GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 19, 2023

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

RE: License #: AS410403033
Investigation #: 2023A0467040
Brightside Living - Heathcliff

Dear Mr. Husted:

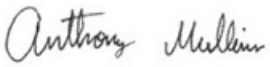
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410403033
Investigation #:	2023A0467040
Complaint Receipt Date:	04/11/2023
Investigation Initiation Date:	04/11/2023
Report Due Date:	06/10/2023
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 - Heathcliff
Facility Address:	2611 Heathcliff Dr SE Grand Rapids, MI 49546
Facility Telephone #:	(614) 329-8428
Original Issuance Date:	04/22/2020
License Status:	REGULAR
Effective Date:	10/22/2022
Expiration Date:	10/21/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A continues to have bedbugs after two months, causing her to miss day program.	No
Resident A is not receiving personal care as described in her assessment plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/11/2023	Special Investigation Intake 2023A0467040
04/11/2023	Special Investigation Initiated - Telephone Spoke to the complainant via phone.
04/17/2023	Inspection Completed On-site
04/18/2023	Contact – Document sent: Emailed Mr. Husted requesting copies of professional bedbug treatments.
04/19/2023	Contact – Document received. Recipient Rights Officer, Michael Kuik from N-180 provided his communication with AFC staff members.
04/19/2023	APS referral – sent via email.
04/19/2023	Exit conference with the owner/designee, Corey Husted.

ALLEGATION: Resident A continues to have bedbugs after two months, causing her to miss day program.

INVESTIGATION: On 4/11/23, I received a Recipient Rights complaint regarding Resident A. The complaint states that Resident A has been living with bed bugs for more than two months. As a result, she is not able to go to day program.

4/11/23, I spoke to Michael Kuik, Recipient Rights Officer through Network 180. Mr. Kuik stated that he has not contacted Resident yet. Mr. Kuik and I agreed to meet at the home on Monday, 4/17/23 at 10:30 am.

On 4/17/23, I made an unannounced onsite investigation to the facility. Upon arrival, staff member Wendy Shelley answered the door and allowed entry into the home. Minutes later, Recipient Rights Officer, Mr. Kuik arrived at the home. Introductions were made with Resident A, who was observed sitting on the couch in the living

room. Resident A agreed to discuss the case allegations. Resident A stated that things were “good” at the AFC home. Resident A was unable to give a specific time frame as to how long she has lived in the home. However, she did state “yes” when asked if she’s lived in the home for a long time. Resident A shook her head up and down, indicating “yes” when asked if the home has bed bugs. It should be noted that it was difficult for Resident A to answer direct questions or to respond with anything other than yes or no.

After speaking to Resident A, Mr. Kuik and I spoke to staff member Wendy Shelley. Ms. Shelley informed us that Resident A has limited verbal communication skills. When asked about the home having bed bugs, Ms. Shelley confirmed this, stating that the home has had an ongoing issue for one year. Ms. Shelley stated that the owner, Corey Husted has had the home professionally treated by Griffin Pest Solutions quarterly, which involves the residents leaving the home for four hours. In addition to this, Ms. Shelley stated that the residents’ mattresses have been replaced and staff have been keeping their clothes in the garage and washing/using them when needed. Ms. Shelley stated that although the professional bed bug treatments usually occur quarterly, Griffin Pest Solutions has been to the home more often to address the issue. The last time Griffin Pest Solutions was at the home was this past Tuesday (4/11/23). As a result of the ongoing bed bug issue, Resident A has not been able to attend day program for 5 to 6 months. Ms. Shelley did not have receipts from Griffin Pest Solutions but stated that Mr. Husted will. It should be noted that the home was clean during this onsite inspection. I did not observe any signs of bedbugs on furniture in the living room or bedrooms in the home.

After speaking to Ms. Shelley, Mr. Kuik and I spoke to Resident B. Resident B stated that she has been at the home since January 2023 and acknowledged that the home has had bed bugs. Resident B stated that the last time she saw a bed bug was a few weeks ago. She did not have additional information to add regarding this.

After speaking to Resident B, Mr. Kuik and I spoke to Resident C with Ms. Shelley per her request. Resident C stated that she has lived at the home for two months and recalled seeing a bed bug last week on her roommate’s bed. Resident C acknowledged that the home is being professionally treated by Griffin Pest Solutions. Resident C denied any bedbugs being on her or her personal belongings. Resident C was thanked for her time.

On 4/17/23, I spoke to staff member Cheyenna Ryerson via phone. Ms. Ryerson stated that she has worked at the home on and off for the past seven years. Ms. Ryerson typically works 3rd shift although she has worked other shifts in the home. Ms. Ryerson was informed of the bed bug allegations and confirmed that the home continues to have bed bugs. Ms. Ryerson stated that she has never physically seen the bed bugs herself. However, she is aware of this issue due to it being relayed to her, in addition to the home having Griffin Pest Control professional treatments. Ms. Ryerson stated that there have been at least three bed bug treatments to her knowledge with the last treatment occurring recently. Ms. Ryerson was unable to

give a more specific time frame. Ms. Ryerson stated that the home has had this ongoing bedbug issue for approximately one year and does not know why this issue has not been resolved, considering that the home receives professional treatments. Ms. Ryerson stated that the home is clean and the other AFC home she works at does not have this issue. As a result of the bed bug issue, Ms. Ryerson confirmed that Resident A has been unable to attend Day Program.

On 4/18/23, I sent an email to the owner/designee, Corey Husted, requesting copies of all professional bedbug treatments through Griffin Pest Solutions for 2023. Mr. Husted responded and provided receipts as requested. The dates of service are between 12/27/22 through 04/11/23. Mr. Husted stated that he went to the home last week while the manager (John) of Griffin Pest Control was at the home treating it. Mr. Husted stated that, "there was a lot of activity in and around the wooden bed used by (Resident A)." The wooden bed reportedly, "has a lot of nesting site potential as John had told me it was difficult to treat." Despite this, the area was fully treated. Mr. Husted initially thought the bed belonged to a resident. Yesterday, he told his team that he wanted the bed frame replaced with a steel frame after finding out it belongs to him. Mr. Husted stated that he also plans to replace the carpet in the bedroom.

On 04/19/23, I conducted an exit conference with the owner/designee, Corey Husted. He was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	The home currently has an ongoing bedbug issue. Resident A, Resident B, and Resident C confirmed this. Staff members Ms. Shelley and Ms. Ryerson also confirmed this. The home is currently being professionally treated by Griffin Pest Control, with the most recent treatment occurring on 4/11/23. Unfortunately, Resident A has missed Day Program due to the home having bed bugs. However, Mr. Husted is professionally treating the home. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is not receiving personal care as described in her assessment plan.

INVESTIGATION: On 4/11/23, I received a Recipient Rights Complaint regarding Resident A. The complaint states that Resident A's personal care needs are not being met as she is not receiving showers on her scheduled days and not receiving assistance with brushing her teeth and getting dressed per her assessment plan. The complaint stated that staff member Wendy Shelley provides good care when she's working. However, when Ms. Shelley is not working, Resident A's care is subpar.

On 4/17/23, I made an unannounced onsite investigation to the facility. Upon arrival, staff member Wendy Shelley answered the door and allowed entry into the home. Minutes later, Recipient Rights Officer, Mr. Kuik arrived at the home. Introductions were made with Resident A, who was observed sitting on the couch in the living room. Resident A agreed to discuss the case allegations. Resident A stated that things were "good" at the AFC home. Resident A did not know how many baths she's supposed to get per week in the home. Resident A shared that staff member Wendy Shelley gives her baths as scheduled. She also shook her head up and down, indicating "yes" when asked if Ms. Shelley does a good job attending to her care needs. Resident A also acknowledged that Ms. Shelley helps her brush her teeth and get dressed when she is working. Resident A was unable to answer if other staff members assist her in addressing her personal care needs. Resident A was thanked for her time. It should be noted that it was difficult for Resident A to say anything other than yes or no.

After speaking to Resident A, Mr. Kuik and I spoke to Ms. Shelley. Ms. Shelley was asked if Resident A's care needs are being met. Ms. Shelley stated that she addresses Resident A's care needs, and other residents when she is working. However, it has been a struggle for other staff members to give Resident A a shower and to do residents' laundry on their scheduled days. Ms. Shelley stated that she has made Mr. Husted, Ms. Greenhoe (administrator), and Ms. Allen (office manager) aware of her concerns and they planned to reach out to staff to address it. Ms. Shelley confirmed that there have been days that she has returned to work and observed Resident A wearing the same clothes from the previous day. Ms. Shelley also stated that she has had to change out Resident A's toothbrush due to it being "hard as a rock." Ms. Shelley did not give a specific time frame that this occurred.

Ms. Shelley showed Mr. Kuik and I a log for Resident A that staff are supposed to check off and initial that they completed personal care needs for Resident A. On April 5th, 6th, 8th, 11th, 12th, 13th, 15th, and 17th, there were no initials logged, indicating that Resident A's personal care needs were not addressed. Another log was reviewed that staff are to check off and initial that Resident A "will fully wash the frontside of her body with 50% success each day." On the same dates listed above, there were no initials logged, indicating that this was not completed. I reviewed Resident A's assessment plan. The assessment plan was signed on 9/22/22, indicating that Resident A requires assistance with toileting, bathing, grooming, dressing, and personal hygiene. After speaking to Ms. Shelley, Mr. Kuik and I spoke to Resident B. Resident B acknowledged that she needs assistance with her

personal care due to having scoliosis. Resident B was adamant that her personal care needs are being met and she denied any concerns in the home.

After speaking to Resident B, Mr. Kuik and I spoke to Resident C with Ms. Shelley present per her request. When asked about her personal care needs, Resident C stated that she is independent and does everything herself. Resident C denied any concerns within the home and stated, “I’m happy here.”

On 4/17/23, I spoke to staff member Cheyenna Ryerson via phone. I informed Ms. Ryerson of the allegations of staff reportedly not attending to Resident A’s personal care needs, such as bathing, brushing her teeth, and getting her dressed. Ms. Ryerson confirmed that Resident A needs assistance with all care needs. Ms. Ryerson also confirmed that one time she witnessed Resident A without her care needs being addressed. It was evident to Ms. Ryerson that Resident A needs were not attended to based on her physical appearance, which she was not happy about. Ms. Ryerson stated that this occurred “maybe a half year ago” and she expressed her concerns to her boss, Angela Allen and she planned to address the concerns with the staff member. Ms. Ryerson stated that the staff member in question, Kaylin (last name unknown) is no longer employed at the home.

Ms. Ryerson was asked about recent concerns of Resident A’s personal care needs not being met. Ms. Ryerson stated that her last time working in the home was approximately one month ago. Ms. Ryerson stated that staff member Willean (last name unknown but believed to be Enoch) is not addressing resident needs. Instead, she feels that Willean “bickers” at residents. Ms. Ryerson was thanked for her time.

On 04/19/23, I conducted an exit conference with the owner/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 400.14303	**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:	Resident A’s assessment plan indicates that she requires assistance with toileting, bathing, grooming, dressing, and personal hygiene. Based on the ADL logs for Resident A, there were multiple days this month that she did not receive personal care as required. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, it was brought to my attention that Resident A's Medication Administration Record (MAR) was not initialed on certain days for some of her medications. I reviewed Resident A's MAR for April 2023, which indicated the following: Resident A did not receive her Buspirone Tab 15MG, Cetirizine Tab 10MG, Fish Oil Cap 1400MG, Omeprazole Cap 20MG, and Propranolol Tab 60MG medication on 4/5/23, 4/8/23, and 4/14/23 at 8:00 pm. Resident A also did not receive her Trazadone Tab 100MG on 4/5/23, 4/8/23, and 4/14/23 at 8:30 pm.

In addition to this, Resident A's MAR indicated that she did not receive her Ferrous Sulf Tab 325MG EC medication for all of April due to "waiting on pharmacy," which is not an acceptable reason for a resident to miss doses of medication.

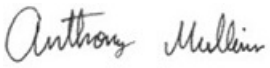
On 04/19/23, I conducted an exit conference with the owner/designee, Corey Husted. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

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 residents' 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:	I reviewed Resident A's April 2023 MAR, which consistently showed that there were no initials for her medication on 4/5/23, 4/8/23, and 4/14/23 at 8:00 pm or later. It should be noted that it's possible the medications were provided to the resident. However, without proper documentation, I can't confirm Resident A received her prescribed medications. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

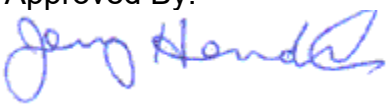
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



04/19/2023

Anthony Mullins — Date
Licensing Consultant

Approved By:



04/19/2023

Jerry Hendrick — Date
Area Manager