



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 8, 2025

Tracie Hernandez  
Cornerstone AFC, LLC  
P.O. Box 277  
Bloomington, MI 49026

RE: License #: AS800369570  
Investigation #: 2025A1031041  
Hamilton Home

Dear Licensee Designee:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 356-0100.

Sincerely,

A handwritten signature in blue ink that reads "KDuda".

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**

<b>License #:</b>	AS800369570
<b>Investigation #:</b>	2025A1031041
<b>Complaint Receipt Date:</b>	07/07/2025
<b>Investigation Initiation Date:</b>	07/07/2025
<b>Report Due Date:</b>	09/05/2025
<b>Licensee Name:</b>	Cornerstone AFC, LLC
<b>Licensee Address:</b>	P.O. Box 277 Bloomingtondale, MI 49026
<b>Licensee Telephone #:</b>	(269) 628-2100
<b>Administrator/Licensee Designee:</b>	Amber Hernandez-Bunce
<b>Name of Facility:</b>	Hamilton Home
<b>Facility Address:</b>	518 Hamilton Street Bangor, MI 49013
<b>Facility Telephone #:</b>	(269) 427-6023
<b>Original Issuance Date:</b>	04/14/2015
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/14/2023
<b>Expiration Date:</b>	10/13/2025
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Steve Girard burned Resident A with a fork.	Yes

**III. METHODOLOGY**

07/07/2025	Special Investigation Intake 2025A1031041
07/07/2025	Special Investigation Initiated - Letter
07/11/2025	Inspection Completed On-site
07/11/2025	Contact - Face to Face Interview with Resident A and Danielle Mitchell.
07/11/2025	Contact - Telephone Interview with Lindsey Taylor.
07/11/2025	Contact - Voicemail left with Steve Girard.
08/04/2025	Contact - Document Sent Police Report Requested.
08/05/2025	Contact - Voicemail left with Steve Girard.
08/06/2025	Contact – Email exchange with Lindsey Taylor.
09/08/2025	Exit Conference held with Amber Hernandez-Bunce.

**ALLEGATION:**

**Steve Girard burned Resident A with a fork.**

**INVESTIGATION:**

On 7/7/25, I received an email from licensee designee Amber Hernandez-Bunce containing an incident report regarding a staff member burning Resident A with a fork. Ms. Hernandez-Bunce reported the staff was immediately removed from the facility pending investigation.

On 7/7/25, I reviewed the incident report dated 7/4/25. The incident report read that Resident A informed the manager that staff put a fork in boiling water then pressed it

on his chest and left a mark. The crisis line was contacted along with the police, adult protective services, and recipient rights.

On 7/11/25, I conducted an unannounced visit to the facility and interviewed Resident A. Resident A had a large fork-shaped raised burn that was scabbed over in the middle of his chest. Resident A reported direct care worker (DCW) Steve Girard thought it would be funny to burn him. Resident A reported Mr. Girard was boiling hotdogs and put a fork in the boiling water and then placed the fork on his chest. Resident A reported he was shocked that this occurred and did not think Mr. Girard would actually burn him. Resident A reported he was taken to the hospital for treatment. Resident A reported there were no witnesses as it was only him and Mr. Girard in the kitchen.

On 7/11/25, I interviewed the facility manager Danielle Mitchell at the facility. Ms. Mitchell reported Resident A approached her when she arrived at the facility and informed her that Mr. Girard had burned him with a fork on his chest. Ms. Mitchell reported Resident A received medical treatment and it was determined that he had second and third degree burns on his chest where the fork was placed. Ms. Mitchell reported Resident A does not have any history involving self-harming behaviors and believes staff did harm Resident A.

On 7/11/25, I attempted to interview Resident B but he did not want to engage in the interview process.

On 7/11/25, I interviewed adult protective services worker Lindsey Taylor via telephone. Ms. Taylor reported she interviewed Resident A and he reported Mr. Girard put the fork in boiling water while making hotdogs and then placed the fork on his chest. Ms. Taylor reported she observed a large fork-shaped burn on Resident A's chest when she interviewed him. Ms. Taylor reported the placement of the fork mark did not look self-inflicted due to the positioning of the mark and the location of the mark on Resident A's chest. Ms. Taylor reported she will be substantiating Mr. Girard for abuse.

On 7/11/25 and 8/5/25, I left a voicemail with Mr. Girard. As of 8/6/25, I have not received a return telephone call.

On 8/6/25, I exchanged emails with Ms. Taylor. Ms. Taylor reported she received the police report on 8/6/25 from the Bangor Police Department and provided the report. Ms. Taylor reported again that she is substantiating Mr. Girard for abuse.

On 8/6/25, I reviewed the police report regarding the incident. Resident A reported he was burned with a fork by Mr. Girard during the first interview. Resident A was interviewed again and stated he burned himself but stated this because he did not want to get Mr. Girard in trouble. Mr. Girard was interviewed and denied the allegations. Mr. Girard reported that Resident A burned himself with the fork unintentionally by grabbing a hotdog out of the pot of water and then wiping the fork

on himself forgetting that he did not have a shirt on. Resident B was interviewed and reported he did not see the incident occur as he was upstairs but did hear Resident A scream and say ouch. There were no other witnesses to the incident. The report was sent to the prosecutor's office for charges and was denied due to the lack of evidence to prosecute.

On 8/7/25, I requested and received Mr. Girard's training verification for recipient rights and behavioral intervention. Mr. Girard successfully completed both training courses in January 2025.

On 8/20/25, I conducted a workforce background clearance check for Mr. Girard and he was determined to be an eligible employee on 1/16/25.

On 8/20/25, I requested and received Resident A's *Assessment for AFC Residents and Individual Plan of Service (IPOS)*. Resident A's IPOS and AFC Assessment read Resident A requires monitoring, supervision and prompts to assist with daily living skills such as completing chores, cleaning his bedroom, and maintaining his daily hygiene. Resident A also requires supervision in the community due to previously engaging in risky behaviors.

<b>APPLICABLE RULE</b>	
<b>R 400.14308</b>	<b>Resident behavior interventions prohibitions.</b>
	<b>(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.</b>
<b>ANALYSIS:</b>	There was enough evidence found to support that Mr. Girard mistreated Resident A by either burning him with a fork or ineffectively supervising him. Resident A was consistent with his allegations when interviewed by APS, police, staff, and licensing. Resident A did say at one point that he burned himself, but then stated he was afraid to get Mr. Girard in trouble. Resident A was observed to have a significant burn mark on his upper chest area. APS substantiated Mr. Girard for abuse as a result of their investigation. The placement of the mark was on Resident A's upper chest with the prongs facing downwards towards his stomach, which would have been difficult for him to do to himself.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

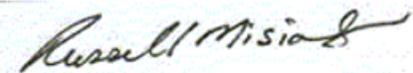


8/5/25

Kristy Duda  
Licensing Consultant

Date

Approved By:



8/20/25

Russell B. Misiak  
Area Manager

Date