GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 10, 2023

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

RE: License #: AS410400152
Investigation #: 2023A0467024
Brightside Living - Comstock Park

Dear Mr. Husted:

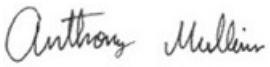
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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) 356-0183.

Sincerely,



Anthony Mullins, 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 #:	AS410400152
Investigation #:	2023A0467024
Complaint Receipt Date:	12/19/2022
Investigation Initiation Date:	12/20/2022
Report Due Date:	02/17/2023
Licensee Name:	Brightside Living LLC
Licensee Address:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Kalia Greenhoe
Licensee Designee:	Corey Husted
Name of Facility:	Brightside Living - Comstock Park
Facility Address:	4312 Division Ave N Comstock Park, MI 49321
Facility Telephone #:	(616) 551-1034
Original Issuance Date:	08/01/2019
License Status:	REGULAR
Effective Date:	02/01/2022
Expiration Date:	01/31/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident assessment plans are not being completed and signed annually.	No
Resident care agreement forms are not being completed and signed annually.	No
Staff member Mary Thrush disposed of Resident F's medication, causing him to go several days without it.	Yes
Resident A ingested medications that were not his due to staff leaving the medication out. Resident A was hospitalized for a week because of this.	No
Additional Findings	Yes

III. METHODOLOGY

12/19/2022	Special Investigation Intake 2023A0467024
12/20/2022	Special Investigation Initiated - On Site
01/10/2023	APS Referral – Complaint sent to APS via email.
01/10/2023	Exit conference completed with licensee designee, Corey Husted.

ALLEGATION: Resident assessment plans are not being completed and signed annually.

INVESTIGATION: On 12/19/22, I received a BCAL online complaint stating that assessment plans are not being completed and signed annually. The complaint alleged that signatures have been cut and pasted from previous forms.

On 12/20/22, I made an unannounced onsite investigation to the facility. Upon arrival, staff member Mary Thrush allowed entry into the home and agreed to discuss the allegations. Ms. Thrush denied any knowledge of licensing required forms being falsified or not completed annually. Ms. Thrush stated that she doesn't handle required licensing documentation other than incident reports. Ms. Thrush stated that she "highly doubts" that assessment plans are being falsified. Ms. Thrush stated that the home has a total of five residents. Four were present during my onsite investigation and one was away at day program. Ms. Thrush provided me with copies of each of the resident's assessment plans as requested. All five residents had completed and up to date assessments plans. There was no evidence to suggest that signatures are being cut and pasted from previous forms.

On 01/10/23, I conducted an exit conference with licensee designee, Corey

Husted. He was informed of the findings and denied having any questions.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	I reviewed assessment plans for all five residents during my onsite investigation. All five residents had signed and up-to-date assessment plans. There was no evidence to suggest that signatures were being cut and pasted from previous forms. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident care agreements are not being completed and signed annually.

INVESTIGATION: On 12/19/22, I received a BCAL online complaint stating that resident care agreements are not being completed and signed annually. The complaint alleged that past signatures are being cut and pasted from previous forms.

On 12/20/22, I made an unannounced onsite investigation to the facility. Staff member Mary Thrush denied any knowledge of required documents, including resident care agreements being falsified. Ms. Thrush provided me with copies of the resident care agreements for the five residents in the home. All five residents had completed and signed resident care agreements. There was no evidence to suggest that signatures were being cut and pasted from previous forms.

On 01/10/23, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**

	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	I reviewed resident care agreements for all five residents during my onsite investigation. All five residents had signed and up-to-date care agreements. There was no evidence to suggest that signatures were being cut and pasted from previous forms. Therefore, a preponderance of evidence does not exist to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff member Mary Thrush disposed of Resident F's medication, causing him to go several days without it.

INVESTIGATION: On 12/19/22, I received a BCAL online complaint stating that an unknown resident's medication was missing, and staff falsified the Medication Administration Record (MAR) to say the resident received it. The complaint did not specify the name of the resident or a specific time frame as to when this event occurred.

On 12/20/22, I made an unannounced onsite investigation to the facility. I spoke to staff member Mary Thrush. Ms. Thrush stated that Resident F was missing his medication, and this was due to her accidentally disposing of it in coffee grounds. The medication that Ms. Thrush is referring to is an amphetamine, which she identified as Adderall. Ms. Thrush stated that she and Mr. Husted completed an incident report, and the medication was replaced as she paid for it out of her paycheck due to being the person that disposed of it. It should be noted that an incident report was received on 11/9/22 regarding this matter. Ms. Thrush stated that she was tired and accidentally disposed of the wrong medication. Ms. Thrush was adamant that prior to this event, she had never had an issue like this occur. Ms. Thrush stated that Resident F moved out of the home a few weeks ago.

Ms. Thrush acknowledged that the owner/designee, Mr. Husted had her complete a urinalysis and she was positive for amphetamine. Resident F's medication that Ms. Thrush disposed of was also an amphetamine. Ms. Thrush was adamant that she bought Adderall from someone on the street and did not take Resident F's medication.

On 1/4/23, I made an unannounced onsite visit to the facility. Upon arrival, staff member Derrick Brown answered the door and allowed entry into the home. I asked Mr. Brown for copies of Resident F's MARs from November and December 2022. Mr. Brown was unable to provide me with hard copies of the Resident MARS due to

running out of printer paper. Mr. Brown called office manager, Angela Allen and she agreed to send me the requested MARs via email.

On 1/4/23, I spoke to the owner/designee, Corey Husted via phone. Mr. Husted confirmed Resident F's medication (Adderall) was destroyed by staff member Mary Thrush and an incident report was sent to me on 11/9/22. It should be noted that Mr. Husted and I also spoke about this via phone around the time this incident occurred. Mr. Husted was adamant that Resident F did not miss any of his scheduled medications as the medication was replaced prior to running out.

On 1/9/23, I received Resident F's MARs for November and December 2022 via email from office manager, Angela Allen. The November MAR indicated that Resident F was in fact prescribed an amphetamine medication. The medication he was prescribed was Methylphenid Tab 10MG as opposed to Adderall like Mr. Husted and Ms. Thrush indicated. However, the medication does fall in the amphetamine/stimulant category and serves a similar purpose to Adderall. The MAR indicated that on 11/9/22, Resident F did not receive his 12:00 pm dose of Methylphenid due to "waiting on pharmacy." Mr. Husted and Ms. Thrush were adamant that Resident A never missed a dose of medication due to the medication being replaced but the MAR states otherwise. It should also be noted that from 11/9/22 through 11/30/22, the MAR states that Resident F did not receive this medication due to "waiting on pharmacy."

On 01/10/23, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and stated that he plans to investigate how this occurred. Mr. Husted denied having any questions and agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Ms. Thrush confirmed that she accidentally disposed of Resident F's amphetamine medication (Methylphenid) while cleaning the basement. Mr. Husted confirmed this as well and completed an incident report. Ms. Thrush and Ms. Husted were

	adamant that Resident F did not miss a dose of Methyphenid as it was replaced prior to running out. Resident A's 11/2022 MAR indicated that from 11/9/22 to 11/30/22, Resident F did not receive his Methyphenid medication due to "waiting on pharmacy." Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Allegation: Resident A ingested medications that were not his due to staff leaving the medication out. Resident A was hospitalized for a week because of this.

Investigation: On 12/19/22, I received a BCAL online complaint stating that an unknown resident ingested medications that were not his due to staff leaving medications out. Resident A was reportedly hospitalized for a week because of this. The complaint also alleged that an unknown resident with dementia is receiving Melatonin although he is not prescribed the medication.

On 12/20/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to staff member Mary Thrush. Ms. Thrush was asked about the allegations and stated that Resident A has been diagnosed with dementia. She also confirmed that Resident A ingested medications that were not his and this caused him to be in the hospital for a week. Ms. Thrush stated that a 3rd shift staff member named Dana Staten left the medication out and this is how Resident A gained access to it. Ms. Thrush did not know the name of the medications that Resident A ingested, but she believed this incident occurred this past July. Ms. Thrush stated that an incident report was completed for this as well. Ms. Thrush denied any knowledge of Resident A receiving a medication that he is not prescribed.

After speaking to Ms. Thrush, I attempted to speak to Resident A at the dining room table. Resident A stated that he is doing "good." Resident A repeatedly told me that his nurse and doctor are both doing well. Resident A appeared to be disinterested in my questions and preferred to talk about other things unrelated to the investigation. It should be noted that it was difficult to understand Resident A during our brief conversation.

After speaking to Resident A, I spoke to Resident B. Resident B stated that he has lived in the home for "a while" and things are going well for him. Resident B confirmed that all his needs are being met in the home, including receiving his medications on time. Resident B stated that he feels safe in the home and denied having any concerns.

After speaking to Resident B, I spoke to Resident C. Resident C stated that he has lived in the home for approximately three to four years. When asked how things are going, Resident C stated, “not so good.” Resident C expanded on this statement by saying that Resident B causes trouble by grabbing his genitalia. Resident C stated that he has to move out of the way or tell Resident B to stop when he tries to grab him. With the exception of this, Resident C stated that everything else is going well. Resident C stated that he feels safe and denied any concerns.

After speaking to Resident C, I asked Ms. Thrush about Resident B’s behavior towards Resident C. Ms. Thrush stated that staff are aware of this and Resident B has a behavior plan to address this, which includes redirecting him and separating the residents.

I then spoke to Resident D. Resident D stated that he has lived at the home for nearly two years and things are going well. Resident D described the home as a “good place” and spoke highly of staff member Ms. Thrush. Resident D was adamant that his needs are being met, including receiving his medication on time. Resident D was thanked for his time. Resident E was not interviewed due to being away from the home at the time of my onsite investigation.

On 1/4/23, I made an unannounced visit to the facility. Upon arrival, staff member Derrick Brown answered the door and allowed entry into the home. I asked Mr. Brown for copies of Resident A’s MAR. Mr. Brown was unable to provide me with hard copies of the Resident MARS due to running out of printer paper. Mr. Brown called office manager, Angela Allen and she agreed to send me the requested MARS via email.

On 1/4/22, I spoke to Mr. Husted via phone. Mr. Husted acknowledged Resident A ingested medications and was admitted to the hospital. Mr. Husted stated that his staff, Ms. Staten placed medications for another resident on the med cart as she planned to pass it. Prior to doing so, Resident A took the medication and swallowed it. Mr. Husted denied the medication being left out. I asked Mr. Husted about Resident A reportedly receiving Melatonin although he is not prescribed it. Mr. Husted stated that only the pharmacy can add and delete medications from the MAR and Resident A and all other residents receive their medications as prescribed. Mr. Husted stated that residents do not even receive over the counter medication unless it’s added to their MAR.

On 1/9/23, I reviewed Resident A’s MAR, which indicated that he was in fact prescribed Melatonin. There is no evidence of Resident A receiving Melatonin that is not prescribed to him.

On 1/9/22, I spoke to staff member Dana Staten via phone. Ms. Staten was unable to recall exactly when the incident with Resident A occurred, but she did remember what took place. Ms. Staten stated that she was passing medications at the med cart. While do so, Ms. Staten stated that she made a movement to where her back

was turned and, “before I knew it he (Resident A) took it,” referring to the medications on the cart that were not his. Ms. Staten immediately started telling Resident A no. Ms. Staten stated that she called 911, Resident A’s guardian, and management.

In addition to this, Ms. Staten stated that she completed an incident report and left it on the locked med cart for management to retrieve. Ms. Staten stated that the event was an accident. Ms. Staten stated that Resident A is repetitive in what he does due to his diagnosis, and he grabbed the medications quickly. Ms. Staten was adamant that she never left any medication unattended and nothing like this has occurred in the past.

On 01/10/23, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and confirmed that the process is to pass medications to one resident at a time. Mr. Husted also stated that the med cart has been moved to a different location in the home to decrease other residents access to it while staff are focusing on passing meds. Mr. Husted denied having any questions.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Ms. Thrush stated that Ms. Staten left the medication out, resulting in Resident A ingesting it. Mr. Husted and Ms. Staten both stated that the incident was an accident. Ms. Staten stated that she was at the med cart when Resident A quickly took the medication off the cart and swallowed them. Ms. Staten responded immediately by making the appropriate calls. Ms. Staten was adamant that she never left the med cart unattended and has never had a similar incident occur. Based on the information provided, it appears as if Ms. Staten took reasonable precautions to prevent this incident by passing medications as she typically would, which includes passing medications to one individual at a time. Resident A did not have a prior history of grabbing medications off the med cart when it was not his turn to do so. This was an isolated incident. Therefore, there is not a preponderance of evidence to support the allegation.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, I spoke to office manager Angela Allen on 1/5/23. Ms. Allen informed me that staff member Mary Thrush was using her login information to initial residents' MARs as if she passed the medications. Ms. Allen stated that she does not work in the home at all and any MAR that has her initials on them were completed by Ms. Thrush due to having her login information. Ms. Allen stated that she changed her password once she found out about this and Ms. Thrush now uses her own login.

I reviewed Resident A's MARs from June 2022 through December 2022 and Ms. Allen's initials were on nearly all medications passed for Resident A during this time period. I also reviewed Resident F's MAR from November and December 2022 and Ms. Allen's initials were on all of Resident F's MAR for November 2022.

In addition to this, I also reviewed Resident F's November 2022 MAR. The MAR indicated that he did not receive his Methylphenid medication on the following days and times as there were no initials to confirm this: 11/5/22 at 12:00 pm, 11/6/22 at 8:00 am, 12:00 pm, and 5:00 pm, 11/9/22 at 5:00 pm, 11/10/22 at 12:00 pm, 11/22/22 at 12:00 pm and 5:00 pm, 11/25/22 at 8:00 pm, and 11/29/22 at 12:00 pm.

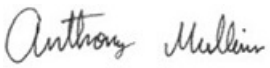
On 01/10/23, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

	(vi) A resident's refusal to accept prescribed medication or procedures. **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	The home uses an electronic MAR system and Ms. Allen stated that Ms. Thrush was using her login information to initial MARs when she would pass medications. Ms. Allen stated that she does not work in the home and any MAR that has her initials were completed by Ms. Thrush. Ms. Thrush used Ms. Allen's initials on Resident A's MAR from June through November 2022. Ms. Thrush also used Ms. Allen's initials on Resident F's MAR in November 2022, which is falsifying documentation. There are also several dates in November 2022 that Resident F's MAR was not initialed for his Methylphenid medication. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

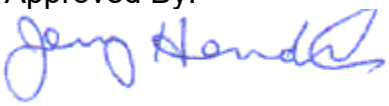
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



01/10/2023

Anthony Mullins Date
Licensing Consultant

Approved By:



01/10/2023

Jerry Hendrick Date
Area Manager