



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 20, 2026

Amber Bunce
Cornerstone AFC, LLC
P.O. Box 277
Bloomington, MI 49026

RE: License #: AS030369569
Investigation #: 2026A0583024
Grand Street

Dear Ms. 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 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 #:	2026A0583024
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:	Amber Bunce
Licensee Designee:	Amber Bunce
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?
Resident A's Lorazepam tablets are unaccounted for.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/18/2026	Special Investigation Intake 2026A0583024
02/18/2026	Special Investigation Initiated - On Site
02/19/2026	APS Referral
03/20/2026	Exit Conference Administrator Hillary Mahone

ALLEGATION: Resident A's Lorazepam tablets are unaccounted for.

INVESTIGATION: On 02/18/2026 I received the above complaint allegation, which alleged that multiple tablets of Resident A's Lorazepam were unaccounted for.

On 02/18/2026 I completed an unannounced onsite investigation at the facility and interviewed Mr. Cooley. Mr. Cooley stated that Resident A is prescribed one tablet of Lorazepam .5MG once daily as needed. Mr. Cooley stated that today he was informed from staff Justin Bunch, that Resident A's Lorazepam "count was off". Mr. Cooley explained that staff are required to document the number of Resident A's Lorazepam tablets on the "narc sheet" after every administered dose and document the administration in Resident A's MAR. Mr. Cooley stated that Resident A currently has nine Lorazepam tablets. Mr. Cooley stated that Resident A's "narc sheet" states that on 02/09/2026 Resident A had 15 tablets remaining and on 02/18/2026 Resident A had 9 tablets remaining. Mr. Cooley stated that he has no knowledge of staff members stealing this medication and he administers the medication as prescribed. Mr. Cooley stated he does not know how to open Resident A's MAR in the monthly view form for my review.

While onsite I observed Resident A's blister package of Lorazepam .05 MG. The package indicates Resident A is prescribed Lorazepam .05 Mg tablet once daily as needed MAX four dosages per week. The package contained nine tablets. I observed Resident A's Hometown Pharmacy Disposition of Remaining Doses sheet AKA Narcotics count sheet. The document contained Lorazepam administering counts from 12/07/2025 until 02/18/2026. I observed that the document indicated that on 02/09/2026 Resident A had 15 tablets remaining and on 02/18/2026 Resident A had 9 tablets remaining. I observed that Resident A received one tablet

of said medication on the following dates: 12/7, 12/8, 12/10, 12/14, 12/19, 12/20, 12/27, 12/28, 1/3, 1/4, 1/9, 1/10, 1/25, 2/7, 2/9, and 2/18.

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

On 02/23/2026 I interviewed staff Eric Pirrone (House Manager) via telephone. He stated that Resident A's Lorazepam has been accounted for. He explained that staff were documenting the administration of Resident A's Lorazepam in Resident A's MAR and not updating Resident A's "narc sheet". He stated that all Resident A's Lorazepam has been accounted for and staff have been retrained to document the administration in Resident A's MAR and on the "narc sheet".

On 02/23/2026 I interviewed Resident A via telephone. He confirmed that he is prescribed Lorazepam as needed. He stated he is unaware of his Lorazepam missing.

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. Resident A's MAR confirmed that Resident A is prescribed Lorazepam .5 MG tablet "Take 1 tablet by mouth Once Daily as Needed (max Four Doses Per Week)". Resident A's' MAR indicated Resident A was administered Lorazepam .5 MG on 12/20/2025, 12/24/2025, 12/25/2025, 12/26/2025, and 01/10/2026.

On 03/19/2026 I received an email from licensee designee Amber Bunce. The email stated the following: *"My initial response was based on a conversation with our regional director, who had already connected with the location. However, I wasn't fully confident in that answer and asked for a deeper review of the medications on hand. I had Kendrell conduct a detailed audit covering the period from December 2nd through February, and he identified six Ativan 0.5 mg doses that are still unaccounted for.*

To clarify, the substantiation of missing medications is accurate. After your visit and identification of potential missing narcotics, we initiated an internal investigation and contacted the appropriate authorities. During that process, we confirmed that there are six missing doses, and our findings continue to reflect those same six missing narcotics."

On 03/20/2026 I completed an exit conference via telephone with administrator Hillary Mahone. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.675	Resident medications.

	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	<p>I observed Resident A's blister package of Lorazepam .05 MG. The package indicates Resident A is prescribed Lorazepam .05 Mg tablet once daily as needed MAX four dosages per week. I observed the package contained nine tablets.</p> <p>I observed Resident A's Hometown Pharmacy Disposition of Remaining Doses sheet AKA Narcotics count sheet. I observed that the document contained Lorazepam administering counts from 12/07/2025 until 02/18/2026. The document indicated that on 02/09/2026 Resident A had 15 tablets remaining and on 02/18/2026 Resident A had 9 tablets remaining, leaving six tablets unaccounted for.</p> <p>Resident A's MAR confirmed that Resident A is prescribed Lorazepam .5MG tablet "Take 1 tablet by mouth Once Daily as Needed (max Four Doses Per Week)". Resident A's MAR indicated Resident A was administered Lorazepam .5 MG on 12/20/2025, 12/24/2025, 12/25/2025, 12/26/2025, and 01/10/2026.</p> <p>Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that Resident A's Lorazepam tablets are unaccounted for.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS: Staff did not administer Resident A's Lorazepam as prescribed.

INVESTIGATION: While onsite I observed Resident A's blister package of Lorazepam .05 MG. I observed the package indicates Resident A is prescribed Lorazepam .05 Mg tablet once daily as needed MAX four dosages per week. I observed Resident A's Hometown Pharmacy Disposition of Remaining Doses sheet indicates Resident A received one tablet of Lorazepam .5 MG on 12/24/2025, 12/25/2025, and 12/26/2025.

On 02/23/2026 I interviewed Resident A via telephone. He confirmed that he is prescribed Lorazepam as needed. He stated he was concerned that staff were administering his PRN Lorazepam too often. He explained that he is prescribed a maximum of four doses of Lorazepam in seven days however staff had administered

the medication more than prescribed. He stated that he could not recall the dates of the administration.

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. I observed that Resident A's MAR confirmed that Resident A is prescribed Lorazepam .5 MG tablet "Take 1 tablet by mouth Once Daily as Needed (max Four Doses Per Week)". Resident A's MAR indicated Resident A was administered Lorazepam .5 MG on 12/27/2025 and 12/28/2025.

On 03/20/2026 I completed an exit conference via telephone with administrator Hillary Mahone. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	<p>Resident A's MAR from 12/01/2026 until 02/23/2026 indicates that Resident A is prescribed Lorazepam .5 MG tablet "Take 1 tablet by mouth Once Daily as Needed (max Four Doses Per Week)". I observed that Resident A's MAR indicated Resident A was administered Lorazepam .5MG on 12/27/2025 and 12/28/2025.</p> <p>Resident A's Hometown Pharmacy Disposition of Remaining Doses sheet AKA Narcotics count sheet indicated that Resident A was administered one tablet of Lorazepam .5 MG on 12/24/2025, 12/25/2025, and 12/26/2025.</p> <p>Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, staff did not administer Resident A's Lorazepam .5 MG as prescribed. Staff administered 5 doses of said medication within a week.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

Toya Zylstra

03/20/2026

Toya Zylstra
Licensing Consultant

Date

Approved By:

Jerry Hendrick

03/20/2026

Jerry Hendrick
Area Manager

Date