



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 10, 2025

Crystal Dillon
Brightside Assisted Living LLC
2140 Robinson Road
Jackson, MI 49203

RE: License #: AH380381401
Investigation #: 2025A0585047
Brightside Assisted Living & Memory Care

Dear Ms. Dillon:

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 feel free to 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 (517) 284-9730.

Sincerely,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

| | |
|---------------------------------------|--|
| License #: | AH380381401 |
| Investigation #: | 2025A0585047 |
| Complaint Receipt Date: | 04/07/2025 |
| Investigation Initiation Date: | 04/08/2025 |
| Report Due Date: | 06/07/2025 |
| Licensee Name: | Brightside Assisted Living LLC |
| Licensee Address: | 2140 Robinson Road Jackson, MI 49203 |
| Licensee Telephone #: | (517) 787-4150 |
| Administrator: | Maegan Camburn |
| Authorized Representative: | Crystal Dillon |
| Name of Facility: | Brightside Assisted Living & Memory Care |
| Facility Address: | 2388 Robinson Road Jackson, MI 49203 |
| Facility Telephone #: | (517) 787-4151 |
| Original Issuance Date: | 09/01/2017 |
| License Status: | REGULAR |
| Effective Date: | 08/01/2024 |
| Expiration Date: | 07/31/2025 |
| Capacity: | 38 |
| Program Type: | AGED ALZHEIMERS |

II. ALLEGATION(S)

| | Violation Established? |
|--|---------------------------|
| Caregiver was heard on a voicemail recording discussing other residents with Resident A and another caregiver. | Yes |
| Additional Findings | No |

III. METHODOLOGY

| | |
|------------|--|
| 04/07/2025 | Special Investigation Intake 2025A0585047 |
| 04/08/2025 | Special Investigation Initiated - Telephone Contacted complainant regarding allegations. |
| 04/09/2025 | Inspection Completed On-site Completed with observation, interview and record review. |
| 04/09/2025 | Inspection Completed-BCAL Sub. Compliance |
| 04/25/2025 | Exit Conference. Conducted via email to authorized representative Crystal Dillon and administrator Maegen Camburn. |
| | |

ALLEGATION:

Caregiver was heard on a voicemail recording discussing other residents with Resident A and another caregiver.

INVESTIGATION:

On 04/7/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged that on 04/06/2025 at 8:02 p.m., a voicemail was received from Resident A where two caregivers were having a conversation with him that was disrespectful and unprofessional behavior.

On 04/08/2025, I interviewed the complainant by telephone. The complainant stated that Resident A called her and left her voicemail. She said that he forgot to hang up the phone and she could hear a conversation between Resident A and two staff. The complainant forwarded me a copy of the voicemail message.

On 04/09/2025, I interviewed the administrator Maegen Camburn at the facility. I let the administrator listen to the voicemail message and she identified the two employees (Employee #1 and Employee #2). She said that there were no complaints about either of them being unprofessional. She said that in the past, there have been two staff who were disciplined due to making videos of residents. She said that both employees had training and regular in-service. She said that Resident A is able to communicate and verbally express himself. She said that staff shouldn't talk about residents in front of other residents, and it was unprofessional.

Upon request, the administrator shared a copy of Resident A's service plan, staff training and facility policy for review.

Training documents were reviewed that showed that Employee #1 and Employee #2 had training that included residents' rights, personal care, and service plan.

The voicemail message in part: Employee stated that another resident had slid off the bed and she found her on the floor. The employee said, I wanted to slap her because I didn't know nothing other than she was on the floor and they didn't make sure that she was in the fucking bed. Resident A said yes, like I did last night. As the conversation continue, you can hear Resident A say something that I couldn't understand, but you hear the employee say, "I can't do this with you, I have an hour". The other employee said, "I can do it". The employee said, no and she said I was going to come back and get him. Employee said, "He is going to call his family and tell on us." Resident A said, "I didn't call anybody."

Facility's *Employee & Handbook & Policy* in the section marked Miscellaneous Resident/Family relations read: Employee should always be mindful when resident and family are visiting. Keep all conversations professional.

| APPLICABLE RULE | |
|------------------------|---|
| R 325.1921 | Governing bodies, administrators, and supervisors. |
| | (1) The owner, operator, and governing body of a home shall do all of the following: (a) Assume full legal responsibility for the overall conduct and operation of the home. |
| ANALYSIS: | Staff were not talking in a professional manner in the present of a resident. Staff were heard discussing another resident to a resident and using profanity. Therefore, this claim is substantiated. |
| CONCLUSION: | VIOLATION ESTABLISHED |

IV. RECOMMENDATION

Contingent upon completion of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.



04/24/2025

Brender Howard
Licensing Staff

Date

Approved By:



04/24/2025

Andrea L. Moore, Manager
Long-Term-Care State Licensing Section

Date