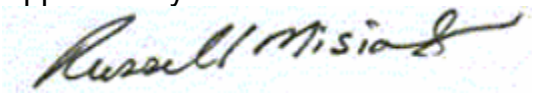
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that there be no change to the license.

8/28/23

Kristy Duda — Date
Licensing Consultant

Approved By:



8/28/23

Russell B. Misiak — Date
Area Manager