GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 16, 2021

Corey Husted
Brightside Living LLC
PO Box 220
Douglas, MI 49406

RE: License #: AM410403710
Investigation #: 2021A0355032
Brightside Living - Mistywood

Dear Mr. Husted:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 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,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AM410403710
Investigation #:	2021A0355032
Complaint Receipt Date:	04/20/2021
Investigation Initiation Date:	04/20/2021
Report Due Date:	06/19/2021
Licensee Name:	Brightside Living LLC
Licensee Address:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Kalia Greenhoe
Licensee Designee:	Corey Husted
Name of Facility:	Brightside Living - Mistywood
Facility Address:	3371 Mistywood St SE Caledonia, MI 49316
Facility Telephone #:	(614) 329-8428
Original Issuance Date:	05/01/2020
License Status:	REGULAR
Effective Date:	11/01/2020
Expiration Date:	10/31/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was sent to the emergency room four times in a month and missed each of the four follow-up appointments that were scheduled.	Yes

III. METHODOLOGY

04/20/2021	Special Investigation Intake 2021A0355032
04/20/2021	APS Referral Received from
04/20/2021	Special Investigation Initiated - Telephone network 180, Office of Recipient Rights
04/23/2021	Inspection Completed On-site Interviewed staff; reviewed Resident A's file
04/27/2021	Contact - Telephone call received Update with Rights staff
06/15/2021	Exit Conference Licensee designee; update on Resident A

ALLEGATION: Resident A was sent to the emergency room four times in a month and missed each of the four follow-up appointments that were scheduled.

INVESTIGATION: On 04/20/2021, I received a complaint via the Adult Protective Services (APS) Centralized Intake Unit reporting that Resident A was seen in the emergency room (ER) at Mercy Health Hospital on 3/17/21, 3/19/21, 3/24/21, and 4/1/21. Resident A was seen on 3/17 with low hemoglobin, on 3/19 with angioedema, on 3/24 for uncontrolled seizure like activity, and on 4/1 for a 'break-through seizure'. Follow-up appointments had been arranged and confirmed with the AFC for each ER visit for 3/25/21, 3/31/21, 4/16/21, and 4/19/21. Resident A reportedly missed each of the follow-up appointments. APS declined this referral for investigation.

On 04/23/2021, I conducted an unannounced investigation at the facility and interviewed staff Mackenzie Sturm. Ms. Sturm stated that Resident A missed the first three appointments because there were no staff to take Resident A to them. Ms. Sturm stated that the two administrative staff who usually take residents to

appointments were working in other homes and the licensee designee, himself, was also working in another home due to the staffing shortage. Ms. Sturm stated that she had taken another resident to the doctor on the day the 4th appt. was scheduled and had Resident A with her, planning to take him to his doctor following the first appt. Ms. Sturm stated that the other resident's appt. took a long time so that she missed Resident A's scheduled time. Ms. Sturm stated that she called the doctor's office to see if she could still bring Resident A but was told she would have to reschedule. Ms. Sturm stated that she had recently taken Resident A for his follow up appointment and the doctor told her it appeared to be a neurological issue possibly requiring adjustments to Resident A's medications so the doctor referred Resident A to a neurologist.

Present in Resident A's file was information documenting each emergency room visit and the follow-up visit that Ms. Sturm described with a referral to Resident A's neurologist.

On 06/15/2021, I conducted by telephone an exit conference with the licensee designee, Corey Husted. Mr. Husted stated that when Resident A saw his neurologist, the neurologist indicated the belief that the health issues Resident A is experiencing are not based neurologically but are medical in nature so Resident A's anti-convulsant medications were not changed. Mr. Husted stated that Resident A will begin seeing a Visiting Physician's doctor that sees other residents in the facility. Mr. Husted stated that the doctor assigned to his homes has provided excellent care to his residents so he is optimistic that Resident A's medical issues will be appropriately addressed. Mr. Husted accepted the finding of this investigation.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Four follow-up appts. to Resident A's four emergency room visits were missed. Three due to staffing issues and one due to another resident's appt. lasting too long so Resident A missed the fourth appt.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

06/16/2021

Grant Sutton — Date
Licensing Consultant

Approved By:

06/16/2021

Jerry Hendrick — Date
Area Manager