GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 24, 2024

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

RE: License #: AS410403032
Investigation #: 2025A0583001
Brightside Living - Rosemary

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) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410403032
Investigation #:	2025A0583001
Complaint Receipt Date:	10/21/2024
Investigation Initiation Date:	10/22/2024
Report Due Date:	11/20/2024
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 - Rosemary
Facility Address:	445 Rosemary St SE Grand Rapids, MI 49507
Facility Telephone #:	(616) 551-3051
Original Issuance Date:	04/24/2020
License Status:	REGULAR
Effective Date:	10/24/2024
Expiration Date:	10/23/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
The facility is adequately staffed to meet Resident A's care needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/21/2024	Special Investigation Intake 2025A0583001
10/21/2024	APS Referral
10/22/2024	Special Investigation Initiated - On Site
10/24/2024	Exit Conference Licensee Designee Corey Husted

ALLEGATION: The facility is adequately staffed to meet Resident A's care needs.

INVESTIGATION: On 10/21/2024 complaint allegations were received from the Adult Protective Services Centralized Intake. The allegations were screened out for Adult Protective Services investigation. The complaint stated the following: "*On 10/19/2024, (Resident A) was sent to the ER from the AFC home due to displaying aggressive behaviors. (Resident A) was able to provide minimal insight as to why he was brought to the ER and stated he was there for hitting. (Resident A) has hitting behaviors, so when he gets upset or agitated he tries to hit people, including staff and other residents in the home. The ratio for residents to staff is 6 to 1. House manager, Charolenia, states that there is no extra staff to put on (Resident A) and they don't have anything in place to ensure the safety of the home if (Resident A) becomes agitated again. Charolenia states that she has also spoken with administrative staff about the need for a safety plan but nothing has been done about it. Charolenia states that (Resident A) is supposed to have a behavioral support specialist that comes out once a month but she hasn't seen them in couple months. Paula states that she had no idea that the specialist hasn't been coming out to see (Resident A). There are concerns that if the behavioral specialist is coming out once a month then it's not enough to really assist (Resident A). (Resident A) also struggles with his ADLs. With one staff to every 6 people in the home, it is unknown how they are really able to assist (Resident A) with his day to day care".*

On 10/22/2024 I completed an unannounced onsite investigation at the facility and privately interviewed staff Charlena Picket, Resident A, Resident B, Resident C, and Resident D.

Staff Charlena Pickett stated that she was worked at the facility for approximately four years and Resident A has resided at the facility for approximately one year. Ms. Pickett stated that Resident A has demonstrated physical and verbal aggression towards other residents and staff of the facility since Resident A's admission. Ms. Pickett stated that Resident A assaults the other residents of the facility and tends to target his roommate. Ms. Pickett stated that despite Resident A's aggression, he continues to share a bedroom with Resident C, who requires the use a wheelchair. Ms. Pickett stated that Resident A recently scratched Resident C causing Resident C to sustain "scratches on his arm and face". Ms. Pickett stated that "a few months ago" Resident A hit Resident B in the face with a hat causing Resident B to sustain "a gash on his nose". Ms. Pickett stated that "last Saturday" Resident A hit Resident D in the head and Resident D "has a shunt in his head". Ms. Pickett stated that after striking Resident D in his head, local law enforcement was contacted, and Resident A was sent to the Emergency Department for evaluation. Ms. Pickett stated that no charges were filed, and Resident A was discharged back to the facility with a recommendation from medical providers to add an additional staff for additional support. Ms. Pickett stated that Resident A has been assigned a Behavioral Specialist from Network 180, however a behavior plan and additional staffing have not been added. Ms. Pickett stated that she has spoken to the licensee designee Corey Husted on multiple occasions regarding Resident A's continued aggression. Mr. Pickett stated that Mr. Husted "talked to (Resident A)" about his physical aggression however Resident A continues to exhibit these behaviors. Ms. Pickett stated that a Safety Plan has never been implemented to provide additional safety measures and there has been no additional staffing added. Ms. Pickett stated that staff "do not know what to do" to manage Resident A's aggression. Ms. Pickett stated that the facility operates with one staff member for the six residents who reside at the facility however an additional staff is needed to help support Resident A with his aggression. Ms. Pickett stated that Resident A typically assaults residents when staff are not within eye shot of Resident A therefore an additional staff and a safety plan may help curb Resident A's physical aggression towards other residents.

While onsite I reviewed Resident A's Assessment Plan, signed 10/01/2023. The document states that Resident A requires staff assistance with personal hygiene, toileting, and grooming however the document does not identify how staff provide assistance in these areas. The document is not marked with a yes or no in the area of "controls aggressive behaviors".

While onsite I reviewed the following Incident Reports:

10/19/2024: (Resident A) "ripped (Resident D's) hat and hit in the head and grabbed his shirt".

10/18/2024: (Resident A) "hit (Resident D) in the head and chest".

07/13/2024: (Resident C) stated that (Resident A) was hitting him in his head while he was sleeping.

07/12/2024: (Resident C) stated that (Resident A) hit him and came after him.

07/04/2021: (Resident D) reported that (Resident A) started yelling at (Resident D) and hit (Resident D) while (Resident D) was on the toilet.

06/11/2024: (Resident A) was yelling at roommate to shut and got up and hit him in his face.

05/15/2024: (Resident A) grabbed (Resident C's) walker and started shaking it.

05/02/2024: (Resident C) stated that (Resident A) came hit him in the face for no reason.

04/02/2024: (Resident A) pushed and hit (Resident C) in the back.

03/07/2024: (Resident D) presented with bite marks that (Resident D) attributed to (Resident A) hitting and biting (Resident D).

Resident A presented as appropriately dressed and groomed. Resident A stated that he shares a bedroom with Resident C. Resident A stated that he has hit Resident C because Resident C "teases me". Resident A stated that he "gets along" with everyone at the facility and is comfortable there.

Resident B stated that Resident A is "not nice". Resident B stated that Resident A "picks on" residents of the facility and on one occasion Resident A hit Resident B on the back of his neck. Resident B stated that he is not comfortable with Resident A residing at the facility because he is assaultive, and staff have not managed his behaviors appropriately. Resident B stated that staff verbally reprimand Resident A for assaulting residents, but the behaviors continue.

Resident C stated that Resident A "hits me". Resident C stated that Resident A has "scratched" Resident C on his arms and the injuries are currently healed.

Resident D stated that Resident A "hits me in my head" and that staff "do not do anything about it". Resident D stated that he is not comfortable with Resident A residing at the facility due to Resident A's aggression.

On 10/24/2024 I completed an Exit Conference with licensee designee Corey Husted via telephone. Mr. Husted stated that he would implement an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**

	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	While onsite I reviewed Resident A's Assessment Plan for AFC Residents, signed 10/01/2023. I observed that the document is not marked with a yes or no in the area of "controls aggressive behaviors". While onsite I reviewed multiple Incident Reports describing aggressive actions by Resident A. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Resident A has demonstrated a pattern of physical aggression towards facility residents. Resident A's Assessment Plan is incomplete because it does not identify that Resident A is physically aggressive. Staff Charlena Pickett stated that the facility operates with one staff member for the six residents that reside at the facility however an additional staff is needed to help support Resident A with his aggression. Staff Charlena Pickett stated that Resident A typically assaults residents when staff are not within eye shot of Resident A therefore an additional staff and a safety plan may help curb Resident A's physical aggression towards other residents. The current level of staff in the home is insufficient to address Resident A's physical aggression.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A's Assessment Plan is incomplete and outdated.

INVESTIGATION: While onsite I reviewed Resident A's Assessment Plan, which was signed one 10/01/2023. The document states that Resident A requires staff assistance with personal hygiene, toileting and grooming however the document does not identify how staff provide assistance in these areas. In addition, the document is not marked yes or no in the area of "controls aggressive behaviors".

On 10/24/2024 I completed an Exit Conference with licensee designee Corey Husted via telephone. Mr. Husted stated that he would submit an acceptable

Corrective Action Plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's Assessment Plan states that Resident A requires staff assistance with personal hygiene, toileting, and grooming however the document does not identify how staff provide assistance in these areas. The document is also not marked with a yes or no in the area of "controls aggressive behaviors". A preponderance of evidence was discovered during the course of the special investigation to substantiate a violation of the applicable rule. Resident A's Assessment Plan was last completed on 10/01/2023 and is therefore outdated as it is required to be completed annually. This document is incomplete and does not include the manner in which Resident A's needs will be met by facility staff in the areas of personal hygiene, toileting, and grooming. Furthermore, the document is incomplete and does not indicate whether Resident A "controls aggressive behaviors" because this area was left unmarked.
CONCLUSION:	**VIOLATION ESTABLISHED**

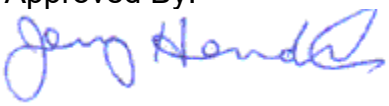
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

10/24/2024

Toya Zylstra Date
Licensing Consultant

Approved By:



10/24/2024

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Jerry Hendrick Date
Area Manager