GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2022

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

RE: License #: AL280410649
Investigation #: 2022A0340047
Brightside Living - West Shore

Dear Mr. Husted:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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) 356-0183.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL280410649 |
| | |
| **Investigation #:** | 2022A0340047 |
| | |
| **Complaint Receipt Date:** | 07/27/2022 |
| | |
| **Investigation Initiation Date:** | 07/27/2022 |
| | |
| **Report Due Date:** | 09/25/2022 |
| | |
| **Licensee Name:** | Brightside Living LLC |
| | |
| **Licensee Address:** | 690 Dunegrass Circle Dr<br>Saugatuck, MI 49453 |
| | |
| **Licensee Telephone #:** | (614) 329-8428 |
| | |
| **Administrator:** | Corey Husted |
| | |
| **Licensee Designee:** | Corey Husted |
| | |
| **Name of Facility:** | Brightside Living - West Shore |
| | |
| **Facility Address:** | 2651 Leaf Lane<br>Grawn, MI 49637 |
| | |
| **Facility Telephone #:** | (614) 329-8428 |
| | |
| **Original Issuance Date:** | 03/14/2022 |
| | |
| **License Status:** | TEMPORARY |
| | |
| **Effective Date:** | 03/14/2022 |
| | |
| **Expiration Date:** | 09/13/2022 |
| | |
| **Capacity:** | 14 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL, AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was not sent to the hospital in a timely manner. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 07/27/2022 | Special Investigation Intake<br>2022A0340047 |
| 07/27/2022 | APS Referral |
| 07/27/2022 | Special Investigation Initiated - Letter<br>ORR |
| 07/27/2022 | Contact – Telephone call made<br>Munson Hospital |
| 08/01/2022 | Inspection Completed On-site |
| 08/22/2022 | Telephone call made<br>Staff Sherry Sheffer |
| 08/23/2022 | Exit Conference<br>Licensee Corey Hustead |

**ALLEGATION: Resident A was not sent to the hospital in a timely manner.**

**INVESTIGATION:** On July 27, 2022, a complaint was received from Adult Protective Services. It stated Resident A was sent to Munson Hospital on July 25, 2022, but there are concerns he should have been sent sooner.

On July 27, 2022, I contacted Carol Barke from the Office of Recipient Rights. She was aware of the situation and had concerns. Resident A was sent to Munson Hospital on July 25, 2022, but his health had been in significant decline for several days prior. The worker who called for the ambulance reportedly told them that she thought Resident A was dying. He had not been eating or drinking for several days. Three months ago he had Covid and seemed to never recover. Hospice had been called previously but they had declined his eligibility for services. While in the hospital Resident A is being evaluated by OBRA for nursing home care. He will not be returning to the Brightside Home. He has been doing better under hospital care. Ms. Barke did not know Resident A's current diagnosis.

On July 27, 2022, I contacted Munson Hospital. I was put in contact with the hospital social worker, Holly Moore. Ms. Moore informed me that she had never seen someone in such a poor condition coming from a home. She stated Resident A had reportedly been refusing to eat for 1-2 weeks, ingesting very minimal amounts of Boost. She had been informed that the staff at Brightside thought he was dying and that was the reason the ambulance was called.

While reviewing Resident A's chart, Ms. Moore informed me that he is in severe dehydration, skin breakdown with pressure ulcers and open wounds, rectal bleeding, acute kidney injury from the dehydration, and malnourished. He is wheelchair bound and incontinent. Ms. Moore stated it was "quite obvious" he was not getting his brief changed regularly due to the breakdown of his skin. She also stated that she did not believe he was being repositioned as often as needed since his sores were so bad. There were also sores on his shoulder where it rubbed against his wheelchair, which she believed, indicated he was left for long periods of time sitting in his chair. Ms. Moore stated Resident A should have been sent into the hospital long before he was and suggested I speak with his nurse for more information.

I was then put in contact with Resident A's attending nurse, Betsy McQueer. She was attempting to feed him when the phone was handed over. She informed me that when Resident A arrived she was unsure if he was going to survive. He is now recovering and eating and drinking. He is not able to communicate, but she is hopeful that as he improves so will his ability to do so.

Through the hospital records system, Ms. McQueer relayed to me that Resident A was brought to the hospital previously on May 27, 2022, for wound care due to infection. On June 8, 2022, he was seen for hyperglycemia and dehydration. He is prescribed Boost and is supposed to be drinking four per day. Ms. McQueer stated that she does not believe he is getting that amount. His chart shows that he has lost 25 pounds since April. She said he is a "little guy" so that much weight loss is "significant". The Boost is supposed to be in addition to his meals, not in place of his meals. She described his physical condition as "severe malnourishment and severe dehydration" and stated that based on his wounds and overall condition, staff should have sent him to the hospital much sooner. Ms. McQueer further stated it is unknown how long Resident A will remain hospitalized.

On August 1, 2022, I conducted an unannounced home inspection. Staff Laurie Jones was working on this day. When I arrived and identified myself Ms. Jones knew I was there regarding Resident A. She spontaneously stated, "I should have sent him sooner." I asked Ms. Jones to tell me more about that. She stated that Resident A had been "declining for weeks" and "getting worse each week". Ms. Jones stated she thought Hospice was going to get involved but then they did not. He had a bed sore and Munson Home Health had been coming to treat it twice per week for wound care. The Home Health nurse had told Ms. Jones that Resident A could be sent to the hospital at any time due to "failure to thrive". For three weeks

he had only been taking in some applesauce, some yogurt, and drinking Boost. He had not been eating solid foods.

Prior to Resident A being sent to the hospital on the 25th, Ms. Jones stated she had attempted to give Resident A his medications with pudding, but it made him vomit. I asked to see Resident A's weight chart and she stated that because he was bed bound they were unable to take his weights.

Ms. Jones also informed me that Resident A's bowel movements had become "slimy and nonstop". He had also not urinated for two days. Unfortunately, Ms. Jones was off for three days and when she came back she saw that he had become "delirious, incoherent and grabbing at the air". Ms. Jones cleaned him up and saw his anus was raw, red, and oozing. She called Home Health and they advised her to call 911.

I asked about his wound care and when they last saw Resident A. Ms. Jones told me that wound care was discontinued for some reason, and it had been a while since they had been out. Staff then had to learn how to clean and "pack" it.

Ms. Jones stated that since there was talk of Hospice getting involved that someone would have told staff to send him or Hospice would have taken care of him. I pointed out to Ms. Jones that Hospice did not get involved with Resident A's care so it is the responsibility of staff to call the doctor or 911 or whomever necessary if there is concern or he is declining. Ms. Jones acknowledged that she should have sent him prior to her time off, but she did not do so and the staff working while she was gone failed to do so as well.

Ms. Jones provided me with a copy of the Incident Report pertaining to Resident A being sent to the hospital on 7/25/22. It was completed by Ms. Jones on 7/25/2022 and signed by Licensee Corey Husted on 7/27/2022. It stated: *'When I came in at 7 am for my shift I went to check on (Resident A). He was delirious, grabbing at the air, his eyes were darting like he was fearful. While cleaning his brief he was seeping black liquid stool, his rectum area was completely raw, bleeding. He was not able to talk, his breathing was sporadic. He was clearly in the process of passing away. I called Munson Home Health and the triage nurse advised me to call ambulance as I had no means of comfort care as (Resident A) is not on Hospice Care. I called (guardian's name) his guardian to let her know.'*

I then reviewed the shift notes for Resident A. In the days prior to being sent to the hospital, it states: *'7-20 7-3 pm: he pooped this am-refused shake & applesauce. Turned every 2 hrs. dry all shift.*

*7-21 7-3 pm: Had a hard time giving meds this am. He was gaging w/ the pudding-refuses to drink & eat. Runny BM, didn't urinate. Nurse here today-He had a BB & shave (not happy about it).*

*3-11 pm: had bm same consistency as all day. Turned every 2 hrs.*

*7-22  7a- 7p: Had bm, dry all day besides that, turned every 2 hrs.*

*7-23  7a-7p: dry all shift, turned every 2 hrs.'*

*notes do not specify 7-24 but it says: *'7-25  7p-7a (Resident A) had BM all night. He was very raw and started to bleed.  He was very delusional would not drink anything, searching for things in the air when nothing was there.  He had shallow breathing was not able to take 8 am meds, was transported to Munson.'*

I obtained copies of Resident A's Assessment Plan, and Health Care Appraisal.  Ms. Jones referred to the schedule and stated that Sherry Sheffer had worked 3rd shift prior to Resident A being sent to the hospital.  Attempts were made to contact Ms. Sheppard, however, there was no voicemail and no answer during my several attempts to call at this time.

On August 1, 2022, I reviewed Resident A's Assessment Plan.  It was signed by his guardian on 3/3/22.  Under "Eating/Feeding" it states*, 'staff cuts up food due to choke hazard'*.  Under "Toileting" it states, *'Staff assists with brief changes'.*

On August 1, 2022, I reviewed Resident A's Health Care Appraisal.  It was signed by Brittany Dehlers (unknown credentials) on 8/25/2021.  Under "special diet" it states, *'currently on pureed diet, referring to (illegible) for thickener recommendation.'*  I requested any discharge instructions available from a previous hospital visit.  Per instructions from a 5/26/22 visit to Munson Medical Center, Resident A had been diagnosed with "Sacral decubitus ulcer" and "Dehydration".  General wound care suggestions and Dehydration "Education Materials" were provided, including directions that they are to call his provider if the "problem in not improved".  It was also recommended that he follow up with his primary care.

Ms. Jones also provided me with a copy of what appears to be discharge instructions from Crystal Lake Health Center dated 6/29/22 and signed by Brittany Haskin, PA-C which states, *'(Resident A) was a patient in the Interlochen Office practice on 6/29/22.  (Resident A) has multiple pressure sores and should not be placed into a position for any period of time where he has direct pressure on these sores.  He should be repositioned every 2 hours to prevent additional sores from developing.'*

On August 22, 2022, I interviewed staff Sherry Sheffer.  I informed her who I was and the complaint regarding Resident A.  I asked her to tell me about Resident A's condition the shift prior to him being sent to the hospital.  Ms. Sheffer recalled that during her shift (11 pm-7 am) on July 24-25, Resident A had been grasping at the air and wasn't responding as he normally did when she would ask him questions.  Prior to this shift, Resident A would exclaim in pain when being turned or during a brief change.  On this shift he did not make any noise.  She stated that he really started to decline two days prior to being sent out to the hospital.  Staff Laurie Jones came into

work around 7 am on 7/25/22 and Ms. Sheffer showed her the condition Resident A was in. Ms. Jones called Home Health and they told her to call for an ambulance which she did.

Ms. Sheffer added that a couple days prior Resident A began to choke on the pudding or applesauce he had been offered. He began to refuse medications at this time as well. Ms. Sheffer believed it was due to him not being able to swallow. Also, a couple of days prior to being sent to the hospital is when his BM's changed to what she described as liquid tar. She knew this was not going to be good on his skin or the wound on his tailbone.

I asked Ms. Sheffer to tell me more about his wound. She said that it did seem to get better at one point but then Wound Care was discontinued and staff had to learn how to provide care. She acknowledged some confusion in doing this because one co-worker had told her to change the bandage every time his brief was changed and another had said the bandages were water proof so it wasn't necessary to change it every time. Sometimes the bandages fell off so the whole area would have to be cleaned and "repacked". About two weeks prior to going to the hospital the wound was so painful that he could not bear to sit in his chair because of it. He used to sit outside and was able to scoot himself around. Two days prior to being sent to the hospital is when the wound started to ooze.

I asked Ms. Sheffer about Resident A's eating habits. She told me that he had not been eating his normal pureed diet for approximately two weeks prior. She felt this was a gradual decline because he was taking in so little food and water. He would only take sips of water and would refuse more. Ms. Keffer also described Resident A as a "little guy". We discussed that any weight loss would be significant. We then discussed that it would be better to call for an ambulance when a concern was to arise and let the hospital determine everything was okay rather than to not call and it be too late.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15310** | **Resident health care.** |
| | **(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.** |
| **ANALYSIS:** | The allegation was made that Resident A was not sent to the hospital when his health began to decline.<br><br>Munson Hospital social worker Holly Moore stated Resident A was in a severe state of dehydration and malnutrition along with pressure ulcers and open wounds. She stated Resident A should have been sent into the hospital long before he was. |

| | |
|---|---|
| | Munson Hospital Nurse Betsy McQueer stated that Resident A needed hospital care and should have been sent in sooner than he was.<br><br>Staff Laurie Jones acknowledged that she should have sent Resident A to the hospital at least three days prior to when he was sent.<br><br>Staff Sherry Sheffer stated in the two days prior to being sent to the hospital Resident A's health deteriorated significantly. His health had been declining for the two weeks prior.<br><br>Due to the severity of Resident A's condition, the opinions of Munson Hospital staff, the acknowledgement of Ms. Jones, and the condition of Resident A reported by Ms. Sheffer in the two days prior, care was not sought for Resident A in a timely manner. Therefore, a violation of the above-cited rule is confirmed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On August 23, 2022, I conducted an exit conference with Licensee Corey Hustead. I informed him that due to the significant findings I will be requesting a Provisional License. Mr. Hustead expressed frustration, stating when they had previously sent Resident A to the hospital, he was sent home. He also indicated to me that Resident A's insurance no longer covered the expense of wound care so that was left up to the staff.

## IV. RECOMMENDATION

Upon receiving an acceptable Corrective Action Plan, I recommend the current license status be changed to a Provisional for the above-cited quality of care violation.

Rebecca Piccard August 23, 2022

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Rebecca Piccard, Licensing Consultant Date

Approved By:

August 24, 2022

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Jerry Hendrick, Area Manager Date