GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 21, 2026

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

RE: License #: AS800413641
Investigation #: 2026A1031013
North Lake 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,

KDuda

Kristy Duda, 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 #:	AS800413641
Investigation #:	2026A1031013
Complaint Receipt Date:	11/19/2025
Investigation Initiation Date:	11/19/2025
Report Due Date:	01/18/2026
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277 Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2100
Licensee Designee/Administrator:	Amber Hernandez-Bunce
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:	REGULAR
Effective Date:	07/31/2025
Expiration Date:	07/30/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff left the facility and left residents unattended.	Yes

III. METHODOLOGY

11/19/2025	Special Investigation Intake 2026A1031013
11/19/2025	Special Investigation Initiated - Letter Email exchange with Candice Kinzler.
11/19/2025	Contact – Document Received.
11/26/2025	Contact - Document Received Assessment Plans and Individual Plan of Service.
12/01/2025	APS Referral
12/04/2025	Contact - Telephone call made Voicemail left with Mikayla Huitt.
12/15/2025	Contact - Telephone call made Voicemail left with Mikayla Huitt.
12/16/2025	Inspection Completed On-site
12/16/2025	Contact - Face to Face Interview with Resident A, Resident B, and Autumn Fletcher.
12/16/2025	Exit Conference held with Amber Hernandez-Bunce.
12/17/2025	Contact - Document Received Employment Termination.
12/17/2025	Contact - Document Received Email Exchange with Candice Kinzler.

ALLEGATION:

Staff left the facility and left residents unattended.

INVESTIGATION:

On 11/19/25, I received an email from Van Buren County recipient rights director Candice Kinzler that contained an incident report that was submitted by the facility. I reviewed the incident report dated 11/17/25 and it read that the facility manager received a call from Resident A stating that direct care worker (DCW) Mikayla Huitt was not at the facility working. The facility manager contacted Ms. Huitt via telephone and was asked if she was at the facility as Resident A reported she was not at the facility. Ms. Huitt reported she was at the facility but was sitting in her car as she had an emergency phone call due to her home not having power. The facility manager then went to the facility and saw Ms. Huitt working in the facility. The facility manager had a conversation with Ms. Huitt and then left the facility. A few hours later, the facility manager received another call from Resident A and Resident B stating that Ms. Huitt was not in the facility and her car was gone. The facility manager arrived early for their shift and Ms. Huitt was in the facility working when she arrived.

On 11/19/25, I received documentation that outlined an internal investigation into the incident completed by the licensee designee/human resources staff. The document read that on 11/16/25 at approximately 9pm, two residents witnessed Ms. Huitt getting into her car and driving off and returning approximately 15 to 30 minutes later. Resident A reported that Ms. Huitt was arguing with an individual on the telephone about her electricity being turned off. Ms. Huitt later knocked on Resident A's door and told him she was going to her car to make an emergency phone call. Ms. Huitt then walked outside and Resident B heard a car engine start and then pull out of the driveway. Ms. Huitt returned to the house and worked the remainder of her shift. Ms. Huitt was interviewed on 11/17/25 regarding the incident. Ms. Huitt reported she went to her car to make a call because she did not want any distractions. Ms. Huitt reported she moved her car because her car was very loud and she did not want to distract the residents. Ms. Huitt reported she was on the phone in her car for about 10 to 15 minutes and continued to report that she worked her entire shift and never left the facility. Ms. Huitt reported a couple hours later her boyfriend contacted her asking to borrow her car. Ms. Huitt’s mom then dropped her boyfriend off at the facility and he took her car.

On 11/26/25, I requested and received Resident A and Resident B’s individual plan of service (IPOS). Resident A’s IPOS read that he requires at least a 3:1 resident to staff ratio while in the facility for supervision and staff are to always be aware of his whereabouts. Resident B’s IPOS read that he requires 24/7 supervision for his health and safety.

On 12/4/25 and 12/15/25, I left a voicemail with Ms. Huitt requesting a return telephone call to discuss the allegations. As of 1/15/26, I have not yet received a return telephone call.

On 12/16/25, I conducted an unannounced visit to the facility and interviewed the facility manager Autumn Fletcher, Resident A, and Resident B.

Ms. Fletcher reported when she arrived at the facility Ms. Huitt was working and denied leaving the facility. Ms. Fletcher reported Ms. Huitt reported that she was taking an emergency telephone call in her car because she did not want the residents to overhear her conversation. Ms. Flether reported that both Resident A and Resident B were consistent in reporting that Ms. Huitt left the facility in her car and was not working. Ms. Fletcher reported when she left her shift last night, Ms. Huitt relieved her and she observed her car parked on the right side of the parking lot. Ms. Fletcher reported when she arrived back at the facility in the morning, Ms. Huitt's car was parked on the left side of the parking lot, which she thought was odd since she reported she did not leave the facility.

Resident A and Resident B were interviewed separately and were both consistent in reporting they saw Ms. Huitt leave the facility in her car during the night shift. They both reported she was gone for approximately 15 to 30 minutes. They reported Ms. Huitt was on a telephone call and seemed to be very upset about something. Resident A reported Ms. Huitt parked her car on the side of the parking lot when she returned and continued to talk on the telephone in her car. Resident A reported staff are not supposed to leave them alone, so he contacted the crisis line to inform them that there was no staff.

On 12/16/25, I conducted an in-person exit conference with licensee designee Amber Hernandez-Bunce. Ms. Hernandez-Bunce was informed of the allegations and was in agreeance with the findings. Ms. Hernandez-Bunce reported she has tried to reach out to Ms. Huitt and requested that she contact licensing to complete the interview process. Ms. Hernandez-Bunce reported she or her staff have not heard from Ms. Huitt since the alleged incident occurred. Ms. Hernandez-Bunce reported she will be terminating Ms. Huitt's employment.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	There was enough evidence found to support that Ms. Huitt did not meet the needs of the residents in accordance with their individual plan of service. Resident A and Resident B were both

	consistent in reporting that Ms. Huitt left the facility and Ms. Huitt reported in a separate interview that she was sitting in her car. Ms. Huitt failed to provide appropriate supervision for the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

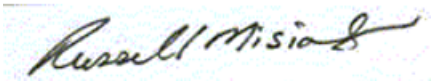
IV. RECOMMENDATION

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

1/15/26

Kristy Duda — Date
Licensing Consultant

Approved By:



1/21/26

Russell B. Misiak — Date
Area Manager