GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 1, 2025

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

RE: License #: AS410403035
Investigation #: 2026A0467005
Brightside Living - Whispering Oaks

Dear Mr. Husted:

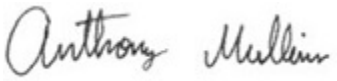
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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,



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 #:	AS410403035
Investigation #:	2026A0467005
Complaint Receipt Date:	11/24/2025
Investigation Initiation Date:	11/24/2025
Report Due Date:	01/23/2026
Licensee Name:	Brightside Living LLC
LicenseeAddress:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Corey Husted
Licensee Designee:	Corey Husted
Name of Facility:	Brightside Living - Whispering Oaks
Facility Address:	6601 Crystal Downes Dr SE Caledonia, MI 49316
Facility Telephone #:	(616) 803-5338
Original Issuance Date:	04/22/2020
License Status:	REGULAR
Effective Date:	10/22/2024
Expiration Date:	10/21/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Staff member Teresa Wollen is stealing and/or willfully disposing of Resident A's Oxycodone medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/24/2025	Special Investigation Intake 2026A0467005
11/24/2025	APS Referral Not necessary based on findings
11/24/2025	Special Investigation Initiated - On Site
11/24/2025	Contact - Telephone call made Spoke to AFC staff member, Teresa Wollen
11/26/2025	Contact – Document received Received an email from owner/licensee Corey Husted that included a copy of staff member Teresa Wollen's medication training transcript
11/26/2025	Exit Conference Licensee Designee Corey Husted

ALLEGATION: Staff member Teresa Wollen stole and/or willfully disposed of Resident A's oxycodone medication.

INVESTIGATION: On 11/24/25, I reviewed an email from licensee designee, Corey Husted. In the email, Mr. Husted informed me that he was made aware that Resident A's controlled medication, Oxycodone 5mg was missing from the lock box. Mr. Husted stated that he went to the home on Tuesday, 11/18/25 to take inventory and was unable to locate the medication. Mr. Husted shared that Resident A's Oxycodone was filled by the pharmacy on 11/11/25 with a total of 30 tablets. When staff member, Fantasia Corbett left the home on 11/13/25, Resident A's 30 tablets were accounted for in the lock box with the count sheet. When Ms. Corbett returned to work on 11/18/25, Resident A's Oxycodone and count sheet were missing from the lock box. Ms. Corbett searched the home to confirm the medication was not misplaced and then notified Mr. Husted.

Mr. Husted confirmed that from 11/14/25 to 11/17/25, staff member Teresa Wollen was the only employee working at the home. Mr. Husted contacted Guardian

Pharmacy and they confirmed that the medication was requested to be filled on 11/7/25 by Ms. Wollen and 30 tablets were filled on 11/11/25. Mr. Husted contacted Ms. Wollen and asked if she knew where Resident A's Oxycodone medication was, and she told him that she had disposed of it on Saturday, 11/15/25 because it upset Resident A's stomach and she no longer wanted to take the medication. Ms. Wollen stated that she disposed of the medication by putting them in coffee grounds next to the medication cart. Mr. Husted checked the can next to the medication cart and shared that it did not appear as if there were enough pills that had been disposed of.

On 11/24/25, I made an unannounced onsite investigation at the facility. Staff member Fantasia Corbett answered and allowed entry. Ms. Corbett shared that Resident A and Resident B both have controlled substances. Resident A has Oxycodone 5mg that she takes as needed and Resident B has Vyvanse and Valum that she takes scheduled and as needed. Ms. Corbett confirmed that when she left the home on 11/13/25, all of Resident A's 30 Oxycodone tablets were accounted for, along with Resident B's medication. When she returned to work on Tuesday, 11/18/25, she was unable to find Resident A's medication and the count sheet. Resident B's medications were accounted for and I confirmed this while onsite. Ms. Corbett confirmed that Ms. Wollen was the only employee who worked since she left work on 11/13/25. Ms. Corbett called Ms. Wollen to inquire about the whereabouts of Resident A's medication, and she stated that she disposed of the medications due to Resident A's stomach hurting from taking them. Ms. Corbett is unsure exactly how Ms. Wollen disposed of the medication. Ms. Corbett stated that Resident A never requests her Oxycodone while she's working on shift, but she reportedly receives them often when Ms. Wollen is working. Ms. Corbett informed Mr. Husted of these concerns and he addressed the issue.

After speaking to Ms. Corbett, I spoke to Resident A briefly while she was sitting in the chair in the living room. Resident A confirmed her date of birth and stated that she has lived in the home for approximately 1 year. Resident A stated that things are going well for her, including receiving her medications as prescribed. Resident A was unable to recall the name of her medications but confirmed that she takes a pain medication for her stomach, despite it causing pain at times. Resident A was unsure as to when she last received or requested pain medication. Resident A did not have any additional information to add.

On 11/24/25, I spoke to staff member, Teresa Wollen via phone regarding the allegation. Ms. Wollen confirmed that she worked at the home from 11/14/25 to 11/17/25. Ms. Wollen stated that she disposed of Resident A's Oxycodone 5mg in coffee grounds on Saturday, 11/15/25 or Sunday, 11/16/25 during her shift due to the medication hurting her stomach. Ms. Wollen stated that she is unsure of how many pills she disposed of, but stated it was "quite a few" because the prescription was recently filled. Ms. Wollen felt the need to dispose of the medication because she did not want other staff members to accidentally give Resident A the medication. I explained to Ms. Wollen that she cannot dispose of a resident's medication without an order from a doctor. Ms. Wollen stated that she was not aware of this as she had

disposed of resident's medications in the past without a doctor's order. Ms. Wollen stated that she has had training on medication management. However, she shared that the training she received was years ago and did not include this information. Ms. Wollen stated that she left the count sheet for Resident A's Oxycodone in the office along with other paperwork. Ms. Wollen is unsure as to where the count sheet could have gone. Ms. Wollen shared that she informed Mr. Husted that she is willing to take a drug test, but she also takes the same medication to address her medical needs.

On 11/26/25, I received an email from Mr. Husted that included a transcript of Ms. Wollen's training. The transcript confirmed that she has completed Medication Administration & Monitoring, and Medication Types, Uses & Effects several times since starting employment, with the last time being in June and August 2025. Mr. Husted was adamant that the training included information about proper disposal of medications. Mr. Husted also stated that Ms. Wollen was trained by three different staff members over the last three years, which also included the proper process of disposing medications.

On 11/26/25, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report. As part of the corrective action plan, Mr. Husted stated that he will terminate Ms. Wollen due to the concern that the medication was stolen.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	Ms. Wollen disclosed that she disposed of Resident A's Oxycodone 5mg because the medication was hurting her stomach. It was confirmed through this investigation that a doctor's order to dispose of this medication was not obtained. Per this licensing rule, prescription medications are to be kept in the original pharmacy container and labeled. The count sheet for Resident A's Oxycodone was missing and Ms. Wollen was the only staff with access to it during a 4-day period. Mr. Husted provided documentation to confirm that Ms. Wollen was trained

	in medication management and she would have known not to dispose of any medication without a doctor's order. Based on the information provided, there is a preponderance of evidence to support a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegation listed above, I was informed by Mr. Husted that staff member Teresa Wollen initialed Resident A's Medication Administration Record (MAR) on 11/14/25 through 11/17/25, indicating that she gave the resident her as needed Oxycodone 5mg tablets. However, Ms. Wollen told Mr. Husted that she disposed of the medication on Saturday, 11/15/25 due to it causing stomach pain for Resident A. Ms. Wollen also told me that she disposed of the Oxycodone on Saturday, 11/15/25 or Sunday, 11/16/25. I asked Ms. Wollen if she disposed of the medication, why she initialed the MAR as if she passed them to Resident A. Ms. Wollen stated that she didn't realize she initialed the MAR and "if I did, it was a mistake."

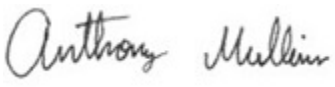
On 11/26/25, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**

	(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as-needed basis. The review process must include the resident's prescribing licensed health care professional and resident, resident's designated representative, and responsible agency if applicable. **(e) Not adjust or modify a resident's prescription medication without instructions from a physician, physician assistant, advanced practice nurse, or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any instructions regarding a resident's prescription medication.** **(f) Contact the resident's licensed health care professional or the appropriately licensed health care professional who prescribed the medication when a medication error occurs.** **(g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff shall document and follow the instructions given by the licensed health professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.**
ANALYSIS:	Ms. Wollen initialed Resident A's MAR to indicate that the medication was passed on 11/16/25 and 11/17/25, despite disclosing that she disposed of the medication on 11/15/25. 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 changes to the current license status.



12/01/2025

Anthony Mullins, Licensing Consultant Date

Approved By:

12/01/2025

Jerry Hendrick, Area Manager Date