GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 5, 2024

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

RE: License #: AS410400152
Investigation #: 2025A0467008
Brightside Living - Comstock Park

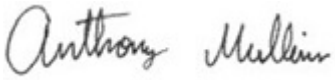
Dear Ms. Greenhoe:

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.

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 #:	2025A0467008
Complaint Receipt Date:	11/19/2024
Investigation Initiation Date:	11/20/2024
Report Due Date:	01/18/2025
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 is not receiving his medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/19/2024	Special Investigation Intake 2025A0467008
11/20/2024	Special Investigation Initiated - Letter Spoke to Recipient Rights Officer, Melissa Gekeler via email.
11/20/2024	APS Referral
11/20/2024	Inspection completed – Onsite
11/27/2024	Exit conference with licensee designee, Kalia Greenhoe

ALLEGATION: Resident A is not receiving his medication as prescribed.

INVESTIGATION: On 11/19/24, I received a complaint from Recipient Rights Officer, Melissa Gekeler. The complaint alleged that following Resident A's medication review appointment on 9/9/24, AFC staff were supposed to increase the dose of his Clozapine medications every 7 days. Instead, staff members continued to give Resident A his 50mg dose until the medication ran out. Once Resident A's 300mg prescription was received, staff did not start him on the medication because they realized his medication was never titrated up as instructed by his doctor. As a result of this, Resident A did not receive any of his Clozapine medications for one to two weeks until he began displaying behavioral issues (threatening staff and eloping).

On 11/20/24, I spoke to Recipient Rights Officer, Melissa Gekeler via phone. Ms. Gekeler stated that Resident A has not received his Clozapine medication as prescribed since 10/22/24. Ms. Gekeler stated that the AFC staff started giving Resident A his Clozapine medication on 11/12/24 after being instructed by licensee designee, Ms. Greenhoe, despite there not being a current physician's order for it.

On 11/20/24, I made an unannounced onsite investigation to the facility. Upon arrival, staff member Sarah Burgess answered the door and allowed entry into the home. Ms. Burgess confirmed that Resident A's Clozapine was supposed to be increased by 50mg weekly. This medication is scheduled to be passed on 2nd shift, and staff never increased his dose. Instead, Resident A continued to receive his

50mg dose. Ms. Burgess stated that Resident A started at 50mg and it should have been increased to 100mg, then to 200mg. Once this was completed, Resident A was supposed to start his full dose, which is 300mg. Per Ms. Burgess, nighttime staff were not paying attention to Resident A's MAR, which resulted in him not receiving his medications as prescribed. Ms. Burgess stated that several weeks ago, she reached out to Resident A's doctor and asked for his Clozapine medication to be switched to the morning time so she could ensure that would be given as prescribed. However, she never heard back from the doctor.

Ms. Burgess shared that Resident A has lived at the home since 10/9/23 and this has only been an issue as of late. Ms. Burgess stated that the medication issue stems from Resident A not having insurance or money to cover it. Ms. Burgess stated that Resident A's mother was initially his guardian and she allowed for his insurance and SSI to lapse. This resulted in Guardian Pharmacy refusing to fill his medications. As a result of this, Resident A's pharmacy was switched to Wege Pharmacy. Resident A's pharmacy eventually switched back to Guardian Pharmacy after his insurance was obtained again. Resident A now has a court appointed guardian Courtney Hornbeck and she has been more responsive than Resident A's mother/former guardian.

Ms. Burgess confirmed that 10/21/24 was the end date of Resident A's original Clozapine prescription, and Resident A did not receive the medication from 10/22/24 through 11/11/24. Ms. Burgess provided me with a copy of Resident A's MAR to confirm this. While not receiving his medication, Ms. Burgess stated that Resident A was not acting like himself. To expand on this, Ms. Burgess stated that Resident A thought he was German, yelled at other residents in Spanish, yelling outside, and would appear to be crying randomly. This is no longer an issue. Ms. Burgess stated that Resident A is currently receiving 2-50mg tablets (100mg total) of Clozapine at night for the next 7 days. From 11/26/24 to 12/2/24, Resident A will receive 4-50mg tablets (200mg total) at night. Once this is completed, Resident A will receive his required dose of 300mg.

Introductions were made with Resident A and he agreed to discuss the allegation. Resident A stated that he has lived at the home for approximately three years. Resident A had no knowledge of not receiving his medications as prescribed as he stated that staff give him his medications daily as scheduled. Resident A stated "maybe yes" when asked if he has ever refused any medications. Resident A informed me that he needs to take his vitamin. I instructed Resident A to speak with staff in the home. It should be noted that Resident A would switch back and forth between English and Spanish during this conversation. Resident a denied any issues at the home and did not have any additional information to add.

On 11/27/24, I spoke to licensee designee, Kalia Greenhoe via phone regarding the allegation. Ms. Greenhoe stated that she has been in communication with Resident A's caseworker, guardian, and Kortney Post (supervisor for the court appointed guardian). Resident A's SSI was cut off, in addition to his insurance. Ms. Greenhoe

stated that Resident A's doctor dropped him due to not having insurance, which is what led to the current medication issue. Ms. Greenhoe spoke to all identified parties in an attempt to fix this issue due to Resident A being an undocumented immigrant. However, they continued to have issues with it, including switching to Wege Pharmacy temporarily and receiving his medications in Spanish before getting them sent back in English. Ms. Greenhoe was adamant that the medication issue has only been recent and the rest of the time Resident A has been in the home, there were no issues.

I conducted an exit conference with Ms. Greenhoe while on the phone. Ms. Greenhoe is aware that the AFC home is responsible to ensure that he receives all medications as prescribed, regardless of the issues with his insurance, guardian, and/or pharmacy. Due to not receiving his medication as prescribed, Ms. Greenhoe is aware that the facility will be cited and a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Ms. Burgess and Ms. Greenhoe both confirmed that Resident A's SSI and insurance lapsed, making it difficult for him to obtain his prescribed medication. Ms. Burgess confirmed that Resident A's Clozapine was not titrated up as scheduled. She also confirmed that Resident A did not receive his Clozapine medication from 10/22/24 through 11/11/24. I reviewed Resident A's MARs to confirm this. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegation listed above, I requested to review Resident A's MARs. In doing so, it was determined that from September 2024 through November 2024, there were several medications that indicated that staff were "waiting on pharmacy" or the medication was "out of facility," neither of which would be an appropriate explanation as to why Resident A did not receive his medications. The medications included: Divalproex Tab 500MG, Amlodine Tab 10MG, Carvedilol Tab 25MG, Spironolact Tab 25MG, Glycopyrrol Tab 1MG, Clozapine Tab 100MG, Levocarnitin Tab 330MG, Losartan Pot Tab 100MG, Fluticasone, Trazadone, and Incruse Elpt Inh 62.5MCG.

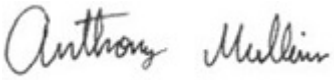
On 11/20/24, Ms. Burgess stated that staff were likely marking that the medication was out of facility although it should have stated “waiting on pharmacy.”

On 11/27/24, licensee designee Ms. Greenhoe confirmed that staff were documenting “out of facility” for medications, even though that is not a reasonable explanation for a resident to miss any medications. I conducted an exit conference with Ms. Greenhoe, and she’s aware that a corrective action plan is due 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.**
ANALYSIS:	I reviewed Resident A’s MARs and confirmed that staff members are not properly documenting why Resident A missed a medication. The licensee is aware that the only reasonable explanations for a resident to not receive their medications as prescribed is refusal or being admitted to the hospital. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



12/05/2024

Anthony Mullins Date
Licensing Consultant

Approved By:

12/05/2024

Jerry Hendrick Date
Area Manager