GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 4, 2024

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

RE: License #: AL280410649
Investigation #: 2025A0870002
Brightside Living - West Shore

Dear Corey 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

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,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL280410649
Investigation #:	2025A0870002
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/14/2024
Report Due Date:	12/13/2024
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 died after choking on food. He has a documented history of choking and gained unsupervised access to food items.	Yes

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A0870002
10/14/2024	Special Investigation Initiated - On Site Interviews with facility staff and Licensee Designee Corey Husted.
10/25/2024	Contact - Telephone call made Telephone interview with Dr. Edmond Donahue.
11/21/2024	Contact - Telephone call made Case discussion with Centra Wellness CMH, Recipient Rights Specialist, Danyal Englebrecht-Blakeslee.
11/26/2024	Inspection Completed-BCAL Sub. Non-Compliance
12/04/2024	APS Referral Referral made to the Michigan Department of Health and Human Services; Protective Services centralized intake unit.
12/04/2024	Exit Conference Completed with Licensee Designee Corey Husted.

ALLEGATION: Resident A died after choking on food. He has a documented history of choking and gained unsupervised access to food items.

INVESTIGATION: On October 14, 2024, Centra Wellness Community Mental Health, Recipient Rights Office (ORR) contacted AFC Licensing Consultant Rhonda Richards to inform her that they had been notified of Resident A's death and will be initiating a Recipient Rights investigation into the issue. They further informed Ms. Richards that their office will be conducting an on-site investigation this day. Mr. Richards provided me with the name and telephone number of the ORR official investigating the allegation to coordinate investigative efforts.

On October 14, 2024, I conducted an on-site special investigation at the Brightside Living – West Shore AFC home. I was accompanied by Centra Wellness CMH

Recipient Rights Specialist Danyal Englebrecht-Blakeslee. We met with Licensee Designee Corey Husted in private at the facility. Mr. Husted stated that Resident A was taken to the hospital, by ambulance, late afternoon on Friday October 11, 2024. He noted that this was due to Resident A choking on food. Mr. Husted stated the facility was notified later that evening, by EMS personnel, that Resident A had died. Mr. Husted informed me that two staff were working in the facility at the time along with seven residents, including Resident A. He noted the two staff members were Christine Smith and Kristi Blankenship.

Mr. Husted provided me with copies of Resident A's *Assessment Plan for AFC Residents (BCAL-3265)*, dated September 5, 2024, *Health Care Appraisal (BCAL-3947)*, dated September 6, 2024, Centra Wellness CMH Individualized Plan of Service (IPOS), effective date of January 16, 2024, and an *AFC Licensing Division – Incident/Accident Report (BCAL-4607)*, dated October 14, 2024.

I reviewed the *AFC Licensing Division – Incident/Accident Report (BCAL-4607)*. This report was completed by staff member Christine Smith on October 11, 2024. In this report Ms. Smith wrote that Resident A, "gained access to office, got in frig and started consuming food from office frig" (sic). She noted this incident occurred on October 11, 2024, at 4:48 p.m. Ms. Smith reported that Resident A, "went to living room started choking" (sic), and that staff "called 911 at 4:45", and "staff did Heimlich maneuver 911 on phone directing us what to do till they showed up." (sic).

Resident A's *Health Care Appraisal (BCAL-3947)* notes under the category of Special Dietary instructions and recommended caloric intake: "dysphagia-6 soft moist and mildly thick liquids, 1:1 assist."

Resident A's *Assessment Plan for AFC Residents (BCAL-3265)* states under the category of eating/feeding; needs help – yes, "he's on soft food diet – little at a time because he swallows his food – gulps – choking, thick-it liquids." It also notes under the category of special diets; "yes" and states, "choking – aspiration – thicken liquids, IDDSI – level -6."

Resident A's Individualized Plan of Service (IPOS), notes that, "(Resident A) had a hospitalization this year, due to chocking. (Resident A) ended up in the hospital for about 2 weeks." Resident A's plan also states, "redirection to an activity when focusing on food." This plan contains a "treatment plan training" document which lists both Ms. Smith and Ms. Blankenship as participants in a September 12, 2024, training class to facility staff members regarding Resident A's IPOS.

On October 14, 2024, I conducted an interview with staff member Christine Smith. Ms. Smith stated she was working at the facility at the time of Resident A's choking incident, along with staff member Kristi Blankenship. She stated that the facility had six residents, which includes Resident A, present in the facility at the time of the choking incident. Ms. Smith noted that the residents had already been fed dinner and she was in the kitchen cleaning the stove while Ms. Blankenship was in a back

bedroom “changing” Resident B. She stated that Ms. Blankenship came out of the back bedroom area into the living room and found Resident A choking. Ms. Smith stated that Ms. Blankenship “screamed” for her, and she went to the living room and observed that Resident A could not breath. She stated she began to perform the Heimlich maneuver on Resident A, but this did not work. Ms. Smith stated she dug food out of Resident A’s mouth with her fingers while Ms. Blankenship ran to the telephone and called 911. Ms. Smith stated she placed Resident A on the floor and began chest compressions and breathing until the police arrived. She noted the ambulance arrived shortly after and they left for the hospital with Resident A shortly thereafter. Ms. Smith stated that “this all occurred after dinner time” and “(Resident A) had gone to his bedroom.” She stated she did not hear or see Resident A after she saw him go to his bedroom until she heard Ms. Blankenship yell for her to come to the living room. Ms. Smith stated the substance she dug out of Resident A’s mouth appeared to be bread and she believes Resident A got the food from the refrigerator or a drawer in the office, “because it typically has staff food and snacks.” She also noted that the office typically is locked, but Resident A has, in the past, gained access to the office and also access to a locked pantry in the kitchen. Ms. Smith informed me that Resident A has his food items cut into small “toddler” sized pieces and staff use “thick-it” in his drinks/liquids, due to his choking risk.

On October 14, 2024, I conducted an interview with staff member Kristi Blankenship. Ms. Blankenship stated she was working with Ms. Smith the afternoon/evening of Friday October 11, 2024. She noted the facility had six residents, which includes Resident A, home at the time. Ms. Blankenship stated she was in a back bedroom with Resident B for “about 10-15 minutes” and when she came out of the bedroom area, she noticed “more than one” pretzel bag wrappers on the floor, and the office door was slightly open. She noted that Ms. Smith was in the kitchen at the time. Ms. Blankenship stated she went to look for Resident A and located him in the living room “half slid off the couch onto the floor with a blue face.” She stated she immediately tried to remove whatever was in his mouth and yelled for Ms. Smith. Ms. Blankenship stated she believes the substance in Resident A’s mouth was partially chewed pretzels. She noted that when Ms. Smith entered the living room Ms. Smith began the Heimlich maneuver, while she got the telephone and called 911. Ms. Blankenship stated that she, along with Ms. Smith, began CPR until the police and EMS arrived. Ms. Blankenship noted that the office door is typically shut and locked but Resident A “constantly” tries to get in to get to food. She noted he pushes on the door handles. Ms. Blankenship stated she has seen the door to the office not work correctly and will open even when it is locked.

On October 14, 2024, I had Ms. Smith lock the office door. I attempted to open the locked door using a moderate amount of force. I was unable to turn the door handle, nor open the door.

On October 25, 2024, I spoke by telephone with Dr. Edmond Donahue. Dr. Donahue is the pathologist who examined Resident A following his death. He stated Resident A’s cause of death is listed as “choking, due to dysphasia” and the death is

classified as “accidental.” Dr. Donahue stated that he signed Resident A’s death certificate on October 13, 2024.

It is noted that nothing in any of the above cited documents, assessments or plans that were reviewed during this investigation called for or directed facility staff to provide Resident A with any enhanced supervision or specific instructions pertaining to supervision.

For Reference: Public Act no. 218 of the public acts of 1979, as amended, Sec. 6 (4), states “Protection”, subject to section 26a(2), means the continual responsibility of the licensee to take reasonable action to insure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation, and social, moral, financial and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the resident’s assessment plan states that the resident needs continuous supervision.

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:	Resident A’s *Assessment Plan for AFC Residents (BCAL-3265)*, *Health Care Appraisal (BCAL-3947)*, and Centra Wellness CMH Individualized Plan of Service (IPOS), all note that Resident A has a history of choking, is a choking risk, and requires a soft food diet with “thick-it” used with liquids. Despite Resident A’s propensity for accessing and consuming food, he was able to gain unsupervised access to food items, understood to be pretzels, from the facility office, and consumed them without staff knowledge or supervision. Resident A choked on the food items, understood to be pretzels, which resulted in his death. Resident A was not provided with protection and safety in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

On December 4, 2024, I conducted an exit conference with Licensee Designee Corey Husted. I explained my findings as noted above and reviewed my

recommendation that the license be modified to a six-month Provisional status for the above-cited quality-of-care violation. Mr. Husted stated he understood the finding and had no additional questions or information to provide concerning this investigation. He did note that he feels Resident A's responsible agency did not provide him with the resources to appropriately care for Resident A. Mr. Husted stated he will develop a corrective action plan to address the cited rule and will include a notation accepting the issuance of a six-month Provisional status license.

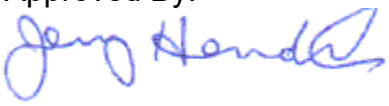
IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the license be modified to a six-month provisional license status.

December 4, 2024

Bruce A. Messer Date
Licensing Consultant

Approved By:



December 4, 2024

Jerry Hendrick Date
Area Manager