GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 13, 2023

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

RE: License #: AS410403032
Investigation #: 2023A0467031
Brightside Living - Rosemary

Dear Mr. Husted:

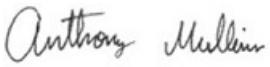
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

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 #:	AS410403032
Investigation #:	2023A0467031
Complaint Receipt Date:	02/06/2023
Investigation Initiation Date:	02/06/2023
Report Due Date:	04/07/2023
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 - Rosemary
Facility Address:	445 Rosemary St SE Grand Rapids, MI 49507
Facility Telephone #:	(614) 329-8428
Original Issuance Date:	04/24/2020
License Status:	REGULAR
Effective Date:	10/24/2022
Expiration Date:	10/23/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not notify Resident A's guardian of his absence in a reasonable time.	Yes

III. METHODOLOGY

02/06/2023	Special Investigation Intake 2023A0467031
02/06/2023	Special Investigation Initiated - Telephone
02/07/2023	Inspection Completed On-site
02/13/2023	APS Referral – Complaint sent via email
02/13/2023	Exit conference completed with licensee designee, Corey Husted.

ALLEGATION: Staff did not notify Resident A's guardian of his absence in a reasonable time.

INVESTIGATION: On 2/6/23, I received a BCAL online complaint stating that on Friday, 2/3/23, Resident A walked out of his AFC home at approximately 5:30 am with his walker after telling the AFC staff he was going to the hospital. The AFC staff reportedly waited until 7:00 am to call the police and never notified Resident A's guardian.

On 2/6/23, I spoke to the complainant via phone. The complainant stated that Resident A left the home on 2/3/23 while wearing a coat and sandals. The complainant stated that Resident A did not have socks on when he left the house. The complainant stated that Resident A was found on Friday (2/3/23) at approximately 10:30 am by the police. He was located by Division and 28th Street in Grand Rapids, which is approximately ¾ of a mile away from the home.

Per the complainant, Resident A left the home at 5:30 am and told staff that he was leaving to go to the hospital. This was relayed to the complainant by GRPD. The complainant stated that her biggest concern is that Resident A notified staff he was leaving and they waited an hour-and-a-half to notify police. The complainant also stated that she was notified by the police as opposed to the AFC staff.

On 2/7/23, I made an unannounced onsite investigation to the facility. Upon arrival, live-in staff member, Charlena Pickett answered the door and allowed entry into the

home. Ms. Pickett assisted me to Resident A's room and introductions were made. Resident A agreed to discuss allegations. Resident A was asked to share what occurred this past Friday, 2/3/23. Resident A stated that he left the home between 5:00 am and 6:00 am to go to the gas station, "up the street to get a soda or two." Resident A denied that he told staff that he was leaving the home although he knew he should have. Resident A stated that he thought he would be away from the home for 15 to 20 minutes. However, he was away from the home a lot longer than expected. While walking to the gas station, Resident A stated, "I got turned around." Resident A stated that the police found him and brought him back to the home.

When he left the home, Resident A stated that he was wearing a shirt, pants, coat, and his sandals that he pointed to on the floor. Resident A stated that he left the home without wearing socks due to his feet being numb and not being able to feel anything. Resident A stated that his feet have been numb for approximately 3-4 years and he had his toes on his right foot amputated one year ago. Resident A stated that he returned home around 10:00 am. Resident A stated that this was the first time he left the house, which is why he believes he got turned around. Resident A acknowledged that he should have told staff prior to leaving the home. Resident A stated, "I wish I would have told them" so he could be home sooner.

After speaking to Resident A, I spoke to live-in staff member, Charlena Pickett. Ms. Pickett stated that she was not working on the day this incident occurred. Instead, her colleague Beatrice Nixon was working when Resident A left the home. Ms. Pickett stated that Ms. Nixon told her that she checked on Resident A at 3:30 am. Ms. Pickett stated that Ms. Nixon typically starts to make breakfast at or around 5:00 am. Ms. Pickett stated that when Ms. Nixon went to check on Resident A at 5:00 am, "he was gone." Ms. Pickett stated that Ms. Nixon called her and "she was hysterical" due to not knowing where Resident A was. Ms. Pickett stated that Ms. Nixon asked her what she should do and, "I told her to call 911 and she did." Ms. Pickett stated that she believes Ms. Nixon called 911 around 5:30 am when the two of them ended their phone call.

Ms. Pickett stated that Resident A never told Ms. Nixon that he was leaving. Ms. Pickett stated that this is the only time that Resident A has left the home without notifying anyone. Ms. Pickett stated that Ms. Nixon notified Mr. Husted and he reportedly notified Resident A's guardian of this incident. Ms. Pickett stated that Mr. Husted said the guardian called and stated that Resident A told her he was going to the hospital. Ms. Pickett stated that if Resident A needed to go to the hospital, all he had to do was let Ms. Nixon know and she would have called an ambulance for him. Ms. Pickett stated that Resident A told Ms. Nixon after he returned home that he left to get food.

On 2/8/23, I spoke to staff member Beatrice Nixon via phone. Ms. Nixon confirmed that she was working this past Friday (2/3/23) when Resident A left the home. Ms. Nixon stated that Resident A did not tell her that he was leaving the home and she also did not hear him leaving. Ms. Nixon stated that Resident came out of his room

and went to the bathroom while she was starting the coffee pot. After Resident A went to the bathroom, his bedroom light was still on and she assumed that he returned to his bedroom. Ms. Nixon stated that she made breakfast and went to Resident A's room to notify him that breakfast was ready, which is when she noticed he was not in his room. Ms. Nixon stated that she asked other residents if they knew of Resident A's whereabouts and they stated no.

Ms. Nixon stated that the last time she laid eyes on Resident A was at 3:30 am when he went to the bathroom. When she noticed Resident A was not in the home, Ms. Nixon stated that it was 7:20 am. Ms. Nixon stated that she was "scared to death" because his whereabouts were unknown. When Resident A returned, he reportedly told Ms. Nixon that he went to get coffee on 28th street and went the wrong way.

On 2/9/23, I spoke to licensee designee, Corey Husted via phone. Mr. Husted stated that he was told that Resident A left the home at 5:30 am. Mr. Husted was told this information by Resident A's guardian and the police that located Resident A. Mr. Husted stated that his staff member, Beatrice Nixon was awake at 3:00 am when Resident A mentioned going to the hospital. Mr. Husted stated that Ms. Nixon did not think Resident A would leave at that time of day.

Mr. Husted stated that Ms. Nixon told him that she went to wake Resident A for breakfast at 7:00 am and he was no longer in his room. Mr. Husted stated that Ms. Nixon did not know Resident A was gone. Mr. Husted stated that Ms. Nixon called her supervisor, Charlena Pickett and she was informed to call the police, which she did. After Ms. Nixon called the police, Mr. Husted stated that she called him around 7:30 am and informed him that she already called the police. Mr. Husted was unable to recall if he texted Resident A's guardian or if she texted him first about the incident. Mr. Husted stated that he received a call from Trinity Health (St. Mary's) saying that Resident A was ready to discharge and he returned home around 2:30 pm the same day without any discharge paperwork from the hospital. Mr. Husted acknowledged that it was likely a couple hours after staff noticed Resident A was away from the home before his guardian was notified.

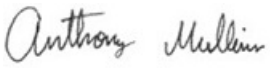
On 02/13/2023, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following: **(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.** **(b) Contact the local police authority.**

ANALYSIS:	The complainant stated that she was informed of the incident by Grand Rapids Police Department. Mr. Husted stated that he was unsure if he reached out to Resident A's guardian first about the incident. However, he acknowledged that direct communication with the guardian did not occur until a few hours after it was noticed that Resident A was missing from the home. 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 changes to the current license status.



02/13/2023

Anthony Mullins — Date
Licensing Consultant

Approved By:

02/13/2023

Jerry Hendrick — Date
Area Manager