GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 29, 2024

Kalia Greenhoe
Brightside Living LLC
PO Box 220
Douglas, MI 49406

RE: License #: AS410400152
Investigation #: 2024A0467031
Brightside Living - Comstock Park

Dear Ms. Greenhoe:

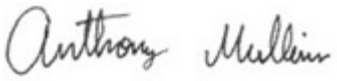
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410400152
Investigation #:	2024A0467031
Complaint Receipt Date:	04/23/2024
Investigation Initiation Date:	04/23/2024
Report Due Date:	06/22/2024
Licensee Name:	Brightside Living LLC
Licensee Address:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Kalia Greenhoe
Licensee Designee:	Kalia Greenhoe
Name of Facility:	Brightside Living - Comstock Park
Facility Address:	4312 Division Ave N Comstock Park, MI 49321
Facility Telephone #:	(616) 551-1034
Original Issuance Date:	08/01/2019
License Status:	REGULAR
Effective Date:	02/01/2024
Expiration Date:	01/31/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A ingested Resident B's medications as a result of staff member, Ashley Hill leaving the medication unsupervised.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/23/2024	Special Investigation Intake 2024A0467031
04/23/2024	Special Investigation Initiated - Letter Spoke to complainant via email
04/23/2024	APS Referral
04/24/2024	Inspection Completed On-site
04/24/2024	Contact - Telephone call made Spoke to AFC staff member, Ashley Hill
04/24/2024	Contact – Telephone call received Spoke to Drew Blackall with Kent County APS
04/29/2024	Exit conference completed with licensee designee, Kalia Greenhoe.

ALLEGATION: Resident A ingested Resident B's medications as a result of staff member, Ashley Hill leaving the medication unsupervised.

INVESTIGATION: On 4/23/24, I received a complaint from Kent County Recipient Rights officer, Michael Kuik. The complaint alleged that on 4/21/24, 3rd shift staff member, Ashley Hill left Resident B's Depakote medication out on the table, leading to Resident A ingesting it. As a result, Resident A was sent to Corewell Health – Butterworth Emergency Department (ED) on 4/21/24 to be treated. The home manager, Sarah Burgess reported that ED staff instructed the AFC staff to "let (Resident A) sleep it off." Resident A's symptoms included being "tired and groggy." Ms. Hill was reportedly reprimanded because of this incident.

On 4/23/24, I reviewed an Incident Report confirming that Resident A ingested Resident B's medications. Ms. Hill noted that the residents sat in the wrong seats, and Resident A took Resident B's medications because he thought they were his. Ms. Hill notified the appropriate parties, including Resident A's guardian.

On 4/23/24, I spoke to recipient rights officer, Michael Kuik regarding the complaint. We agreed to meet at the facility the next day to conduct a joint investigation.

On 4/24/24, I received a call from Drew Blackal, Kent County Adult Protective Services (APS) worker. Mr. Blackal inquired about Resident A's whereabouts. I confirmed that Resident A has since returned to the AFC facility after being discharged from the hospital. Mr. Blackall agreed to meet myself and recipient rights at the facility around 9:30 am today.

On 4/24/24, I made an unannounced onsite investigation at the facility. Upon arrival, Mr. Kuik with recipient rights was present and APS worker, Drew Blackall arrived approximately 15-20 minutes after. I knocked on the front door and AFC staff member, Sarah Burgess answered the door and allowed entry into the home.

Ms. Burgess was interviewed at the dining room table. Mr. Burgess was aware that we were at the home due to Resident A ingesting Resident B's medication. Ms. Burgess confirmed that the incident occurred this past Sunday, 4/21/24 at or around 8:00 pm. Mr. Burgess stated that AFC staff member, Ashley Hill was working 3rd shift on the day in question. Ms. Burgess stated that on Sunday night, she received a text message from Ms. Hill stating that she's sending Resident A to the ED due to taking Resident B's medication. Ms. Burgess stated that Ms. Hill put all of the resident's medication in individual cups at the same time. However, residents are supposed to be given their medications one at a time. Ms. Hill pointed to a sign on the wall next to the medication cart that provided this instruction as well. Ms. Burgess stated that Ms. Hill put all residents' medications in their cups and sat them on the table. Unbeknownst to Ms. Hill, Resident A and Resident B switched seats and Resident A ingested Resident B's medication. Ms. Burgess stated that Resident C noticed that Resident A took the wrong medications and informed Ms. Hill.

Ms. Burgess stated that Resident A took the following medications that were not his: Clonzapine 100mg, Depakote 1500, Glycopyrrol 1mg, and Levocarnitin 330mg. Despite Resident A taking the wrong medications, Resident B was given his prescribed medications after Resident C informed Ms. Hill of the incident. Ms. Burgess provided me with copies of Resident A's and Resident B's Medication Administration Record (MAR), which reflected this. Ms. Burgess stated that Resident A is currently away from the home at Day Program. Ms. Burgess stated that Resident A is "doing much better" after initially stumbling, slurring his words, and drooling while trying to feed himself. Although Resident A is not 100% back to baseline, he insisted on going to day program today. Ms. Hill provided me with contact information for staff member Ashley Hill. Ms. Burgess was thanked for her time as this interview concluded.

On 4/24/24, I spoke to AFC staff member, Ashley Hill via phone. Ms. Hill confirmed that she worked at the home this past Sunday, 4/21/24. Ms. Hill was asked to share what happened that led to Resident A ingesting Resident B's medications. Ms. Hill stated that when she arrived at work, she began prepping the resident's pills at the

medication cart. After doing so, Ms. Hill stated that she put the medications for each resident at the table where they typically sit. Ms. Hill told the residents that their medications and snacks were ready. Ms. Hill stated that the residents came to the table and sat down. During this time, Ms. Hill walked to the back of the home briefly. When Ms. Hill returned to the living room, she was informed by another resident that Resident A ingested Resident B's medication. At this point, Ms. Hill noticed that Resident A and Resident B were not in their typical seats, which led to Resident A taking the wrong medications.

After being informed of the incident, Ms. Hill stated that she called the office manager, Angela Allen and informed her of what occurred. While awaiting further instructions from management, Ms. Hill stated that she observed Resident A closely and checked on him every 30 minutes to make sure he was doing okay. Ms. Hill stated that she noticed Resident A began turning red and slurring his words, which prompted her to call Ms. Allen again and recommended that he gets sent out to the Emergency Department (ED). Ms. Hill called an ambulance and Resident A was transported to Butterworth ED. Ms. Hill also called Resident A's guardian to inform him of the incident.

Ms. Hill was asked how she typically passes medications to the residents. Ms. Hill stated that she has worked at the home since December 2023 and "that's how I've been passing them ever since I got there." Moving forward, Ms. Hill stated that she plans to pass medications one at a time to prevent a similar situation from occurring. Ms. Hill was asked if she has received formal medication training. Ms. Hill stated, "kind of, but not really." Ms. Hill believes that she completed a 3-hour medication training online. Except for one time at a different facility, Ms. Hill was unable to recall if she's shadowed staff prior to passing medications on her own. Ms. Hill stated, "I think they just threw me in there to be honest." Ms. Hill was adamant that this is the only time an incident like this has occurred while working at the home. Ms. Hill was thanked for her time as this interview concluded.

On 4/26/24, APS worker Drew Blackall conducted an interview with Resident A at the home. Resident A told Mr. Blackall that he receives his medication daily and denied any concerns. Resident A denied receiving the wrong medication recently or being admitted to the hospital for any reason.

On 04/29/24, I conducted an exit conference with licensee designee, Ms. Greenhoe. She 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.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Ms. Hill confirmed that she prepped all the residents' medications at the same time and sat them on the table. Ms. Hill walked away, leaving the medications unsupervised, leading to Resident A ingesting Resident B's medications. Home manager Ms. Burgess confirmed this as well. Ms. Burgess stated that medications are supposed to be passed one at a time to prevent an incident like this from occurring. There was also a sign on the wall next to the medication cart that clearly states that "residents are to take their medications one at a time in the dining room where you can physically watch them take them." Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

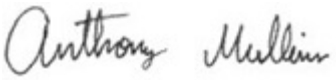
INVESTIGATION: While investigating the allegation listed above, I requested verification that AFC staff member, Ashley Hill has completed her medication training. Licensee designee, Kalia Greenhoe stated that she would speak to Angela Allen, office manager and have her send me training verification via email. As of the completion of this report, I have yet to receive the requested documentation.

On 04/29/24, I conducted an exit conference with licensee designee, Kalia Greenhoe. She 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.**
ANALYSIS:	I did not receive documentation to confirm that Ashley Hill has been appropriately trained to pass medications. 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 change to the current license status.



04/29/2024

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Anthony Mullins Date
Licensing Consultant

Approved By:

04/29/2024

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Jerry Hendrick Date
Area Manager