



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2026

Karmen Ball
Cornerstone II Inc
P. O. Box 277, Bloomingdale, MI 49026

RE: License #: AS800309333
Investigation #: 2026A1032020
Cornerstone House

Dear Karmen Ball:

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 and 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. 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,

Dwight Forde, 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 #:	AS800309333
Investigation #:	2026A1032020
Complaint Receipt Date:	03/02/2026
Investigation Initiation Date:	03/02/2026
Report Due Date:	05/01/2026
Licensee Name:	Cornerstone II Inc
Licensee Address:	44409 Baseline Rd., Bloomingdale, MI 49026
Licensee Telephone #:	(269) 668-7070
Administrator:	Karmen Ball
Licensee Designee:	Karmen Ball
Name of Facility:	Cornerstone House
Facility Address:	22722 M-43, Kalamazoo, MI 49009
Facility Telephone #:	(269) 668-7419
Original Issuance Date:	10/11/2010
License Status:	REGULAR
Effective Date:	04/23/2025
Expiration Date:	04/22/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
An employee did not assist a resident with personal care.	Yes
Employees cursed at a resident.	Yes

III. METHODOLOGY

03/02/2026	Special Investigation Intake 2026A1032020
03/02/2026	Special Investigation Initiated - Telephone
03/20/2026	Inspection Completed On-site Interview with Resident A and Home Manager Princess Clopton
03/27/2026	Contact - Document Received I reviewed copies of Resident B's Assessment Plan and IPOS
04/06/2026	Contact - Telephone call made Interview with Resident B
04/08/2026	Contact - Document Received I reviewed notes of an intervnal Cornerstone Investigation.
04/17/2026	Exit Conference

ALLEGATION:

An employee did not assist a resident with personal care.

INVESTIGATION:

On 3/2/26, I spoke with licensee designee Karmen Ball regarding the status of the employees and the residents. I was advised that the employees in question no longer work for Cornerstone.

On 3/20/26, I interviewed Home Manager Princess Clopton in the facility. Ms. Clopton advised that Resident A was unavailable for an interview since she was off grounds.

Ms. Clopton provided a copy of a document detailing personal care services provided to Resident A. The document reflects assistance with toileting and personal care.

On 3/27/26, I reviewed Resident A's Individual Plan of Service and AFC Assessment Plan. The assessment plan indicates the need for assistance with toileting.

On 4/6/26 I interviewed Resident A by telephone. Resident A stated that she does recall a time recently when she had soiled herself, and former employee Alexis Williams declined to assist her with changing her garments. She advised that this happened in the early morning. Resident A stated that if she needs assistance, she typically calls out for aid.

On 4/8/26, I received an email from licensee designee Karmen Ball, with notes from an internal investigation conducted by Cornerstone. The notes indicate that another employee had witnessed Resident A remaining in soiled clothing for shift change from midnights to morning.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident A's interview, as well as notes from an internal investigation conducted by the licensee were taken into account. Resident A reported that she was left in soiled clothing, and the investigation revealed that there was a staff witness. Resident A's assessment plan calls for assistance with personal care and toileting. This was not done according to the assessment plan, resulting in a violation.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Employees cursed at a resident.

INVESTIGATION:

On 3/20/26, I interviewed Resident B in the facility. Resident B stated that she got into a verbal altercation with former employee Alexis Williams, where Ms. Williams hurled invectives toward her. Resident A was unsure what triggered the argument.

On 3/20/26, Ms. Clopton stated that she was new to the facility and unable to provide any insight into Ms. Williams cursing at or arguing with Resident B.

On 4/8/26, an email from licensee designee Karmen Ball about an internal investigation conducted by Cornerstone included notes that another employee had witnessed Resident B being cursed at by Alexis Williams, who was subsequently let go by the facility.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	I interviewed Resident B, who stated that she was cursed by an employee. I matched this statement with notes from an internal investigation conducted by the licensee, where another employee witnessed the event. Therefore, a violation was established.
CONCLUSION:	VIOLATION ESTABLISHED

On 4/17/26, licensee designee Karmen Ball committed to furnishing the department with an acceptable corrective action plan during an exit conference.

IV. RECOMMENDATION

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

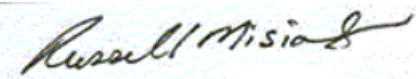


4/17/26

Dwight Forde
Licensing Consultant

Date

Approved By:



4/17/26

Russell B. Misiak
Area Manager

Date