GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 12, 2024

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

RE: License #: AL280410649
Investigation #: 2024A0230036
Brightside Living - West Shore

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 (231) 922-5309.

Sincerely,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL280410649
Investigation #:	2024A0230036
Complaint Receipt Date:	09/19/2024
Investigation Initiation Date:	09/19/2024
Report Due Date:	11/18/2024
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 - West Shore
Facility Address:	2651 Leaf Lane, Grawn, MI 49637
Facility Telephone #:	(614) 329-8428
Original Issuance Date:	03/14/2022
License Status:	REGULAR
Effective Date:	02/28/2023
Expiration Date:	02/27/2025
Capacity:	14
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medications as prescribed which resulted in a seizure.	No
Additional Findings	Yes

III. METHODOLOGY

09/19/2024	Special Investigation Intake 2024A0230036
09/23/2024	Inspection Completed On-site Interview with Staff Member Karen Fodders
09/23/2024	Contact - Face to Face Resident A
09/23/2024	APS Referral
10/14/2024	Contact - Telephone call made RRO-Kate Johnson
10/24/2024	Contact - Telephone call made Jaiden Moore-Resident A's Case Manager
10/24/2024	Exit Conference with Licensee Designee Corey Husted
11/12/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A did not receive his medications as prescribed which resulted in a seizure.

INVESTIGATION: On 09/23/2024**,** I conducted an unannounced on-site investigation at the facility and interviewed facility manager Karen Fodders. I observed Resident A but was unable to interview him due to his cognitive limitations.

Ms. Fodders stated that Resident A had been admitted to the facility on 09/07/2024. He was brought to the home by his mother directly from the hospital, where he had been for two days for respiratory distress. At this time his mother brought all of his medications and his hospital discharge paperwork. Ms. Fodders stated Resident A's medications were administered as prescribed on the bottles and according to hospital paperwork. Ms. Fodders could not produce any documentation of

medication logs for Resident A at the facility from 09/07/2024 through 09/10/2024. Ms. Fodders stated that the facility uses a company called Guardian Pharmacy to manage all resident medications. She stated that she contacted Guardian pharmacy and asked them to set up Resident A's medications into their computer system. She explained that Guardian Pharmacy contacts all resident health care providers to set up medication administration records (MAR) on a computer system. Guardian Pharmacy did not have this task completed and set up for Resident A until 09/11/2024.

Ms. Fodders provided me with the medication logs for Resident A on the MAR from 09/11/2024 through 09/23/2024. It noted no medications administered from the dates of afternoon of 09/15/2024 through 09/17/2024. Ms. Fodders stated this was because Resident A had been admitted to the hospital on 09/15/2024 after suffering a breakthrough seizure due to Benzodiazepine withdrawal. Ms. Fodders reviewed with me the MAR from 09/11/2024 through 09/15/2024 and noted that Guardian Pharmacy had listed Resident A's Clonazepam as discontinued. Clonazepam medication is in the classification of Benzodiazepine. It was noted in the MAR that Resident A had not received Clonazepam for a four-day period. A review of a current MAR from 09/17/2024 through 09/23/2024 indicated that all of Resident A's current medications were listed in the MAR including Clonazepam.

On 10/14/2024, I spoke with Community Mental Health Recipient Rights Officer Kate Johnson who reported that it was her understanding that Guardian Pharmacy had made the mistake of discontinuing Resident A's Clonazepam.

On 10/24/2024, I spoke with Resident A's caseworker Jaiden Moore. Ms. Moore stated she had spoken with Guardian Pharmacy, and they acknowledged that they had made a mistake and discontinued Resident A's Clonazepam on 09/11/2024.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	I reviewed Resident A's medication logs while at the facility and noted that from the dates of 09/11/2024 through 09/15/2024 Resident A did not receive Clonazepam as the instructions from Guardian Pharmacy indicated that medication was to be discontinued. I noted staff had administered all other medications that were listed in the MAR.

	Ms. Fodders stated staff had followed all instructions for Resident A's medications as prescribed by his physician including when he arrived from the hospital on 09/07/2024. While it is true that Resident A did have a seizure which was likely caused by Clonazepam withdrawal, it was not the fault of the facility as they were following the instructions on the MAR from Guardian Pharmacy which indicated it was discontinued.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/23/2024, while at the facility reviewing Resident A's medication logs, I noted that there was no documentation of medications being administered from 09/07/2024 through 09/10/2024. Ms. Fodders stated this was because Guardian Pharmacy had not set up the MAR system for Resident A until 09/11/2024.

On 10/24/2024, I conducted an exit conference with Licensee Designee Corey Husted and reviewed the findings of the investigation. I explained that all medications need to be documented at all times. He agreed and stated he would provide a plan of correction to include the use of paper MARS for times when the electronic MARS may not be available.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.** **(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 shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency. **(e) Not adjust or modify a resident's prescription medication without instructions from a physician 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 appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	I observed that Resident A's medications were not documented from the dates of 09/07/2024 through 09/10/2024. Ms. Fodders acknowledged that there was no documentation as the pharmacy had not set up the electronic MARS.
CONCLUSION:	**VIOLATION ESTABLISHED**

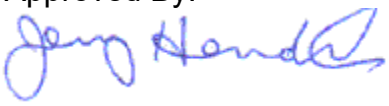
IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction I recommend the status of this license remain unchanged.

11/12/2024

Rhonda Richards Date
Licensing Consultant

Approved By:



11/12/2024

Jerry Hendrick Date
Area Manager