



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

February 04, 2026

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

RE: License #: AS410403030  
Investigation #: 2026A0467011  
Brightside Living - Cedar Springs

Dear Mr. Husted:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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,

A handwritten signature in cursive script that reads "Anthony Mullins".

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**

<b>License #:</b>	AS410403030
<b>Investigation #:</b>	2026A0467011
<b>Complaint Receipt Date:</b>	01/22/2026
<b>Investigation Initiation Date:</b>	01/22/2026
<b>Report Due Date:</b>	03/23/2026
<b>Licensee Name:</b>	Brightside Living LLC
<b>Licensee Address:</b>	690 Dunegrass Circle Dr Saugatuck, MI 49453
<b>Licensee Telephone #:</b>	(614) 329-8428
<b>Administrator:</b>	Corey Husted
<b>Licensee Designee:</b>	Corey Husted
<b>Name of Facility:</b>	Brightside Living - Cedar Springs
<b>Facility Address:</b>	1880 18 Mile Rd NE Cedar Springs, MI 49319
<b>Facility Telephone #:</b>	(616) 263-9685
<b>Original Issuance Date:</b>	04/21/2020
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/21/2024
<b>Expiration Date:</b>	10/20/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Emergency services were not contacted promptly after Resident A was found unresponsive on the floor.	Yes

## III. METHODOLOGY

01/22/2026	Special Investigation Intake 2026A0467011
01/22/2026	Special Investigation Initiated - Telephone Received a call from AFC staff member Kalia Greenhoe regarding the incident.
01/22/2026	APS Referral Not warranted due to resident being deceased
01/26/2026	Contact made with licensee designee Corey Husted (Exit Conference)
01/26/2026	Inspection Completed On-site
01/26/2026	Contact – telephone call made to Riley Brace
01/27/2026	Contact – telephone call made to Kristina Hill
01/28/2026	Contact – document received via email from Kalia Greenhoe
02/03/2026	Contact – telephone call made to Brittany Richardson at the Office of the Medical Examiner in Kent County.

**ALLEGATION: Emergency services were not contacted promptly after Resident A was found unresponsive on the floor.**

**INVESTIGATION:** On 01/22/26, AFC staff member Kalia Greenhoe reported that Resident A was found on the floor without signs of life by staff member Kristina Hill. Ms. Greenhoe indicated that Ms. Hill contacted her first instead of calling emergency services. Emergency services were contacted immediately after their conversation. Ms. Greenhoe stated that the medical examiner determined the cause of death was a stroke. Based on the information provided, I informed Ms. Greenhoe that an investigation would be conducted.

On 01/26/26, I met in person with licensee designee Corey Husted. Mr. Husted

confirmed that the medical examiner determined the cause of death was a stroke. He acknowledged that staff should have contacted emergency services first rather than Ms. Greenhoe. Therefore, he understands a licensing rule violation occurred. Mr. Husted acknowledged the findings and agreed that this discussion serves as the exit conference. A corrective action plan (CAP) must be submitted within 15 days of receipt of this report.

On 01/26/26, I conducted an unannounced onsite investigation at the home. Upon arrival, a resident answered the door and I introduced myself to staff member Denise Collins. Ms. Collins was interviewed in the staff office. Ms. Collins reported that she was not working on the day of the incident but learned from other staff that Kristina Hill and Riley Brace were scheduled to work on 01/21/26. Ms. Collins stated that she heard Resident A was found on the floor in her bedroom and CPR was initiated and 911 was called. Ms. Collin stated that she is unsure of the exact cause of death. When Asked about the emergency preparedness plan, Ms. Collins confirmed that staff are required to contact 911 first in situations like this. Ms. Collins indicated that she has not spoken to other residents about the incident but believes they are aware. Ms. Collins confirmed that Resident A's court appointed guardian was notified by staff and her son was notified by the medical examiner.

On 01/26/26, I spoke to staff member Riley Brace via phone regarding the incident. Ms. Brace confirmed she worked at the home on 01/21/26 with her colleague, Kristina Hill. At approximately 3:40pm., Ms. Hill reportedly observed Resident A lying on the floor next to her bed unresponsive. Ms. Brace stated that Ms. Hill informed her of this and stated, "I don't know what to do." Ms. Brace reported that she immediately separated other residents to prevent them from witnessing the situation. During this time, Ms. Hill contacted staff member Kalia Greenhoe and then called 911. Ms. Brace confirmed that she is aware of the policy requiring staff to contact 911 first in emergencies.

While on the phone with 911, both staff members were instructed to roll Resident A onto her back and begin CPR. Ms. Hill reportedly initiated compressions, and Ms. Brace took over when Ms. Hill became fatigued. EMS arrived shortly after and Ms. Brace escorted them to the bedroom while Ms. Hill resumed compressions. Once EMS arrived in the room, they assumed care. Per Ms. Brace, the medical examiner later confirmed the cause of death as a stroke. Ms. Brace noted that Ms. Hill was working to obtain a death certificate to confirm this. Ms. Brace stated that she is CPR certified, but this was her first time performing CPR. Ms. Brace described the incident as traumatic and reported resigning from her position to focus on her well-being.

On 01/27/26, I spoke to staff member Kristina Hill via phone regarding the incident. Ms. Hill confirmed that she worked at the home on 01/21/26, with her colleague, Riley Brace. Ms. Hill stated that at approximately 12:45pm, Resident A was offered lunch but refused and chose to lay in bed all day. Ms. Hill stated, "for anyone else, this would have been a red flag." However, this was typical behavior for Resident A.

Ms. Hill reported that at approximately 3:30pm, she observed Resident A on the floor next to her bed. Upon approaching Resident A, Ms. Hill noticed that Resident A did not appear to be breathing. Ms. Hill immediately ran to the staff office and informed Ms. Brace of the situation. She then contacted management (staff member Kalia Greenhoe). Ms. Hill stated that she realized she should have called 911 first. However, she believes she contacted Ms. Greenhoe first “out of habit.” Within approximately 60 seconds of the call to Ms. Greenhoe, Ms. Hill reported that she contacted 911.

While speaking with the 911 operator, Ms. Hill was instructed to roll Resident A onto her back and begin CPR. Ms. Hill reported that Ms. Brace assisted in repositioning Resident A, after which Ms. Hill began chest compressions. Ms. Hill stated that Ms. Brace attempted CPR but was unable to continue after one attempt, so Ms. Hill resumed compression.

Ms. Hill reported that she and Ms. Brace heard sirens shortly thereafter, and Ms. Brace escorted EMS personnel into the room. According to Ms. Hill, EMS arrived approximately 8 minutes after CPR began and took over CPR efforts. Resident A was later pronounced deceased. The medical examiner determined the cause of death to be a stroke. Ms. Hill indicated that she is working to obtain documentation to confirm this finding. Ms. Hill stated that Resident A’s guardian was notified on the day of the incident and Resident A’s son was notified by licensee Corey Husted the following day.

On 01/28/26, I received an email from staff member Kalia Greenhoe. The email included requested CPR certifications for Kristina Hill and Riley Brace. Both certifications confirmed that each staff member successfully completed CPR requirements in accordance with the American Health Care Academy’s curriculum for the course.

On 02/03/26, I spoke to Brittany Richardson, staff at the Kent County Medical Examiner office. Ms. Richardson informed me that the Chief Medical Examiner concluded that Resident A’s death was ruled natural due to arteriosclerotic cardiovascular disease, which she further described as plaque buildup in the arteries that prevents blood from flowing through the body. Ms. Richardson was thanked for her time.

<b>APPLICABLE RULE</b>	
<b>R 400.619</b>	<b>Emergency preparedness plan.</b>
	<b>(6) A licensee shall ensure that residents, volunteers, and members of the household are familiar with the emergency preparedness plan and fire safety plan and any assigned responsibilities to carry out the plan.</b>

<b>ANALYSIS:</b>	Ms. Hill contacted staff member Kalia Greenhoe before calling emergency services, despite observing Resident A unresponsive on the floor. All interviewed staff members, including Ms. Hill, acknowledged that emergency services should have been contacted first. Based on these statements, there is sufficient evidence to support a violation of the applicable rule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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

*Anthony Mullins*

02/04/2026

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Anthony Mullins  
Licensing Consultant

Date

Approved By:

*Jerry Hendrick*

02/04/2026

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Jerry Hendrick  
Area Manager

Date