GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 12, 2024

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

RE: License #: AS410400152
Investigation #: 2024A0467042
Brightside Living - Comstock Park

Dear Ms. Greenhoe:

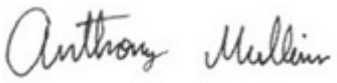
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 #:	2024A0467042
Complaint Receipt Date:	07/01/2024
Investigation Initiation Date:	07/02/2024
Report Due Date:	08/30/2024
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 eloped from the facility and staff never searched for him.	Yes

III. METHODOLOGY

07/01/2024	Special Investigation Intake 2024A0467042
07/01/2024	APS Referral
07/02/2024	Special Investigation Initiated - Telephone
07/02/2024	Inspection Completed On-site
07/17/2024	Contact – telephone call made to Delvon Brown
08/12/2024	Exit conference with licensee designee, Kalia Greenhoe

ALLEGATION: Resident A eloped from the facility and staff never searched for him.

INVESTIGATION: On 07/1/24, I received a BCAL online complaint stating that an unknown male resident at the home has paranoid schizophrenia. On 6/27/24, the unknown male resident wandered away from the home and was found at 5:00 am wearing only shorts and possibly shoes. It was reportedly 58 degrees outside on the day in question. Police were called and the male was eventually brought back to the home. The facility is staffed at night and it is unknown how he was able to leave without staff being alerted.

On 7/2/24, I made an unannounced onsite investigation at the facility. Upon arrival, staff member Sarah Burgess answered the door and allowed entry into the home. Ms. Burgess agreed to discuss the allegation at the dining room table. Ms. Burgess confirmed that the unknown resident that the complaint is referring to is Resident A. Ms. Burgess stated that Resident A has resided at the facility since 5/17/24. Since arriving at the facility, Resident A has had ongoing issues with elopement and refusing his medication.

Ms. Burgess stated that on 6/27/24, Resident A went to the neighbor's house naked and told her that he wanted to hurt someone, as well as asking for a glass of water. Ms. Burgess stated that the neighbor told her that she called 911, and a Kent Couty Sheriff's Deputy was able to locate Resident A and return him to the home. Ms.

Burgess confirmed that Resident A has been diagnosed with schizophrenia and was found by law enforcement without clothes or shoes on. Ms. Burgess stated that staff member, Delvon Brown was working when this incident occurred. Ms. Burgess stated that Mr. Brown reported that Resident A snuck out of the home and it is unknown how long he was outside.

Ms. Burgess stated that per Resident A's guardian, he is not allowed to leave the home without staff, his case worker, or guardian. Ms. Burgess stated that due to ongoing issues with Resident A, his guardian is currently working to obtain an alternative placement for him. Ms. Burgess provided me with copies of several incident reports that confirm Resident A's history of elopement and refusal to take his medications. The incident reports also included the one from 6/27 that led to Resident A being sent to the hospital for further assessment after he was brought back to the home by law enforcement. During my interview with Ms. Burgess, she stated that she is concerned for her safety due to the threats made by Resident A. Due to this ongoing issue, Ms. Burgess will be replaced by a different staff member this morning.

After interviewing Ms. Burgess, I interviewed Resident A. Resident A was observed sitting in a chair inside of the garage. Resident A stated that he has lived at the home for one month and "everything is good" at the home. Despite Resident A reporting that everything is going well at the home, he added, "but I don't like it and I want to stay somewhere else." Resident A stated that he prefers to live in Grand Rapids and he plans to discuss this with his guardian.

Resident A was asked to share what occurred on 6/27/24. Resident A stated that around 5:00 am, he went into the nearby woods. While in the woods, Resident A stated that he saw a shadow, and he became scared because he was unsure if it was his shadow or not. Due to being scared, Resident A stated that he called the police and threw his clothes into the river. After doing so, Resident A stated that he walked to the neighbor's house and knocked on their door. Resident A confirmed that he was only wearing his underwear and the neighbor told him to go back to the street. Resident A was unable to recall how long he was outside prior to going to the neighbor's house.

Resident A confirmed that he has a history of elopement and shared that he does this because he struggles when he isn't allowed to go anywhere he wants. When he leaves the home, Resident A stated that he often asks people for money to buy cigarettes. Resident A also confirmed that he refuses his medications daily because, "I don't like taking meds. Meds make me feel bad, scared, and paranoid." I encouraged Resident A to discuss this with his doctor, which he stated he will do at his next appointment if he can remember. I also encouraged Resident A to communicate with staff when he's scared of anything or has negative thoughts.

On 7/17/24, I spoke to staff member, Delvon Brown via phone and he agreed to discuss the allegation. Mr. Brown stated that he arrived on shift on 6/26/24 between

7:00 pm – 7:30 pm and worked until 7:00 am on 6/27/24. After arriving at the home, Mr. Brown stated that he passed the residents' nighttime medications. After doing so, Mr. Brown stated that he asked the residents about Resident A's whereabouts and none of the residents knew where he was. Mr. Brown stated that he assumed that Resident A was with his guardian. Therefore, he has no idea when he left the home. Mr. Brown stated that he relieved his colleague Sarah Burgess or Chrissy (last name unknown) but he was unable to recall exactly which staff member. Regardless which staff member he relieved on the night on 6/26/24, Mr. Brown confirmed that he never asked them about Resident A's whereabouts. He did share that he checked Resident A's room, and he was nowhere to be found.

Mr. Brown stated that it is normal behavior for Resident A to not be available for his medications as he often refuses. Mr. Brown also added that Resident A often goes outside due to complaining that he is too hot. Sometime in the morning on 6/27/24, Mr. Brown stated that he received a call from the Kent County Sheriff's Department asking if one of the residents was out of the home. Mr. Brown stated that he looked around and noticed that Resident A was still away from the home. Police reportedly told Mr. Brown that Resident A was located at a neighbor's home in just his underwear and socks. Per Mr. Brown, police returned Resident A to the home around 5:45 am or 6:00 am. Mr. Brown stated that Resident A no longer resides in the home after getting into a physical altercation with another resident.

Mr. Brown was asked about the home policy when a resident's whereabouts are unknown. Mr. Brown stated that typically, he would go outside and search for Resident A. If he is unable to be locate the resident, he will ask his colleagues if they know of his whereabouts. If the resident is still unable to be located, Mr. Brown stated that he would call police to assist in finding the resident. Mr. Brown again confirmed that Resident A was not at the home when he arrived on the night of 6/26, and did not return until the morning of 6/27 when law enforcement brought him home. Mr. Brown assumed Resident A was with his guardian without confirming this, and never called 911. Mr. Brown agreed to follow-through with the appropriate steps to locate a resident if a similar incident were to happen again.

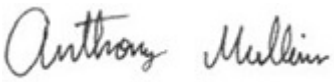
On 8/12/24, I conducted an exit conference with licensee designee, Kalia Greenhoe. She was informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receipt of this report. Ms. Greenhoe stated that she is completing trainings with staff for the next two days and will reeducate staff on the elopement process and when to contact law enforcement for a missing resident.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(2) If an elopement occurs, staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall contact law enforcement.

ANALYSIS:	Mr. Brown confirmed that Resident A was not in the home on the night of 6/26/24. Mr. Brown searched the inside of the home but failed to search the perimeter of the home. Mr. Brown assumed Resident A was with his guardian without confirming this, and never called 911 to assist in locating the resident. Therefore, there is a preponderance of evidence to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



08/12/2024

Anthony Mullins Date
Licensing Consultant

Approved By:

08/12/2024

Jerry Hendrick Date
Area Manager