



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

Tracie Hernandez
Cornerstone II Inc
P. O. Box 277
Bloomington, MI 49026

RE: License #: AS800306200
Investigation #: 2026A1031026
Cornerstone

Dear Licensee Designee:

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 #:	AS800306200
Investigation #:	2026A1031026
Complaint Receipt Date:	05/19/2026
Investigation Initiation Date:	05/19/2026
Report Due Date:	07/18/2026
Licensee Name:	Cornerstone II Inc
Licensee Address:	44409 Baseline Rd. Bloomingtondale, MI 49026
Licensee Telephone #:	(269) 668-7070
Licensee Designee/Administrator:	Karmen Ball
Name of Facility:	Cornerstone
Facility Address:	22858 West M-43 Kalamazoo, MI 49009-9208
Facility Telephone #:	(269) 668-3175
Original Issuance Date:	04/07/2010
License Status:	REGULAR
Effective Date:	10/21/2024
Expiration Date:	10/20/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has a mark on his face believed to be caused by staff.	No

III. METHODOLOGY

05/19/2026	Special Investigation Intake 2026A1031026
05/19/2026	Special Investigation Initiated - Telephone Interview with Mequesha Merritt and Hillary Mahone.
05/19/2026	Contact – Document Received
05/20/2026	Inspection Completed On-site
05/20/2026	Contact - Face to Face Interview Resident A, Resident B, Resident C, Princess Clopton, and Danielle Kish.
05/20/2026	APS Referral
05/28/2026	Contact - Telephone Interview with Lindsay Taylor.
06/10/2026	Contact - Document Sent – Email Exchange with Lindsay Taylor.
06/11/2026	Exit Interview held with Karmen Ball.

ALLEGATION:

Resident A has a mark on his face believed to be caused by staff.

INVESTIGATION:

On 5/19/26, I received a telephone call from the facility’s human resources staff Mequesha Merritt and Hillary Mahone. They both reported there were concerns regarding Resident A as he had an unexplained scratch on his face. They reported direct care worker (DCW) Salihah Cassagnol was working the overnight shift when the injury occurred. They reported the facility manager Princess Clopton reported concerns as there was another occasion where Resident A had bruising on his body after Ms. Cassagnol worked an overnight shift.

On 5/19/26, I received three incident reports via email from Ms. Merritt.

The incident report dated 4/10/26 that was completed by DCW Ms. Cassagnol read that Resident A was weak in the knees and very unstable while assisting him off the toilet. When walking back to his room, Resident A's knees gave out, and he was starting to fall back. Staff assisted Resident A down to the floor so he would not fall and assisted him back up using a gait belt.

A second incident report dated 4/10/26 was completed by Ms. Clopton. The incident report read that Ms. Clopton observed a bruise on Resident A's bottom and bruising on his shoulder when she was assisting him into the shower.

The third incident report dated 5/19/26 was completed by Ms. Clopton. The incident report read Ms. Clopton arrived on shift and noticed Resident A had a long scratch on his face. Ms. Clopton contacted Ms. Cassagnol who was previously on shift and she reported Resident A became upset during the night because she gave him a shower after he urinated on himself.

On 5/20/26, I conducted an unannounced visit to the facility and interviewed Resident A, Resident B, Resident C, Princess Clopton, and DCW Danielle Kish.

Resident A was not able to be interviewed due to being nonverbal. Resident A did point to his forehead on multiple occasions to show me the scratch. I did observe a fresh scratch wound on Resident A's forehead down his nose.

Resident B reported Ms. Cassagnol is not nice to the residents in the facility and she wishes she would work somewhere else. Resident B reported she did not observe Ms. Cassagnol harm Resident A. Resident B reported there was one occasion where Ms. Cassagnol did grab her shoulder when she was trying to use a broom. Resident B reported Ms. Cassagnol often yells at residents, especially Resident A. Resident B reported Ms. Cassagnol often calls her a "smart ass".

Resident C reported she never observed Ms. Cassagnol harm Resident A. Resident C's facial expression immediately changed from smiling to frowning when I mentioned Ms. Cassagnol's name. Resident C reported Ms. Cassagnol has called her "big fat" and "fatty fat" on multiple occasions.

Ms. Clopton reported she came to the facility to start her shift and noticed that Resident A had a large scratch on his face that went from his forehead to his nose. Ms. Clopton reported she called Ms. Cassagnol immediately and asked her what happened because there was not an incident report completed. Ms. Clopton reported Ms. Cassagnol informed her that Resident A was upset because he had to shower after wetting himself and harmed himself by scratching his face. Ms. Clopton reported this was concerning as she noticed bruises on Resident A previously after Ms. Cassagnol had worked with him the night before. Ms. Clopton reported her explanation did not make sense as Resident A does not often engage in self-harming behaviors and when he does, he will usually hit the side of his head with a

closed fist. Ms. Clopton reported Ms. Cassagnol works the overnight shift by herself so she was not able to determine any warning signs of Ms. Cassagnol's behavior with residents.

Ms. Kish reported Ms. Cassagnol works overnight by herself and she did not observe Ms. Cassagnol harm Resident A. However, Ms. Kish reported Ms. Cassagnol appeared to have an odd demeanor when working with Resident A. Ms. Kish reported Resident A would often be the only resident awake when Ms. Cassagnol arrived to work the overnight shift. Ms. Cassagnol seemed to purposely make Resident A irritable or agitated by standing close to him even when he would wave his hand to signal to give him space.

On 5/28/26, I interviewed adult protective services worker Lindsay Taylor via telephone. Ms. Taylor reported she is still in the process of completing her investigation but does have concerns that staff caused the mark on Resident A's forehead.

On 6/10/26, I exchanged emails with Ms. Taylor and she reported she will be substantiating Ms. Cassagnol for abuse against Resident A.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	<p>I was not able to determine whether Ms. Cassagnol caused the injury to Resident A's face as Resident A was not able to verbalize what happened and there were no direct witnesses.</p> <p>However, based on interviews with residents and staff, there was enough evidence to support that Ms. Cassagnol intentionally exposed multiple residents to emotional harm. Multiple residents reported Ms. Cassagnol called them inappropriate names and staff reported concerns regarding how Ms. Cassagnol treated Resident A as she purposely disrespected his personal space knowing this would agitate him.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

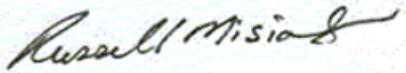


6/10/26

Kristy Duda
Licensing Consultant

Date

Approved By:



6/11/26

Russell B. Misiak
Area Manager

Date