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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 5, 2023

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

RE: License #: AL280410649
Investigation #: 2023A0230031
Brightside Living - West Shore

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 (231) 922-5309.

Sincerely,

A handwritten signature in purple ink that reads "Rhonda Richards".

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL280410649
Investigation #:	2023A0230031
Complaint Receipt Date:	06/21/2023
Investigation Initiation Date:	06/21/2023
Report Due Date:	08/20/2023
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 - West Shore
Facility Address:	2651 Leaf Lane, Grawn, MI 49637
Facility Telephone #:	(614) 329-8428
Original Issuance Date:	03/14/2022
License Status:	REGULAR
Effective Date:	02/28/2023
Expiration Date:	02/27/2025
Capacity:	14
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A, B and C were left in soaked and soiled clothing and bedding on 06/11/2023.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/21/2023	Special Investigation Intake 2023A0230031
06/21/2023	Special Investigation Initiated - On Site Interviews with Staff members Jillisa Fitzgerald and Kristie Blankenship
06/21/2023	Contact - Face to Face Residents A, B, and C
06/22/2023	APS Referral
06/26/2023	Contact - Telephone call made Interview guardian/mother of Residents A, B, and C
06/28/2023	Contact- Telephone call made Home Manager Karen Fodders
06/29/2023	Contact - Telephone call made interview staff member Sherry Sheffer
07/03/2023	Exit Conference With Licensee Designee Corey Husted

ALLEGATION: Resident A, B and C were left in soaked and soiled clothing and bedding on 06/11/2023.

INVESTIGATION: On 06/21/2023, I conducted an unannounced on-site investigation at the facility and interviewed staff members Jillisa Fitzgerald and Kristie Blankenship regarding the above allegation.

Ms. Blankenship stated she did not work on 06/11/2023 and did not come in until the evening shift on 06/12/2023. She was unable to verify the condition the three residents were in on the morning of 06/12/2023. She stated that the current census at the facility is only the three residents.

Ms. Fitzgerald stated when she and staff member Lori Jones arrived in the morning on 06/12/2023 at 7:00 a.m. she observed that Residents A, B, and C had urine-soaked clothing and bedding and Resident A had dried feces on his body. She stated that she and Ms. Jones were there to relieve staff member Sherry Sheffer who had worked 06/11/2023 from 7:00 p.m. until 06/12/2023 at 7:00 a.m.

When she and Ms. Jones discovered the condition the residents were in, Ms. Fitzgerald, Ms. Jones and Ms. Sheffer immediately began to change the residents clothing and bedding and bathe and shower them.

While at the facility I observed Resident A, B and C, all of whom could not be interviewed as they are severely cognitively impaired. They were all clean and well-groomed on the day of my visit.

I reviewed resident records while at the facility and noted that Resident A and B's BCAL- 3265 assessment plan indicated "full assistance" with bathing, grooming, dressing, and personal hygiene. Resident A requires total care, is in a wheelchair and has a feeding tube. Resident C's plan indicated "needs assist" with bathing, grooming, dressing, and hygiene. I noted the assessment plans were not signed by Corey Husted who is the Licensee Designee and Administrator for the facility. They were signed by staff member Kalia Greenhoe.

On 06/21/2023, I interviewed staff member Lori Jones. She informed me that she no longer works at the facility. Ms. Jones confirmed that she and Ms. Fitzgerald had discovered Residents A, B, and C in soaked and soiled bedding and clothing on the morning of 06/12/2023 when they arrived at 7:00 a.m. Ms. Jones stated that the guardian/mother of the three residents also came to visit later that morning. She stated she informed guardian/mother of the condition the residents were in when she arrived at work.

On 06/26/2023, I spoke with Resident A, B, and C's guardian/mother regarding the allegations. She confirmed that she had arrived at the facility in the later morning of 06/12/2023 and was informed by staff member Ms. Jones that her sons had been left overnight in soaked and soiled bedding and clothing. Additionally, she stated that her sons were new to the facility having just arrived on 06/08/2023. She stated she told a staff member about Resident B needing to have tepid water for his shower as he has a history of trauma involving abuse occurring in bathrooms. At this time the staff who was working explained the water temperature could not be regulated because the shower knob was broken. She sent me a photo of the missing knob.

On 06/28/2023, I spoke with home manager Karen Fodders and discussed the broken knob on the faucet. She stated she would contact a plumber to fix the knob and assured me no resident would use that shower until it was fixed.

On 06/29/2023, I spoke with staff member Sherry Sheffer who confirmed the allegations were true regarding Residents A, B and C not being changed throughout

the night of 06/11/2023. She stated she was “overwhelmed” when she was on shift by herself from 9:00 p.m. until Ms. Jones and Ms. Fitzgerald came on shift at 7:00 a.m. She acknowledged that she could not change the clothing or bedding of the three residents the night of 06/11/2023 until the two morning shift staff members came on duty. Additionally, she stated she had never met these residents as they had just arrived three days prior to her shift that night, therefore she “didn’t know much about them and their behaviors”. She stated one of the residents was consistently up all night and physically striking her. Ms. Sheffer stated there is a new protocol in place that the residents will be checked for wet or soiled briefs every two hours. She stated there are now two staff on shift at night until 3:00 a.m. Ms. Sheffer confirmed that from 3:00 a.m. until 7:00 a. m. however she is the only staff member working.

On 07/03/2023, I conducted an exit conference with Licensee Designee Corey Husted and reviewed the findings of the investigation. Mr. Husted agreed that one staff member on for the care of Resident A, B and C from the hours of 3:00 a.m. to 7:00 a.m. needed to increase from one to two staff members. He also stated he would complete new assessment plans to accurately reflect the needs of the residents and sign the plans himself as the Licensee Designee. Additionally, he reported the bathroom shower handle has been fixed by a plumber. Mr. Husted will submit a plan of correction.

APPLICABLE RULE	
R 400.15305	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:	Residents A, B and C’s personal needs including protection and safety were not attended to on 06/11/2023 when their bedding and clothing was urine soaked and soiled and was not changed over a 10-hour period.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/26/2023, the guardian of Residents A, B and C informed me that the knob for one of the showers in the facility was broken therefore the water temperature could not be regulated. I observed a photo of the broken handle. On 06/28/2023 I spoke with Home Manager Karen Fodders who reported she would be contacting a plumber to fix the handle and assured me that no residents would be using that shower until it was fixed.

APPLICABLE RULE	
R 400.15403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	One of the resident bathroom showers had a broken handle which did not allow for proper water temperature regulation. While broken, this shower did not provide adequate safety for the residents.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/21/2023, I reviewed BCAL- 3265 assessment plans for Residents A, B and C which were signed by staff member Kaila Greenhoe and not the licensee designee/administrator Corey Husted.

APPLICABLE RULE	
R 400.15301	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:	Assessment plans for Residents A, B and C were not completed and signed by the licensee Designee/Administrator.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction I recommend the status of this license remain unchanged.

Rhonda Richards

07/05/2023

Rhonda Richards
Licensing Consultant

Date

Approved By:

Jerry Hendrick

07/05/2023

Jerry Hendrick
Area Manager

Date