GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2023

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

RE: License #: AS410403030
Investigation #: 2023A0350010
Brightside Living - Cedar Springs

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) 356-0100.

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 #:	2023A0350010
Complaint Receipt Date:	02/17/2023
Investigation Initiation Date:	02/17/2023
Report Due Date:	03/19/2023
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 - 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 member Brandi Ryan, who was working alone, fell asleep and Resident A went outside unnoticed. Resident A fell out of his wheelchair in the driveway and a passerby notified Ms. Ryan about it.	Yes

III. METHODOLOGY

02/17/2023	Special Investigation Intake 2023A0350010
02/17/2023	Special Investigation Initiated - Letter I sent Kalia Greenhoe, Administrator, and email requesting contact
02/17/2023	Contact - Telephone call made I spoke with Brandi Ryan, DCW
02/17/2023	Contact - Document Sent I sent Ms. Greenhoe an email requesting Resident A's Assessment Plan and CHM Treatment Plan
02/17/2023	Contact - Document Received I received Resident A's Discharge Instructions from Ms. Ryan, as requested
02/21/2023	Contact - Document Received I received a fax from Ms. Greenhoe
02/23/2023	Exit conference – Held with Corey Husted, Licensee Designee

ALLEGATION: Staff member Brandi Ryan, who was working alone, fell asleep and Resident A went outside unnoticed. Resident A fell out of his wheelchair in the driveway and a passerby notified Ms. Ryan about it.

INVESTIGATION: On 02/17/2023, I called and spoke with Brandi Ryan, Direct Care Worker (DCW) and asked her about this allegation. Ms. Ryan stated that she had been working for 48 hours and was asleep when Resident A left the house on 02/16 at 5:30 a.m. Ms. Ryan reported that a stranger rang the doorbell and told her that Resident A had fallen in the driveway. Ms. Ryan told me that once Resident A was back in the home, she checked him over for injuries and did not observe any. However, she said that he later said his neck was hurting and he went to the hospital. I requested that Ms. Ryan send me the discharge instructions from the hospital and the Incident Report pertaining to this incident, and she said she would email them to me. Ms. Ryan said that she usually works 12-hour shifts and does not

sleep while working, but on this occasion she had worked a 48-hour shift and when this incident occurred she was asleep. Ms. Ryan informed me that she worked the 48-hour shift because one staff member recently quit and another one was terminated, leaving the company short-staffed for this home. She added that there were no alarms on the doors.

On 02/17/2023, Ms. Ryan sent me the Discharge Instructions from Resident A's hospital visit on 02/16. No injuries were noted in the report, which stated that his condition upon discharge was "good."

On 02/17/2023, I send an email to Kalia Greenhoe, Administrator, requesting Resident A's Assessment Plan.

On 02/21/2023, Ms. Greenhoe faxed the documents I requested.

On 02/23/2023, I reviewed Resident A's Asessment Plan, which states that while in the community, he gets confused and "can wander and get lost," and that he requires full assistance.

02/23/2023, I called and held an exit conference with Corey Husted, Licensee Designee. I informed Mr. Husted that I was citing a violation of this rule. Mr. Husted did not dispute this finding and said that he has been thinking of a way to prevent this from happening again, and said he was considering putting chimes on the doors. He did say, however, that he would have to have that approved from Community Mental Health. Mr. Husted also reported that it was "very uncharacteristic" for Resident A to leave the home unattended and when he asked him about it, Resident A told him he got confused and did not know why he left the house. Mr. Husted further told me that he took Resident A to his neurologist appointment today, but it could not be determined why Resident A did this uncharacteristic behavior.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Direct Care Worker Brandi Ryan was working alone on 02/16/2023 and fell asleep. While Ms. Ryan was asleep Resident A went outside in his wheelchair unnoticed by Ms. Ryan, and he fell in the driveway. A passerby discovered Resident A, went to the house and got Ms. Ryan's attention.

	Resident A's Assessment Plan states that he requires "full assist" (assistance) while outside the home because he gets "confused," and "can wander and get lost." My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

February 23, 2023

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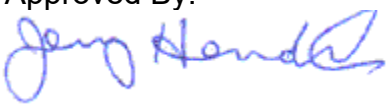
Ian Tschirhart — Date
Licensing Consultant

Approved By:



February 23, 2023

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Jerry Hendrick — Date
Area Manager