



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 14, 2026

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

RE: License #: AS120281503
Investigation #: 2026A1032015
Cornerstone AFC

Dear Amber 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, as well as time frames for completion and implementation.
- 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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AS120281503
Investigation #:	2026A1032015
Complaint Receipt Date:	02/20/2026
Investigation Initiation Date:	02/20/2026
Report Due Date:	04/21/2026
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277, Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2100
Administrator:	Hillary Malone
Licensee Designee:	Amber Bunce
Name of Facility:	Cornerstone AFC
Facility Address:	633 N. Fall River, Coldwater, MI 49036
Facility Telephone #:	(517) 278-7887
Original Issuance Date:	03/08/2006
License Status:	REGULAR
Effective Date:	10/01/2024
Expiration Date:	09/30/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was allowed access to marijuana despite a behavior treatment plan prohibition.	Yes
The facility did not make proper provisions for medications during a brief offsite stay.	No

III. METHODOLOGY

02/20/2026	Special Investigation Intake 2026A1032015
02/20/2026	Special Investigation Initiated - Telephone
03/16/2026	Inspection Completed On-site
03/17/2026	Contact - Telephone call received Interview with Paige Hecox
04/10/2026	Contact - Telephone call made Interview with Resident A
04/10/2026	Contact - Telephone call made Interview with licensee designee Amber Bunce
4/14/2026	Contact - Telephone call made Interview with employee Brie Hecox
04/14/2026	Exit Conference

ALLEGATION:

Resident A was allowed access to marijuana despite a behavior treatment plan prohibition.

INVESTIGATION:

On 2/20/26, I spoke with Lenawee Community Mental Health Authority (LCMHA) supervisor Jearald Dudley, by telephone. Mr. Dudley stated that he was aware that Resident A had in fact obtained marijuana in contravention of her behavior treatment plan.

On 3/16/26, I interviewed Home Manager Melissa Hill in the facility. Ms. Hill stated that Resident A had retrieved a marijuana pen from employee Paige Hecox’s bag. Ms. Hill stated that Ms. Hecox had forgotten that the pen was in her bag. Ms. Hill stated that once it was discovered that the pen was missing, Ms. Hecox told Resident A that she would contact the police if she did not return the pen.

I was unable to interview Resident A because she was in a behavioral unit at a nearby hospital.

On 3/17/26, I interviewed employee Paige Hecox by telephone. Ms. Hecox stated that during third shift, Resident A got into her personal bag and retrieved a marijuana pen, informally referred to as a dab pen. Ms. Hecox stated that she had forgotten that it was in her bag.

On 4/10/26, I interviewed Resident A by telephone. Resident A reported that employee Paige Hecox told her that there was a marijuana pen in her belongings, so she was able to retrieve it from Ms. Hecox’s bag.

APPLICABLE RULE	
R 400.629	Direct care staff; qualifications and training.
	(1) Direct care staff shall be at least 18 years of age and able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents.
ANALYSIS:	While there may have been conflicting reports of how Resident A obtained the marijuana, Resident A was able to obtain it. If in fact Ms. Hecox told Resident A where to find it, it means that Ms. Hecox did not follow written or oral instructions for resident supervision.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The facility did not make proper provisions for medications during a brief off-site stay.

INVESTIGATION:

On 4/10/26, I interviewed licensee designee Amber Bunce regarding the new complaint about medications being improperly secured and Resident A not receiving hers. Ms. Bunce denied having any report that medications were not locked or that not all medications were taken from the home during a brief stay at a hotel.

On 4/10/26, Resident A denied that there were any issues with her receiving her medication while the residents were temporarily housed at a hotel. Resident A stated that the medications were in a drawer in a separate room with the staff and that the residents were staying in an adjoining bedroom.

On 4/14/26, I interviewed employee Brie Hecox. Ms. Hecox denied that during their stay at a hotel, the room with the medications was left unattended. Ms. Hecox stated that the medications were in a drawer and that the narcotics were in a locked box.

APPLICABLE RULE	
R 400.675	Resident medications.
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	There was no indication that residents were able to gain access to unsecured medication. Both Ms. Bunce and Ms. Hecox denied that the medications were left unattended. Resident A also denied not having her medications administered. Provisions appeared to have been made to secure the narcotics and the room was supervised.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

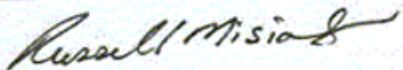


4/14/26

Dwight Forde
Licensing Consultant

Date

Approved By:



4/16/26

Russell B. Misiak
Area Manager

Date