



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 10, 2026

Amber Hernandez-Bunce
Cornerstone I, Inc.
P.O. Box 277
Bloomington, MI 49026

RE: License #: AM800267076
Investigation #: 2026A1031020
Cornerstone AFC

Dear Ms. Hernandez-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.
- 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,

A handwritten signature in blue ink that reads "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 #:	AM800267076
Investigation #:	2026A1031020
Complaint Receipt Date:	05/12/2026
Investigation Initiation Date:	05/12/2026
Report Due Date:	07/11/2026
Licensee Name:	Cornerstone I, Inc.
Licensee Address:	98 45th St Bloomingtondale, MI 49026
Licensee Telephone #:	(269) 521-4130
Administrator:	Hillary Mahone
Licensee Designee:	Amber Hernandez-Bunce
Name of Facility:	Cornerstone AFC
Facility Address:	59859 W M-43 Bangor, MI 49013
Facility Telephone #:	(269) 427-8096
Original Issuance Date:	11/01/2004
License Status:	REGULAR
Effective Date:	08/31/2025
Expiration Date:	08/30/2027
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was assaulted by staff.	Yes

III. METHODOLOGY

05/12/2026	Special Investigation Intake 2026A1031020
05/12/2026	Special Investigation Initiated - Letter Email received from administrator.
05/12/2026	APS Referral
05/15/2026	Inspection Completed On-site
05/15/2026	Contact - Face to Face Interview with Resident A and Jaron Burton.
05/15/2026	Contact - Telephone call made to Joanne Burchett.
05/27/2026	Contact - Document Received Police Report
05/27/2026	Contact - Telephone call made Lindsay Taylor.
06/08/2026	Contact - Telephone call made to Joanne Burchett.
06/10/2026	Exit Conference held with Amber Hernandez-Bunce.

ALLEGATION:

Resident A was assaulted by staff.

INVESTIGATION:

On 5/12/26, I received an incident report from the facility administrator Hillary Mahone via email. The incident reported dated 5/11/26, read that Resident A got into an altercation with direct care worker (DCW) Joanne Burchett in the backyard. Another staff, Jaron Burton, separated Resident A and Ms. Burchett. Ms. Burchett then called the police and they came out to investigate and Resident A was

subsequently arrested. Ms. Burchett was then terminated from employment at the facility immediately.

On 5/15/26, I conducted an unannounced visit to the facility and interviewed the facility manager Mr. Burton and Resident A.

Mr. Burton reported his shift had ended and he was getting his personal belongings together to go home. Mr. Burton reported Resident A was not having a good day and did refuse his medications earlier in the day. Mr. Burton reported Resident A was upset and went outside to calm down. Mr. Burton then heard arguing and went to check what was happening. Mr. Burton saw Ms. Burchett grab Resident A by his jacket and calling him inappropriate names. Resident A then grabbed Ms. Burchett by the throat. Mr. Burton reported Resident A was acting appropriately prior to this situation as he knew he was upset and needed to be alone to calm down by walking outside alone. Mr. Burton reported Ms. Burchett continued to make comments towards Resident A and even threatened to have her son come after him. Ms. Burchett then called the police, and Resident A was arrested due to Ms. Burchett having a small mark on her neck where Resident A had grabbed her. Mr. Burton reported he tried to encourage Ms. Burchett not to contact the police as she instigated Resident A, which ultimately resulted in him becoming more upset and grabbing her although she grabbed him first. Mr. Burton reported he fired Ms. Burchett immediately as her actions were inappropriate towards Resident A as she was physically and verbally aggressive towards him. Mr. Burton reported Ms. Burchett never acted this way towards residents previously and he never had concerns regarding her ability to provide appropriate care.

Resident A reported he was not having a good day and he thinks Ms. Burchett was not having a good day either. Resident A reported he was upset earlier in the day and refused his medications. He went to his bedroom to have time alone and then went outside to take a walk in the yard. Ms. Burchett started yelling at him and calling him names, which made him more upset. Ms. Burchett then came outside and approached him. Resident A reported he asked her to leave him alone and she would not leave him alone, which made him more upset. Ms. Burchett then grabbed his coat and then he grabbed her by the neck to try to choke her. Resident A reported Mr. Burton then came out to break them up and then Ms. Burchett called the police. Resident A reported he was arrested and he was confused on why he was arrested since the staff grabbed him first.

On 5/15/26 and 6/8/26, I attempted to interview Ms. Burchett via telephone and have not received a return telephone as of 6/8/26.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (b) Use any form of restraint without an order from an appropriately licensed health care professional or physical force, other than physical restraint for crisis intervention.
ANALYSIS:	Based on interviews, there was sufficient evidence found to support that Ms. Burchett did not use appropriate crisis intervention. It appears that Ms. Burchett escalated the situation by not allowing Resident A space to calm down when he was upset, which resulted in Resident A reacting and physically harming Ms. Burchett. She also called him inappropriate names and made threatening comments. The facility took appropriate action and terminated Ms. Burchett's employment directly following the incident.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

6/8/26

Kristy Duda
Licensing Consultant

Date

Approved By:

6/10/26

Russell B. Misiak
Area Manager

Date