GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 22, 2023

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

RE: License #: AS410403032
Investigation #: 2023A0583022
Brightside Living - Rosemary

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,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410403032
Investigation #:	2023A0583022
Complaint Receipt Date:	03/07/2023
Investigation Initiation Date:	03/07/2023
Report Due Date:	04/06/2023
Licensee Name:	Brightside Living LLC
Licensee Address:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Corey Husted
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, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
The licensee refuses to allow Resident A to return to the facility after being taken to the hospital.	Yes
Facility staff smoke marijuana and drink alcohol to intoxication while working at the facility.	No
Facility staff verbally mistreat residents.	No

III. METHODOLOGY

03/07/2023	Special Investigation Intake 2023A0583022
03/07/2023	APS Referral
03/07/2023	Special Investigation Initiated - Telephone APS Emily Graves
03/07/2023	Contact - Telephone call made St Mary's Social Worker Basil Hanks
03/07/2023	Contact - Telephone call made Licensee Corey Husted
03/07/2023	Contact - Document Received Licensing Consultant Anthony Mullins
03/072023	Contact – Telephone call made Guardian Renee Stamper
03/09/2023	Inspection Completed Onsite Staff Charlena Pickettt, Resident B, Resident C
03/08/2023	Contact - Document Received Licensee Designee Corey Husted
03/17/2023	Contact – Document Received APS Emily Graves
03/17/2023	Inspection Completed Onsite Staff Charlena Pickettt, Resident B, Resident C
03/22/2023	Exit Conference Licensee Designee Corey Husted

ALLEGATION: The licensee refuses to allow Resident A to return to the facility after being taken to the hospital.

INVESTIGATION: On 03/07/2023 complaint allegations were received from Adult Protective Services. The allegations were assigned for formal Adult Protective Services investigation. The complaint stated, *'(Resident A) was dropped off at the Saint Mary's ER by staff from the Brightside Rosemary AFC and when (Resident A) was dropped off, there were no medical concerns noted at the time'.* The complaint further stated that, *'(Resident A) has been cleared to be picked up, and AFC staff is not allowing (Resident A) to return to the home.'*

On 03/07/2023 I interviewed St. Mary's hospital social worker Basil Hanks via telephone. Ms. Hanks stated Resident A resides at the Brightside Living – Rosemary Adult Foster Care facility. Ms. Hanks stated Resident A arrived at the emergency department on 03/03/2022 at 5:00 PM and was admitted to the emergency department due to adult foster care staff reports of suicidal thoughts. Ms. Hanks stated medical staff have not observed Resident A display suicidal ideation. Ms. Hanks stated Resident A has denied suicidal ideation and has been medically cleared for discharge since 03/06/2023 at 11:00 AM. Ms. Hanks stated she contacted licensee designee Corey Husted and requested Resident A be returned to the facility. Ms. Hanks stated Mr. Husted refused to allow Resident A to return to a facility. Ms. Hanks stated Mr. Husted reported that Resident A was a danger to facility residents due to recently "yelling" and "chasing" a physical therapist out of the facility. Ms. Hanks stated she "found it difficult to believe" that Resident A possess the physical mobility required to chase anyone because Resident A is missing two toes and "shuffles" as he walks. Ms. Hanks stated Mr. Husted reported that "under no circumstance" will Resident A be allowed back into the facility and that if medical staff transport Resident A back to the facility, Mr. Husted will send Resident A back to the emergency department. Ms. Hanks stated she has been in contact with Adult Protective Services staff Emily Graves and Resident A's public gaudian Renee Stamper. Ms. Hanks stated that due to be facility's refusal to accept Resident A back to the facility, Ms. Graves and Ms. Stamper are in the process of securing an emergency placement for Resident A at a new facility.

On 03/07/2023 I interviewed Adult Protective Services staff Emily Graves. Ms. Graves stated she is assigned to investigate the current complaint allegations and has a history of working with Resident A in the past. Ms. Graves stated she is familiar with Resident A's physical and emotional challenges. Ms. Graves stated that facility staff sent Resident A to the Saint Mary's emergency department and refused to allow Resident A back to the facility despite being medically cleared to do so. Ms. Graves stated facility staff have given Resident A an immediate discharge notice despite not being a "substantial risk" of harm to himself or others. Ms. Graves stated she is aware of two incidents leading to Resident A's current hospital admission. Ms. Graves stated on or about 03/02/2023 she was informed that Resident A "had a migraine headache" and yelled at licensee designee Corey Husted for "banging on the wall next to Resident A's bedroom". Ms. Graves stated

that Resident A has a history of “being grumpy when he has migraine headaches”. Ms. Graves stated she was informed that on or about 03/03/2023 Resident A was reported to have “chased a physical therapist out the facility”. Ms. Graves stated Resident A lacks the physical mobility to chase anyone. Ms. Graves stated Resident A can be verbally deescalated during situations of agitation and Resident A has not displayed a history of physical aggression. Ms. Graves stated she is not in agreement that Resident A poses a substantial risk of harm. Ms. Graves stated Ms. Husted has provided Resident A’s public guardian Renee stamper with an immediate discharge notice and is refusing to admit Resident A back to the facility.

On 03/07/2023 I interviewed licensee designee Corey Husted via telephone. Mr. Husted stated that Resident A exhibits behaviors that pose a substantial risk of harm to others. Mr. Husted stated he is aware of two incidents which indicate Resident A is a substantial risk to others. First, Mr. Husted stated that on or about 03/02/2023 Resident A became upset and yelled, “who the F is making that noise” and then proceeded to slam a door because Mr. Husted was making noise while fixing an item at the facility. Second, Mr. Husted stated that on or around 03/03/2023 he was informed by facility staff that Resident A “chased” a physical therapist and nurse out of the facility while yelling and screaming because he did not want their services. Mr. Husted stated the police were called to the residence on 03/03/2023 and Resident A was transported to the St. Mary’s Emergency department. Mr. Husted stated the other residents are afraid of Resident A due to his verbal aggression. Mr. Husted acknowledged that Resident A has not been physically aggressive to staff or residents. Mr. Husted stated that hospital medical staff contacted Mr. Husted after Resident A was medically cleared to return to the facility and Mr. Husted stated that he informed hospital staff he would not accept Resident A back to the facility. Mr. Husted stated that he emailed an immediate discharge notice to Resident A’s guardian, Renee Stamper on 03/04/2023 at 4:00 PM. Mr. Husted stated he did not provide a copy of the discharge notice to LARA, Resident A, or Resident A’s case manager, Dusty Young of Reliance. Mr. Husted stated he did not identify alternate placements for Resident A because Mr. Husted stated it was not his responsibility.

On 03/07/2023 I interviewed Renee Stamper via telephone. Ms. Stamper identified she is Resident A’s public guardian. Mr. Stamper stated that on 03/03/2023 facility staff sent Resident A to the Saint Mary's emergency department and after being medically discharged to return to the facility, licensee designee Corey Husted refused to allow Resident A to return. Ms. Stamper stated Mr. Husted provided Ms. Stamper with an immediate discharge notice for Resident A on 03/03/2023 at 4:00 PM which was a Friday afternoon. Ms. Stamper stated she was not given 24 hours’ notice, but rather an immediate discharge notice. Ms. Stamper stated she convinced hospital staff to admit Resident A inpatient because Resident A was not allowed by Mr. Husted to return to the facility. Ms. Stamper stated she was informed by Ms. Husted that Resident A has cursed at Ms. Husted and slammed a door. Ms. Stamper stated she was not informed of the 03/03/2023 incident until she was served with the discharge notice. Ms. Stamper stated she does not believe

Resident A is a substantial risk of harm to others and is currently attempting to locate a new placement for Resident A.

On 03/07/2023 I received an email from Licensing Consultant Anthony Mullins. The email stated, “I never received a 24-hour discharge notice” regarding Resident A. Mr. Mullins stated he did receive an incident report on 03/06/2023 (dated 3-3-23) which states a 24-hour discharge notice was given.

On 03/07/2023 I reviewed an Incident Report signed by staff Charlena Pickettt and staff Kayla Greenhoe. The incident report is signed 03/03/2023 and states, “visiting nurse from home MD came to see (Resident A) and he got very angry, called them a lot of names, told them don’t come back”. The incident report stated Resident A “started punching the walls, knocked off a picture, and tried to punch lady in the face”. The incident report states that the police were contacted and Resident A was given a “24 hour eviction notice”.

On 03/08/2023 I received an email from Licensee Designee Corey Husted which contained Resident A’s Assessment Plan and Discharge Notice. The document was signed on 01/17/2023 and states Resident A controls aggressive behaviors, gets along with others, and uses a walker for stability.

The Discharge Notice was signed by Licensee Designee Corey Husted 03/03/2023 and states the following: ‘*I believe that Resident A has become too great of a risk of harm to residents in the home, staff, and himself to remain in the Brightside Living - Rosemary adult foster care home. On 3/2/2023. I witnessed firsthand as he busted open his door (at 2 PM) and yelled “Who are the F is banging on the walls! Shut the F up!” then I said sorry Resident A I am fixing a door. He then yelled “F you!” and slammed the door hard. In addition, he literally chased his physical therapist from the home that day. And on 3/3/2023 chased the nurse from the home. He is very physically intimidating, and his roommate has not slept in their shared room since Resident A returned to the home from the hospital the last time. His addiction to pain medications continues to be an issue, but is not currently any excuse as he is getting his meds now. Please remove him from Brightside Living - Rosemary immediately. He is not welcome at any of the Brightside Living homes now, or in the future’*.

On 03/09/2023 I completed an unannounced onsite investigation at the facility and interviewed staff Charlena Pickett, Resident B, and Resident C.

Staff Charlena Pickett stated that on 03/02/2023 Resident A became verbally upset due to licensee designee Corey Husted causing noise associated with fixing a doorknob. Ms. Pickett stated Resident A yelled “shut the F up” to Mr. Husted and slammed the door shut. Ms. Pickett stated that on 03/03/2023 Resident A walked towards a new in-home nurse, Kimberly Harper, and yelled “I’m going to knock your face off your shoulders” and knocked a picture frame off the wall. Ms. Pickett stated Resident A then stated to Ms. Pickett, “I thought you were a nice person, why are you letting these people come into my room” after Ms. Harper visited the facility. Ms.

Pickett stated Ms. Harper contacted the Grand Rapids Police Department and requested Resident A be transported to the St. Mary's emergency department for evaluation. Ms. Pickett stated Resident A has not returned to the facility because Resident A was evicted from the facility.

Resident B stated Resident A was "naughty" and "threw a picture". Resident B stated Resident A "was bad" and "I was scared of him".

Resident C stated Resident A "yells at me and cussed at me". Resident C stated Resident A is a "bad person". Resident C stated Resident A never physically assaulted any resident or staff that Resident C is aware of.

On 03/17/2023 I received an email from Adult Protective Services staff Emily Graves, which summarized Ms. Graves' 03/16/2023 face-to-face interview with Resident A. The summary stated the following: *'APS arrived in room 724 at St. Mary's hospital. (Resident A) was seated in a chair by the window eating. APS asked (Resident A) to explain how he came to be evicted from Brightside-Rosemary. (Resident A) said he didn't know that he was evicted. APS asked him to tell me about how he came to be in the hospital. (Resident A) explained that there had been a series of events that had caused him a lot of stress and anxiety. A doctor and nurse had come to see him and staff had immediately let them into his room. (Resident A) identifies his room as a "sanctuary." It is the only place he feels safe and can block out things that cause him pain and migraine issues. The doctor that came to see him never talks to him, rather he talks to staff instead. This frustrated (Resident A) and he told them to get out of his room. He did not want to see that doctor anymore and (Resident A) believes that the doctor has been billing his insurance despite not providing any care. APS asked if Cory was there to witness this incident and he stated that Cory was not there. A few days later, (Resident A) was trying to sleep sometime between 12PM-2PM. Someone was making noise and banging loudly. (Resident A) said he came out of his room and was planning to cuss the person out. He assumed, incorrectly, that it was another resident who has "fits" and bangs on the walls and it was Cory fixing a door knob. (Resident A) cussed Cory out and went back to his room. (Resident A) does not believe these incidents warrant being eviction, however, he does not want to go back there as he feels like he doesn't fit in with residents and he does not like the staff. APS spoke with (Resident A) about the two new housing options that Renee Stamper was looking into and he was excited. He said that no one in the hospital talks to him and he is getting very lonely. APS empathized with him and thanked him for meeting with me today'.*

On 03/22/2023 I completed an Exit Conference with licensee designee Corey Husted via telephone. Mr. Husted agreed that he had not provided written notice to all required parties however Mr. Husted stated he discharged Resident A emergently because he feared for the safety of his staff and residents should Resident A return to the facility. Mr. Husted stated he would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.**
ANALYSIS:	On 03/03/2022 licensee designee Corey Husted issued an immediate discharge notice to Resident A and refused to allow Resident A to return to the facility after a hospital admission. Adult Protective Services staff Emily Graves and St. Mary's social worker Basil Hanks did not find Resident A to be a substantial risk of harm to himself or others. Resident A was immediately discharged from the facility despite Resident A not presenting as a substantial risk of harm to himself or others; therefore, a preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**

	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Licensee designee Corey Husted did not notify Resident A, Resident A's guardian, Resident A's case manager or the adult foster care licensing consultant not less than 24 hours before discharge, did not evaluate alternatives to discharge, and did not identify the location of discharge. Therefore, a preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff smoke marijuana and drink alcohol to intoxication while working at the facility.

INVESTIGATION: On 03/17/2023 I received an email from Adult Protective Services staff, Emily Graves, which I contained a summary of Ms. Graves 03/16/2023 face-to-face interview with Resident A. During Resident A's interview, Resident A stated facility staff, Charlena Pickett, smokes marijuana and drinks alcohol to intoxication while residents are sleeping. Resident A stated Ms. Pickett is "so hung over" in the mornings that she serves breakfast to residents late.

On 03/17/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Charlena Pickett, Resident B and Resident C.

Staff Charlena Pickett stated that she resides in the lower level of the facility that is not utilized by residents and works every week from "Sunday at 6:00 PM until Friday at 6:00 PM". Ms. Pickett stated she has never smoked marijuana or consumed alcohol at the facility. Ms. Pickett stated she has never worked at the facility while intoxicated and has never prepared breakfast late for residents as a result.

Resident B and Resident C both stated that they have never observed Ms. Pickett consume alcohol or marijuana at the facility. Both residents stated they have never observed Ms. Pickett appear intoxicated. They both also denied breakfast had been served late due to such behaviors. Both residents characterized Ms. Pickett as a friendly and caring staff.

On 03/22/2023 I completed an Exit Conference with licensee designee Corey Husted. Mr. Husted stated he agreed with the findings.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household**.
	(1) A licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household shall be in such physical and mental health so as not to negatively affect either the health of the resident or the quality of his or her care.
ANALYSIS:	Staff Charlena Pickett stated that she has never smoked marijuana or consumed alcohol at the facility. Resident B and Resident C both stated that they have never observed staff Charlena Pickett consume alcohol or marijuana at the facility therefore, a preponderance of evidence was not

	discovered during the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff verbally mistreat residents.

INVESTIGATION: On 03/17/2023 I received an email from Adult Protective Services staff, Emily Graves, which contained a summary of Ms. Graves 03/16/2023 face-to-face interview of Resident A. During Resident A's interview, Resident A stated facility staff, Charlena Pickett "is constantly yelling" at residents "to be quiet".

On 03/17/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Charlena Pickett, Resident B, and Resident C.

Staff Charlena Pickett stated that she treats all residents with dignity and respect. Ms. Pickett stated she does not yell at residents to be quiet. Ms. Pickett stated the allegation was untrue.

Resident B and Resident C both characterized Ms. Pickett as a friendly and caring staff. Both residents stated the allegation was untrue and that they are happy with the level of care provided.

On 03/22/2023 I completed an Exit Conference with licensee designee Corey Husted. Mr. Husted stated he agreed with the findings.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Staff Charlena Pickett stated that she treats all residents with dignity and respect. Ms. Pickett stated she does not yell at residents to be quiet. Ms. Pickett stated the allegation was untrue. Resident B and Resident C both characterized staff Charlena Pickett as a friendly and caring staff. Both residents stated the allegation was untrue, and they are happy with the level of care provided. Therefore, a preponderance of evidence was not discovered during the Special Investigation to substantiate violation of the applicable rule.

CONCLUSION:	VIOLATION NOT ESTABLISHED

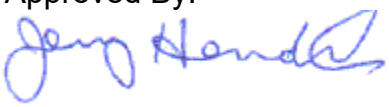
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

03/22/2023

Toya Zylstra — Date
Licensing Consultant

Approved By:



03/22/2023

Jerry Hendrick — Date
Area Manager