



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 4, 2026

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

RE: License #: AS030369569
Investigation #: 2026A0583021
Grand Street

Dear Ms. 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 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) 356-0100.

Sincerely,

A handwritten signature in cursive script, appearing to read "Toya Zylstra".

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AS030369569
Investigation #:	2026A0583021
Complaint Receipt Date:	02/18/2026
Investigation Initiation Date:	02/18/2026
Report Due Date:	03/20/2026
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277 Bloomingtondale, MI 49026
Licensee Telephone #:	(269) 628-2100
Administrator:	Tracie Hernandez
Licensee Designee:	Tracie Hernandez
Name of Facility:	Grand Street
Facility Address:	630 Grand Street Allegan, MI 49010
Facility Telephone #:	(269) 762-2969
Original Issuance Date:	02/10/2015
License Status:	REGULAR
Effective Date:	08/10/2025
Expiration Date:	08/09/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff document the administration of Resident A’s Quetiapine despite Resident A refusing it.	No
Additional Findings	Yes

III. METHODOLOGY

02/18/2026	Special Investigation Intake 2026A0583021
02/18/2026	Special Investigation Initiated - On Site
02/19/2026	APS Referral
03/03/2026	Exit Conference Licensee designee Amber Bunce

ALLEGATION: Staff document the administration of Resident A’s Quetiapine despite Resident A refusing it.

INVESTIGATION: On 02/18/2026 complaint allegations were received from the LARA-BCHS-online system. The complaint alleged the following, “a female that works on 3rd shift offers (Resident A) the medication, he throws it out instead of staff disposing of it properly, and then she documents it as a medication pass”.

On 02/18/2026 I completed an unannounced onsite investigation at the facility and interviewed staff Cody Cooley and Resident A. Mr. Cooley stated that he was not aware of the allegations and had no direct information to provide. He stated that he doesn’t know how to generate Resident A’s monthly Medication Administration Record. He acknowledged that Resident A has a history of refusing to take his prescribed medication.

Resident A stated he has a history of refusing his medications but is currently taking all his medications as prescribed. He stated that he didn’t know the names of each medication he is prescribed and could not identify what the medications look like. He stated that he ingests all the medication provided to him by staff and has no concerns to report. He denied throwing medication away.

On 02/19/2026 I completed an Adult Protective Services complaint via the online portal.

On 02/23/2026 I interviewed staff Eric Pirrone via telephone and he identified himself as the “house manager”. He stated that Resident A has a history of refusing his medications. He stated that Resident A started refusing the administration of his “Seroquel” AKA Quetiapine and this information was reported to Resident A’s case

manager. Mr. Pirrone stated that Resident A recently reported that staff Mondrea Simms has been providing Resident A with the medication, but Resident A throws the medication away without ingesting it and Ms. Simms documents the administration in Resident A's MAR. He stated that he asked Ms. Simms if she documented the administration of Resident A's Quetiapine despite Resident A not ingesting the medication and she stated that Resident A takes the medication as prescribed or she will document the refusal in his MAR.

On 02/23/2026 I received an email from Care Coordinator Jalina Clark that contained Resident A's MAR from 12/01/2026 until 02/23/2026. On 01/22/2026 Ms. Simms documented that Resident A refused his Quetiapine 300 MG.

On 02/26/2026 I interviewed Ms. Simms via telephone. She stated that she always watches Resident A ingest his Quetiapine and documents the administration in Resident A's MAR. She stated that he does have a history of refusing his medications, but she documents the refusals in his MAR. She stated that the allegation is false.

On 03/03/2026 I completed an exit conference via telephone with licensee designee Amber Bunce. She stated that she agreed with the findings.

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(b) Complete an individual medication log that contains all of the following:</p> <ul style="list-style-type: none"> (i) Medication name. (ii) Dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) Initials of the individual who administered the medication at the time given. (vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.
ANALYSIS:	<p>Resident A stated he has a history of refusing his medications but is currently taking all his medications as prescribed. He stated that he doesn't know the names of each medication he is prescribed and cannot identify what the medications look like. He stated that he ingests all the medication provided to him by staff and has no concerns to report.</p> <p>Ms. Simms stated that she always watches Resident A ingest</p>

	<p>his Quetiapine and documents the administration in Resident A's MAR. She stated that he does have a history of refusing his medications, but she documents the refusals in his MAR.</p> <p>Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has not been established that Ms. Simms documents the administration of Resident A's Quetiapine 300 MG despite Resident A not ingesting said medication.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Staff fail to contact a medical professional after Resident A refuses the administration of his prescribed medication.

INVESTIGATION: While onsite on 02/18/2026 Mr. Cooley stated Resident A often refuses his medications. Mr. Cooley stated that he has never contacted an appropriately licensed health care provider to discuss and document their instructions. He stated that he was not trained to do so.

On 02/23/2026 I received an email from Ms. Clark that contained Resident A's MAR from 12/01/2025 until 02/23/2026. On 01/22/2026 Ms. Simms documented that Resident A refused his Quetiapine 300 MG. On 01/23/2026 Mr. Pirrone documented that Resident A refused his Quetiapine 300 MG. On 01/28/2026 Mr. Cooley documented that Resident A refused his Quetiapine 300 MG. There was no documentation in Resident A's MAR regarding staff contacting a medical professional for Resident A's medication refusals.

On 02/26/2026 I interviewed Ms. Simms via telephone. She stated that she has never been trained to contact an appropriate health care provider after a resident refuses their prescribed medications. She stated that she has never contacted a health care provider after a resident has refused medication.

On 02/27/2026 I interviewed Mr. Pirrone via telephone. He stated that Resident A often refuses his medications and he has never contacted a medical professional to discuss and document their instructions. He stated that he was unaware that AFC licensing rules require staff to do so.

On 03/03/2026 I completed an exit conference via telephone with licensee designee Amber Bunce. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.675	Resident medications.

