GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 14, 2026

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

RE: License #: AS410403035
Investigation #: 2026A0467009
Brightside Living - Whispering Oaks

Dear Mr. Husted:

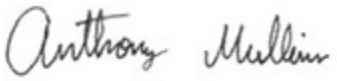
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2026A0467009
Complaint Receipt Date:	01/12/2026
Investigation Initiation Date:	01/12/2026
Report Due Date:	03/13/2026
Licensee Name:	Brightside Living LLC
Licensee Address:	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?
Resident A was hospitalized on 12/26/25 due to not receiving her insulin as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/12/2026	Special Investigation Intake 2026A0467009
01/12/2026	APS Referral Complaint received from Kent County APS worker, Sheena McBride
01/12/2026	Special Investigation Initiated - On Site
01/14/2026	Exit conference with licensee designee, Corey Husted

ALLEGATION: Resident A was hospitalized on 12/26/25 due to not receiving her insulin as prescribed.

INVESTIGATION: On 01/12/26, I received a LARA-BCHS online complaint alleging that Resident A, a Type II diabetic, was hospitalized on 12/26/25, after not receiving her insulin as prescribed. At the time of her hospital admission, Resident A's blood glucose level was 297 mg/dL.

On 01/12/26, I conducted an unannounced onsite investigation at the facility. Staff member Fantasia Corbett allowed entry into the home and provided information regarding the incident. Ms. Corbett confirmed that Resident A was hospitalized on 12/26/25, with a blood glucose level of 297 mg/dL after going several days without insulin.

Ms. Corbett explained that she attempted to refill Resident A's insulin prescription prior to its lapse, but the pharmacy indicated that insurance would not cover a refill until 01/03/26. Ms. Corbett later discovered that Resident A's insulin should have been administered using a sliding scale. However, Resident A was receiving more insulin than prescribed because the Medication Administration Record (MAR) did not reflect the physician's current order.

Ms. Corbett stated that staff are required to administer medications based on the MAR, which they followed. She attributed the error to miscommunication between the physician, pharmacy, and AFC staff. Ms. Corbett reported that the issue has been rectified and Resident A is now receiving insulin as prescribed. Ms. Corbett

showed me Resident A's updated MAR with sliding scale instructions for both Lantus and Humalog, as well as a posted sliding scale chart in the medication room to ensure accurate administration by all staff.

Ms. Corbett introduced me to Resident A, who agreed to discuss the allegation. Resident A reported that she has lived in the home for approximately two years and spoke highly of the care she receives from Ms. Corbett and all other staff members.

Resident A confirmed that she receives her medications daily as prescribed, except for Lactulose, which she often refuses. She acknowledged being hospitalized on 12/26/25, due to feeling ill, which she believes was related to her blood sugar levels. However, she was unable to recall whether her blood sugar was high or low at that time. It should be noted that Resident A was brief during this interview, primarily responding with "yes" or "no" answers.

On 01/14/26, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and aware that a corrective action plan (CAP) is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Ms. Corbett confirmed that Resident A missed days of her insulin medication and/or received the wrong dose due to not having the sliding scale in the MAR. As a result, Resident A was hospitalized on 12/26/25 with a blood sugar level of 297 mg/dL. Therefore, there is a preponderance of evidence to support noncompliance with this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegation listed above, I reviewed Resident A's Medication Administration Records (MARs) for December 2025 and January 2026. The review identified multiple entries indicating that Resident A refused her insulin medications (Lantus & Humalog). This was inconsistent with statements from both Resident A and Ms. Corbett, who stated that Resident A does not refuse her insulin. Ms. Corbett clarified that Resident A did not receive insulin on those days because it was not available onsite while awaiting a pharmacy refill. She explained that the electronic MAR system lacked an option to document "medication

unavailable," so staff selected "resident refused" to continue passing medications for other residents.

I advised Ms. Corbett that Resident A's MAR documentation must accurately reflect actual events. She acknowledged this understanding and will consult with management (Kalia Greenhoe) to correct this issue and prevent future inaccuracies.

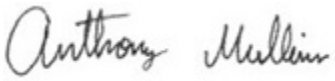
On 01/14/26, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of report.

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. Corbett acknowledged that Resident A's MAR did not accurately reflect real-time events due to limitations within the MAR system. As a result, staff documented "resident refused" insulin doses, although Resident A did not refuse the medication. Therefore, there is a preponderance of evidence to support a finding of noncompliance with 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.

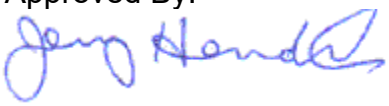


01/14/2026

_____

Anthony Mullins Date
Licensing Consultant

Approved By:



01/14/2026

_____

Jerry Hendrick Date
Area Manager