



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2026

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

RE: License #: AS410403028
Investigation #: 2026A0467045
Brightside Living - Leonard

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,

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

License #:	AS410403028
Investigation #:	2026A0467045
Complaint Receipt Date:	07/17/2026
Investigation Initiation Date:	07/22/2026
Report Due Date:	09/15/2026
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 - Leonard
Facility Address:	2646 Leonard St. NW Grand Rapids, MI 49504
Facility Telephone #:	(616) 805-3212
Original Issuance Date:	04/23/2020
License Status:	REGULAR
Effective Date:	10/23/2024
Expiration Date:	10/22/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff are not supervising Resident A as directed in his assessment plan.	Yes

III. METHODOLOGY

07/17/2026	Special Investigation Intake 2026A0467045
07/17/2026	APS Referral Complaint received from Kent County APS
07/22/2026	Special Investigation Initiated - On Site
07/29/2026	Contact – telephone call made to AFC staff member Cynthia Morgan.
09/01/2026	Exit conference with licensee designee, Corey Husted.

ALLEGATION: Staff are not supervising Resident A as directed in his assessment plan.

INVESTIGATION: On 07/17/26, I received a complaint from Kent County Adult Protective Services (APS). The complaint alleged that Resident A, who is wheelchair bound, arrived alone at Millenium Park in Grand Rapids on 07/05/26 after being dropped off by the Rapid city bus. The complaint further stated that Resident A is not supposed to be unsupervised in the community and has independently left the home numerous times in the past.

On 07/22/26, I conducted an unannounced onsite investigation. Upon arrival, staff member Terri Christensen answered the door allowed entry into the home. Ms. Christensen confirmed that on 07/05/26, Resident A was able to get on the Rapid city bus and was dropped off at Millennium Park. Ms. Christensen received a call from licensee, Corey Husted, requesting that she pick up Resident A from the park. At Mr. Husted's request, Ms. Christensen returned Resident A to the home.

Ms. Christensen described Resident A as "smart and sneaky," explaining that he waits until staff are occupied with other residents before leaving for the bus stop in his wheelchair. Resident A is known to wander and does not have the cognitive ability to understand that he should not be alone in the community. After arriving at the bus station on 07/05/26, Resident A reportedly boarded another bus that transported him to the park. Ms. Christensen stated that Mr. Husted was notified of Resident A's location after someone contacted the Kent County Sheriff's department, who then reached out to staff at the home.

Although Resident A has used public transportation unsupervised in the past, this was his first time going to the park. Ms. Christensen reported that Resident A is not allowed to use the city bus independently. Despite having no funds to ride the bus, drivers have historically allowed him on the bus. However, following this incident, bus drivers have begun refusing to allow him on. Ms. Christensen indicated that these concerns have improved in recent weeks since he can no longer gain access to the bus. She also stated that Resident A's case manager through Network 180 has attempted to obtain a behavioral plan, but the request was reportedly denied because Resident A has not been deemed a threat to himself or others. Due to Resident A's limited cognitive ability, he was not interviewed. He was observed sitting in his wheelchair in the driveway during the visit.

Ms. Christensen stated that her colleague, Cynthia Morgan, was working on 07/05/26 when this incident occurred. Prior to concluding my onsite investigation, Ms. Christensen provided me with a copy of Resident A's assessment plan. The assessment plan states: "(Resident A) does not drive or use the public bus system. He is able to ambulate with a wheelchair or walker. Staff will need to provide transportation in the community as well as supervision when in the community."

On 07/29/26, I spoke to staff member Cynthia Morgan via phone regarding the allegation. Ms. Morgan confirmed that she was working on 07/05/26 when Resident A eloped from the home and traveled to Millennium Park. She stated that Resident A left while she was attending to another resident's needs, and by the time she finished, Resident A "was already gone." Ms. Morgan reported that she went to the end of the driveway to check whether Resident A was still near the bus stop, but the bus had already left. Ms. Morgan did not leave the home to search for him to avoid leaving the other residents at the home unsupervised. After realizing Resident A had left the home, she contacted Ms. Christensen to inform her of the situation.

Ms. Morgan stated that she assumes Resident A first took the Rapid city bus to Central Station in downtown Grand Rapids, where he then boarded another bus that transported him to Millennium Park. Ms. Morgan was unable to recall whether it was Kent County Sheriff deputies or Ms. Christensen that returned Resident A to the home. She confirmed that Resident A has eloped several times in the past. However, since the most recent incident, elopements have stopped because the bus drivers are now refusing to allow Resident A on due to being aware of the situation.

Ms. Morgan confirmed that Resident A's assessment plan states he is not to be in the community unsupervised. She confirmed that he was not injured while away from the home and stated she hopes this is the last time this occurs. Ms. Morgan is hopeful that drivers no longer allowing him on the bus will completely rectify this issue. If elopements start again with Resident A, Ms. Morgan stated it would be beneficial to have a second staff member working to help monitor him more effectively, as managing his safety while attending to other residents' needs can be overwhelming at times.

On 09/01/26, 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 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities. (b) 12 residents for small group and family homes.
ANALYSIS:	Ms. Christensen and Ms. Morgan both confirmed that Resident A was in the community on 07/05/26, and on other occasions without staff supervision. They also verified that his assessment plan clearly states he is not to be in the community without staff supervision. Given that Resident A was able to access public transportation and travel independently through the city without staff oversight, there is a preponderance of evidence supporting this applicable licensing rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Anthony Mullins

09/02/2026

Anthony Mullins
Licensing Consultant

Date

Approved By:

Jerry Hender

09/03/2026

Jerry Hendrick
Area Manager

Date