GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 12, 2022

Kalia Greenhoe
Brightside Living LLC
PO Box 220
Douglas, MI 49406

RE: License #: AS410403030
Investigation #: 2023A0350006
Brightside Living - Cedar Springs

Dear Ms. Greenhoe:

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 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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410403030
Investigation #:	2023A0350006
Complaint Receipt Date:	12/06/2022
Investigation Initiation Date:	12/07/2022
Report Due Date:	01/05/2023
Licensee Name:	Brightside Living LLC
Licensee Address:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Kalia Greenhoe
Licensee Designee:	Kalia Greenhoe
Name of Facility:	Brightside Living - Cedar Springs
Facility Address:	1880 18 Mile Rd NE Cedar Springs, MI 49319
Facility Telephone #:	(614) 329-8428
Original Issuance Date:	04/21/2020
License Status:	REGULAR
Effective Date:	10/21/2022
Expiration Date:	10/20/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Staff failed to get Resident A to his past two follow-up neurologist's appointments.	Yes

III. METHODOLOGY

12/06/2022	Special Investigation Intake 2023A0350006
12/07/2022	Special Investigation Initiated - On Site I spoke with staff lead, Belle Allen
12/07/2022	Contact - Telephone call made I spoke with Kevin Souser, APS
12/07/2022	Contact - Telephone call received I spoke with Kalia Greenhoe, Licensee Designee
12/09/2022	Exit conference – Held with Kalia Greenhoe, Licensee Designee

ALLEGATION: Staff failed to get Resident A to his past two follow-up neurologist's appointments.

INVESTIGATION: On 12/07/2022, I made an onsite inspection and spoke with Belle Allen, Lead. I informed Ms. Allen of the allegation. Ms. Allen told me that an Adult Protective Services (APS) investigator, Kevin Souser, had come out and spoke with her about the same issue. Ms. Allen stated that after hearing about this allegation, she checked the home's wall calendar as well as the calendar on the staffs' computer and there were no neurologist appointments for Resident A on either. I asked Ms. Allen to show me the discharge documents from Resident A's hospitalizations in November, 2021 and October, 2022, and she did. The discharge documents for Resident A's visit to Mercy Health Saint Mary's Emergency Department show that he was there because he had a seizure. He was diagnosed as having a "Breakthrough seizure" by a physician. The Follow-up Care instructions for this visit state that Resident A should, "see a doctor again as discussed. Follow-up care is critical for the success of your recovery." There were no documents in Resident A's file showing that he was seen by a doctor (neurologist) for his seizures until he was sent to University of Michigan Health-West on 10/20/2022 for "seizure-like activity." The Discharge Instructions for this appointment state that Resident A was scheduled for an appointment with a Family Practice doctor, Scott A. Johnson, DO, for 10/26/2022, and an appoint with Ray Torbet, Physician's Assistant, on November 2, 2022. Resident A was not taken to this latter appointment. I asked Ms.

Allen for copies of these documents as well as Resident A's Health Care Appraisal and Resident Care Agreement (RCA). In reviewing the RCA I observed that it states Resident A is entitled to transportation services for one round trip appointment per month, and that additional trips for appointments are provided for a fee of $25 per appointment. Ms. Allen told me that there have been two house managers and a staffing shortage over the past few months, and she believed there were "communication errors" regarding Resident A's follow-up neurologist appointments. Ms. Allen said that she would make the appointment herself and let me know when it is.

On 12/07/2022, I received an email from Ms. Allen. She informed me that she made a neurologist appointment for Resident A for 01/16/2023 at 11:00 a.m. and that she added it to the house calendar.

On 12/07/2022, I called and spoke with Mr. Souser. We traded the information we each obtained so far. Mr. Souser reported that Resident A was hospitalized in October (2022). When he was discharged, a follow-up appointment was made with a neurologist for 11/2/22. The AFC home and Resident A's guardian, Missy Worpel, were both informed of the appointment. However, Resident A did not attend his appointment on 11/02/2022. Resident A missed an appointment with the neurologist in July (2022) as well as with a neurosurgeon sometime in 2021.

On 12/07/2022, I received a telephone call from Kalia Greenhoe, Licensee Designee and Administrator for this home. Ms. Greenhoe said that Ms. Allen told her that I came out to the home and discussed the allegations with her, and Ms. Greenhoe was calling me to see if I needed any further information. I informed Ms. Greenhoe about the allegation of Resident A not being sent to his follow-up neurologist appointments in July and again in November of this year. Ms. Greenhoe stated that Resident A went to the Emergency Room on October 19th of this year by ambulance, and that he was brought back to the home later the same day by EMS. I told Ms. Greenhoe that I reviewed the discharge papers from that visit and it stated that Resident A was scheduled for a follow-up appointment for November 2nd. Ms. Greenhoe was aware of this appointment, but said the neurologist's office called the wrong Brightside Living home, Misty Woods, so the staff at the Cedar Springs home, where Resident A lives, did not receive the call about the appointment. Ms. Greenhoe surmised that the staff members who were working when Resident A returned home did not read his discharge instructions that had his follow-up appointment date and time in them. She informed me that there will be a staff meeting in a few days and she will stress the importance of reading discharge instructions whenever a resident returns from the hospital, and to mark any follow-up appointments on the calendar immediately.

On 12/09/2022, I called and held an exit conference with Kalia Greenhoe, Licensee Designee. I informed Ms. Greenhoe that I was citing a violation of this rule. Ms. Greenhoe stated that she would send me a corrective action plan (CAP) on Monday, December 12, 2022. I told Ms. Greenhoe that she had 15 days to send her CAP.

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:	Resident A went to the Emergency Room on 11/18/2021 for seizures. The discharge instructions for that visit state that a follow-up appointment should be made. However, no appointment was made. Resident A again went to the Emergency Room for seizures on 10/19/2022. The discharge instructions for this visit state that a follow-up appointment was made for 11/02/2022. However, staff failed to read the discharge instructions and therefore did not take note of this appointment. Therefore, Resident A missed this follow-up appointment as well. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remains unchanged, and that this special investigation be closed.

December 9, 2022

Ian Tschirhart, Licensing Consultant Date

Approved By:

December 12, 2022

Jerry Hendrick, Area Manager Date