GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 20, 2026

Amber Hernandez-Bunce
Cornerstone AFC, LLC
P.O. Box 277
Bloomingdale, MI 49026

RE: License #: AS800397501
Investigation #: 2026A1031029
52nd Street Home

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.
- 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. 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,

KDuda

Kristy Duda, 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 #:	AS800397501
Investigation #:	2026A1031029
Complaint Receipt Date:	06/24/2026
Investigation Initiation Date:	06/24/2026
Report Due Date:	08/23/2026
Licensee Name:	Cornerstone AFC, LLC
Licensee Address:	P.O. Box 277 Bloomingdale, MI 49026
Licensee Telephone #:	(269) 628-2100
Administrator:	Hillary Mahone
Licensee Designee:	Amber Hernandez-Bunce
Name of Facility:	52nd Street Home
Facility Address:	31723 52nd Street Bangor, MI 49013
Facility Telephone #:	(269) 762-2969
Original Issuance Date:	02/12/2019
License **Status:**	REGULAR
Effective Date:	08/12/2025
Expiration Date:	08/11/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A missed their medical appointment.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/24/2026	Special Investigation Intake 2026A1031029
06/24/2026	Special Investigation Initiated - Letter Email exchange with Shawn Karalash.
06/26/2026	Inspection Completed On-site
06/26/2026	Contact - Face to Face Charmaine Carr and Resident A.
06/26/2026	Contact - Telephone call made Hillary Mahone and Amber Hernandez-Bunce.
06/26/2026	Contact - Telephone call made Mequesha Merritt.
07/01/2026	Contact - Face to Face Interview with Kendrell Dorrington.
07/01/2026	Contact - Document Sent Documents Requested - Assessments and IPOS.
07/02/2026	Contact - Document Received
08/05/2026	Exit Conference held with Amber Hernandez-Bunce.

ALLEGATION:

Resident A missed their medical appointment.

INVESTIGATION:

On 6/24/26, I received an online complaint that Resident A missed his post-op surgery appointment due to lack of staffing.

On 6/24/26, I exchanged emails with adult protective services (APS) worker Shawn Karalash. Resident A was supposed to have a follow-up appointment on 6/4/26 to have his staples checked following a surgery he had but missed the appointment. Resident A was then taken to the Family Health Center later that day for follow-up. Resident A was taken to the emergency room on 6/15/26 to have his staples removed due to missing his previous appointment. Mr. Karalash reported concerns about the facility being understaffed and noted a desperate need for more staff. Mr. Karalash reported he was informed that there are two staff working at the facility.

On 6/26/26, I conducted an unannounced visit to the facility and interviewed the facility manager Charmaine Carr and Resident A.

Ms. Carr reported Resident A did miss his scheduled appointment on 6/4/26 due to a staff quitting before his shift started. That staff was assigned to transport Resident A to his appointment. Ms. Carr reported there were not enough staff on shift to take Resident A to his appointment and to stay at the facility to ensure supervision of the other residents. Ms. Carr reported there are currently three staff scheduled to work at the facility. One for first, second, and third shift so all staff typically work seven days per week. Ms. Carr reported she has had to ask for assistance from staff that work at other facilities within the company to assist with transportation to appointments. Ms. Carr said it is difficult being the only staff on shift and taking individuals to appointments as there is no one else to provide supervision for other residents.

Resident A reported he did miss his scheduled medical appointment to have his staples checked. Resident A reported there were not enough staff available to take him to his appointment as Ms. Carr was the only one working due to another staff quitting. Resident A reported he was upset he missed his appointment but understood that Ms. Carr could not leave the other residents alone to take him. Resident A reported there are three staff working in the facility and they work every day. Resident A reported he felt bad for Ms. Carr as she cannot do everything for everyone by herself.

On 6/26/26, I interviewed human resources staff Mequesha Merritt and Hillary Mahone via telephone.

Ms. Merritt was informed of the allegations and reported she was aware that Resident A's appointment was missed. However, she was not notified that assistance was needed to take Resident A to his appointment or assistance would have been offered by human resources staff. Ms. Merritt reported that the facility is understaffed and believes more staff is needed in the facility to ensure that residents can attend all scheduled appointments. Ms. Merritt reported there are three staff scheduled in the facility, one for each shift. Ms. Merritt reported staff are working seven days a week and it has been requested that their shifts are extended at times to ensure staffing needs are met.

Ms. Mahone was informed of the allegations. Ms. Mahone reported she was not aware at the time that Resident A had missed his appointment that she heard about afterwards. Ms. Mahone reported there is a need for more staffing at the facility as there are only three staff working at the facility.

On 6/26/26, I interviewed licensee designee Amber Hernandez-Bunce via telephone. Ms. Hernandez-Bunce was informed of the allegations and acknowledged that Resident A did miss his appointment. Ms. Hernandez-Bunce reported the facility is fully staffed as there is always one staff at the facility. Ms. Hernandez-Bunce acknowledged a need for assistance with transporting residents to appointments and reported the company plans to hire staff specifically to transport residents to and from appointments to prevent individuals from missing appointments.

On 7/1/26, I conducted a face-to-face interview with human resources staff Kendrell Dorrington. Mr. Dorrington was informed of the allegations and reported that the facility is understaffed. Mr. Dorrington reported there is a need for more staff at the facility as there is only one staff working every shift which does not allow staff to leave the facility to provide transportation for one resident at a time.

On 8/14/26, I received an email from Mr. Karalash that contained his findings for his investigation. Mr. Karalash substantiated for neglect due to Resident A having "missed an important follow up appointments due to a lack of staffing at the AFC".

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Resident A's physical health needs were not met as recommended by his physician as Resident A missed an important follow-up appointment to have his staples examined. Resident A and facility staff admitted that Resident A did miss an important follow-up appointment due to lack of staffing at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the interviews noted above, there were consistent reports of lack of staff and the need for additional staff in the facility. APS noted concerns regarding staffing and reported there was a desperate need for staff within the facility. Ms. Hernandez-Bunce acknowledged that there is an additional need for staffing for transportation purposes although there is enough staffing for supervision and care provided in the facility.

On 7/2/26, I received and reviewed the facility timecard for staff. In the month of June 2026, there were three staff scheduled to work in the facility. There was one staff scheduled to work first, second, and third shift.

On 7/2/26, I received and reviewed Resident A's *Individual Plan of Service* dated 12/5/26. The assessment read that Resident A requires assistance from staff to attend medical appointments.

On 8/14/26, I received an email from Mr. Karalash that contained his findings for his investigation. Mr. Karalash substantiated for neglect due to Resident A having "missed an important follow up appointments due to a lack of staffing at the AFC".

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	Although the facility meets the minimum requirement for resident to staff ratio, there was not sufficient staff in the facility to ensure that Resident A's physical health needs were met as identified in his assessment plan. Resident A missed a scheduled follow-up appointment. Multiple staff reported concerns that there is a lack of staff in the facility which makes it hard to ensure that residents can attend scheduled medical appointments.
CONCLUSION:	**VIOLATION ESTABLISHED**

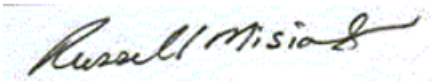
IV. RECOMMENDATION

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

8/17/26

Kristy Duda Date
Licensing Consultant

Approved By:



8/17/26

Russell B. Misiak Date
Area Manager