GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 14, 2025

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

RE: License #: AM410403710
Investigation #: 2025A0357039
Brightside Living - Mistywood

Dear Mr. Husted:

Attached is the Special Investigation Report for the above-mentioned 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) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410403710
Investigation #:	2025A0357039
Complaint Receipt Date:	05/22/2025
Investigation Initiation Date:	05/22/2025
Report Due Date:	07/21/2025
Licensee Name:	Brightside Living LLC
Licensee Address:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Kayla Greenhoe
Licensee Designee:	Corey Husted
Name of Facility:	Brightside Living - Mistywood
Facility Address:	3371 Mistywood St SE Caledonia, MI 49316
Facility Telephone #:	(616) 803-0476
Original Issuance Date:	05/01/2020
License Status:	REGULAR
Effective Date:	11/01/2024
Expiration Date:	10/31/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, AGED DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On the weekend of 05/10-11/2025, residents missed dosages of their medications.	No
Additional Findings	Yes

III. METHODOLOGY

05/22/2025	Special Investigation Intake 2025A0357039
05/22/2025	Special Investigation Initiated - Telephone To Recipient Rights at network 180.
06/16/2025	Contact - Telephone call made To Recipient Rights at network 180.
07/08/2025	Contact - Telephone call made To Recipient Rights, network 180, Jeannie Haff.
07/08/2025	Contact - Telephone call made To Direct Care Staff, Fantasia Corbett.
07/09/2025	Inspection Completed On-site
07/09/2025	Contact - Face to Face Interview with Direct Care Staff, Carter Allen. We reviewed the residents Medication Administration Records.
07/09/2025	Contact - Document Received Received a copy of Resident C's MAR, which we reviewed.
07/09/2025	Contact - Face to Face Interviewed with Resident A, Resident B, Resident C and D.
07/1/ /0/2025	Contact - Telephone call made Interview with Angela Allen, former HR, Kaila Greenhoe, Administrator, Sabari Abullah, Direct Care Staff, Jasmine Chapman, Direct Care Staff, and the Licensee Designee, Corey Husted.
07/14/2025	Telephone Exit Conference with the Licensee Designee, Corey Husted.

ALLEGATION: On the weekend of 05/10-11/2025, Residents missed dosages of their medications.

INVESTIGATION: On 07/08/2025, I received a returned call from Jennie Haff, Recipient Rights Officer from network 180. She explained that the reason the medications had not been passed was because the residents' medication packs were empty and Mr. Husted did not look for the new medications that were stored in the file cabinet. Ms. Haff reported that Direct Care Staff, Fantasia Corbett, had told her that she initially thought the residents had not received their medications because Mr. Husted did not know where to find the other medications. Later on, Ms. Corbett recanted her statements to Ms. Haff because she learned that Ms. Husted had in fact found the residents' medications packs in the cart and he had administered the medications to the residents. Ms. Haff reported that after her interviews with Mr. Husted, interviews with several staff of the home and Resident A, she found that the prescribed resident medications had been passed. Therefore, she stated that there was not a preponderance of evidence to substantiate a violation.

On 07/08/2025, I conducted a telephone, with Direct Care Staff, Fantasia Corbett. She confirmed that she had spoken with Ms. Haff, Recipient Rights Officer, and she originally believed that the residents had not received their medications. She stated that she thought Mr. Husted had called in another staff member to provide information as to where the new medications were stored. She stated later on, Mr. Husted had stated that he had passed the residents' medications. She assured me Mr. Husted had administered residents 'medications.

On 07/09/2025, I made an announced inspection at the facility and met with Direct Care Staff, Carter Allan. We looked at the Quick Mar which is the Resident Medication Admission Record (MAR) for Resident A. We found that the staff's initials were charted for Resident A's, 8:00 AM medications for 05/10-11/2025. As we checked other residents' MARs we found that the staff's initials were properly recorded until we came to Resident C's MAR. I noticed there were many empty spaces without staff's initials. I asked Mr. Allan to copy Resident C's MAR, and he provided the copy for me along with a "MAR Exceptions for (Resident C)" starting with the date of May 2, 2025, at 7:19 PM, through May30, 2025, 7:12PM.

On 07/09/2025, I conducted a face-to-face interview with Resident A. He reported, Mr. Husted had passed his 8:00AM medications on either 05/10/2025 or 05/11/2025. He said he has always received his medications.

On 07/09/2025, I conducted a face-to-face interview with Resident B who stated that he had been admitted to the home after May 11, 2025, but since he has been in the home he has received his medications.

On 07/09/2025, I conducted a face-to-face interview with Resident C. He stated: "I wake up too late to take my meds. I try to get up." I asked him if he remembered if

he had not received his medications on 05/10 -11/2025. He was unsure if he had received his medications.

On 07/09/2025, I conducted a face-to-face interview with Resident D. He stated that he had received his medications on 05/10 - 11/2025. He said he always receives his medications.

On 07/10/2025, I conducted a telephone interview with Angela Allan who stated she was helping out with paperwork 20 hours a week. She stated that she has not passed medications in the home since early April 2025 and has no first-hand knowledge of any residents missing their prescribed medications.

On 07/10/2025, I conducted a telephone interview with Corey Husted, Licensee Designee. He stated that on 05/11/2025, it was the first day of his Administrator's vacation and he came into the home at 8:00 AM to administer resident's medications. He said he only worked two hours, from 8:00AM. to 10:00AM. He reported that some residents wake up early and want to take their medications. He stated his staff who work a 12-hour shift from 7:00PM. to 7:00AM will typically administer medications to the early risers which they had on 05/11/2025. He stated that he had administered all of the other residents' medications on 05/11/2025. He said all of the residents' medications were in the med cart. I explained that I had reviewed Resident C's MAR and had found ten of Resident C's 8:00AM medications which had no staff initials on the date 05/10/2025. I also found there were no initials for his 8:00PM medications on 05/09/2025 or 05/10/2025. I also explained that I had reviewed Resident C's MAR Exception sheet and there was no reason listed for him not receiving his medications for the dates 05/09 -10/2025. He provided the names of the Direct Care Staff and the telephone numbers of the staff who worked the 12-hour shifts on 05/09/2025 and on 05/10/2025, Shabari Abdullh and Jasamine Chapman. He explained that his Administrator, Kayla Greenhoe, was responsible for reviewing the residents' MARs and she should have caught dates where there were no staff's initials recorded for administration of Resident C's medications. He said there could be several explanations as to why the staff's initials were not recorded on the MAR. He was unsure why the MAR Exceptions sheet did not list any reason as to why the medications were not administered on 05/09 – 10/2-25. He explained that the staff work 12-hour shifts from 7A to 7P, then 7P to 7A.

On 07/10/2025, I conducted a telephone interview with the Administrator, Kaila Greenhoe. She explained that home staff go to network 180 for an in-person training on the medication administration class. She was unsure why the spaces for the staff's initials were not recorded. I said that Mr. Husted had told me she was responsible for reviewing the residents' MARs and she said when she was on vacation it was Mr. Husted's responsibility for reviewing the MARs. She stated that the staff had been trained by network 180. She also stated that a Resident can refuse his/her medications.

On 07/10/2025, I conducted a telephone interview with Direct Care Staff, Shabari Abdullh. She was uncertain which shift she worked on 05/10-11/2025, but she stated that the computer system does not always record on the MAR that she had passed the medications because the program will tell her later that she has not passed the medications even though she entered she had. She said this just happened to her and she took a screen shot and sent it to Mr. Husted so he could see what had happened. When I asked her specifically about Resident C's medications not having a staff's initials recorded on 05/10/2025, primarily at 8:00AM and two at 8:00PM, she said, "I don't remember. Maybe it slipped my mind. I gave all his meds to him, unless I forgot to chart it. He never refuses me. Maybe I forgot to click it. I am not sure, but he always takes his meds for me." She felt that the problem was with the Quick Mar system.

On 7/10/2025, I conducted a telephone interview with Direct Care staff Jasmine Chapman. She said she got to work at 7:00AM on 05/10/2025, but Ms. Allen sent her to work at the Comstock Park home from 7:00AM to 1:00PM. She said Ms. Allen would have given medications. She said that either Ms. Allen or another staff member must have used her username and password to get into the computer to pass residents' medications. She stated she always passed Resident C's medications, and he never refused to take his medications for her. She explained that the Quick Mar program on the computer does not always work correctly. She explained that after you pass the medications, and you click off that you passed them then a notification comes up that says you have not passed the medications.

On 07/14/2025, I conducted a telephone exit conference with the Licensee Designee, Corey Husted and he agreed with my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It was alleged that on the weekend of 05/10-11/2025, residents missed dosages of their medications. Ms. Jennie Haff, Recipient Rights Officer, reported that her investigation reveled that the Licensee Designee Corey Husted had in fact administered the residents' medications. Ms. Husted reported to me that he had administered the residents' medications on 10/11/2025. Direct Care Staff, Shabari Abdull Direct Care and Jasmine Chapman reported that Resident C always takes his

	medications, and they were certain that the Quick Mar program was not working correctly. During this investigation evidence was found that residents' did receive their medications as prescribed. Therefore, there is not a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 07/09/2025, I made an unannounced inspection of Brightside Living – Mistywood. I met Direct Care Staff, Carter Allan. He was able to pull up Resident C's MAR (Medication Administration Record) and print it for me. Upon review of Resident C's MAR and the attached sheet of his "Exceptions," I found that he had 56 Reasons recorded for not taking his prescribed medication from 05/02/2025 at 7:19PM through 05/30/2025 at 7:12PM, and they were all the same, "Resident Refused." I also found that there were no staff initials recorded for ten of his prescribed medications at 8:00AM on 05/10/2025, and two of his 8:00PM medication one on 05/09/2025 and one on 05/10/2025. These dates were not listed on the exception sheet and had no corresponding reason on the Exceptions for Resident C.

On 07/09/2025, I conducted a face-to-face interview with Direct Care Staff, Carter Allan. When I pointed out to him the boxes that had no staff initials in them and the refusals recorded on Resident C's Exception sheet, I asked him for the documentation that demonstrated the staff had contacted the appropriate health professional for Resident C not receiving his prescribed medications and the recording of the instructions provided. He said they did not call a health care professional because network 180 did not teach them that they were to do that during their class on medication administration. He said after three tries of offering his medications to him they record the refusal, and destroy the medication. He acknowledged that he did not know there was a rule to contact an appropriate health care professional if a medication error occurs or if a resident refuses his medications.

On 07/10/2025, I conducted a telephone interview with the Licensee Designee, Corey Husted. I explained what I had reviewed Resident C's MAR and found ten boxes without staff's initials at 8:00 on 05/10/2025 and two 8:00 PM medications without staff's initials which would indicate that the prescribe medications had been administered. I also told him I had reviewed Resident C's Exception sheet and there were no corresponding dates on that sheet with the explanation of why he had not received his medications on 05/09 -10/2025. He did not know why there was not a reason recorded for the 05/09 -10/2025. I asked him if he had contacted the appropriate health professional for the refusals recorded on the Exception sheet and

the written instructions. He said he did not know there was a rule for contacting a health professional and writing their response for medication errors or for a resident's refusal of his medications. He explained that Resident C will not get up to take his medications. He said when he finds Resident C in bed at 8:00AM and he is passing medications, he says Resident C, it is time to take your medications, and Resident C does not refuse and takes his meds. He wondered why network 180 did not teach that rule to his staff to contact a health care professional. He also reported that network 180 emphasis was that a resident can refuse his/her medications.

On 07/10/2025, I conducted a telephone interview with the Administrator, Kaila Greenhoe. She explained that Resident A sleeps in late and there have been times that he has slept until 1:00 PM. She stated that she had contacted his doctors to see if the times of the medications could be changed to PM rather than the AM but they had not changed them. I asked her if upon Resident C's many refusals if she or her staff had contacted the appropriate health care professional and recorded the instructions. She explained that they have sent their staff to network 180 for the medication administration class and they do not teach that requirement to them. She also stated that they teach that a resident can refuse their medications. She acknowledged that she did not know that rule, therefore they did not follow the rule.

On 07/10/2025, both Direct Care Staff, Shabari Abdullh and Jasamine Chapman told me that Resident C does not refuse his medications when they administer them.

On 07/09 -10/2025, I reviewed Resident C's MAR for May 2025. I also reviewed his Exception Sheet that recorded his refusal of his prescribed medications.

According to the Exception Sheet, there were four times in the month of May 2025 that Resident C did not receive his ten 8:00AM medications with the reason of "refusal". For the month of May Resident A did not receive 56 of his prescribed medications. An appropriate health care professional was not contacted 12 times for what has been noted as a resident refusal of his medications.

On 07/14/2025, I conducted a telephone exit conference with the Licensee Designee, Corey Husted and he agreed with my findings.

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: (f) Contact the appropriate health care professional if a medication occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.

ANALYSIS:	Upon review of Resident C's Exception sheet, I discovered he had refused 56 of his prescribed medications for May 2025. Direct Care Staff, Carter Allan, acknowledged that he did not know there was a rule for contacting a health care professional when a resident refuses medications. Resident C's MAR for 05/10/2025, had no staff's initials recorded for ten 8:00AM medications and two for 8:00PM medications on 05/09-10/2025 but these missed medications were not found on the Exception Sheet. There was no explanation as to why these were not administered. The Licensee Designee, Corey Husted and the Administrator, Kalya Greenhoe, both acknowledged that they did not know there was a rule for contacting an appropriate health care professional for medication errors or for a resident refuses his medications. They had acknowledged that they were not following the rule, since they were not aware of the rule. On 05/03, 12, 15, 21/2025, according to the Exception sheet for Resident C, he refused all of his ten prescribed 8:00 AM medications four times (40 medications) in the month of May and his health care professional was not contacted. An appropriate health care professional was not contacted 12 times for what has been noted as a resident refusal of his medications in the month of May 2025. These dates included: 05/02, 03, 04, 05, 06, 12, 14, 15, 21, 27, 28, 30/2025, During this investigation evidence was found that the Licensee Designee, the Administrator and direct care staff did not know of the rule that required them to contact an appropriate health care professional if a resident refuses their medications which Resident C had done multiple times. Therefore, there is a violation to this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee provide an acceptable plan of correction and the license remain the same.

Arlene B. Smith 07/14/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

07/14/2025

Jerry Hendrick Date
Area Manager