GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 5, 2024

Kalia Greenhoe
Brightside Living LLC
PO Box 220
Douglas, MI 49406

RE: License #: AS410400152
Investigation #: 2025A0467011
Brightside Living - Comstock Park

Dear Ms. Greenhoe:

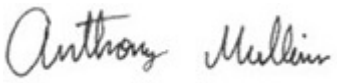
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

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 #:	AS410400152
Investigation #:	2025A0467011
Complaint Receipt Date:	12/03/2024
Investigation Initiation Date:	12/03/2024
Report Due Date:	02/01/2025
Licensee Name:	Brightside Living LLC
Licensee Address:	690 Dunegrass Circle Dr Saugatuck, MI 49453
Licensee Telephone #:	(614) 329-8428
Administrator:	Kalia Greenhoe
Licensee Designee:	Kalia Greenhoe
Name of Facility:	Brightside Living - Comstock Park
Facility Address:	4312 Division Ave N Comstock Park, MI 49321
Facility Telephone #:	(616) 551-1034
Original Issuance Date:	08/01/2019
License Status:	REGULAR
Effective Date:	02/01/2024
Expiration Date:	01/31/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Staff member Kayla Sanders left residents unsupervised at the home on multiple occasions.	No

III. METHODOLOGY

12/03/2024	Special Investigation Intake 2025A0467011
12/03/2024	Special Investigation Initiated - Letter Via email with recipient rights officer, Ashton Byrne
12/04/2024	Inspection Completed On-site
12/04/2024	Exit conference with licensee designee, Kalia Greenhoe
12/05/2024	APS Referral

ALLEGATION: Staff member Kayla Sanders left residents unsupervised at the home on multiple occasions.

INVESTIGATION: On 12/3/24, I received a complaint from Recipient Rights Officer, Ashton Bryne. The complaint alleged that AFC staff member, Kayla Sanders left residents unsupervised at the home on 11/25/24.

On 12/3/24, I spoke Recipient Rights Officer, Ms. Bryne via email and she confirmed that she started interviews and working to sort through and collect additional information.

On 12/4/24, I made an unannounced onsite investigation at the facility. Upon arrival, Resident A was on the porch and allowed entry into the home. I interviewed Resident A at the dining room table. Resident A stated that he has lived in the home for two months and things are going well for the most part. Resident A stated that he prefers to live independently, but he is making the best of his current situation. Resident A confirmed that he was at the home last week Monday (11/25/24). While there, staff member that he referred to as “Kam” left him and other residents at the home unsupervised. “Kam” was later identified as Kayla Sanders. Resident A stated that Ms. Sanders left he and other residents unsupervised in the home for approximately 30 minutes. Resident A was unsure as to exactly where Ms. Sanders went, but he reported that he was scared when left in the home without staff. Resident A stated that this is approximately the 3rd time that he and other residents

were left unsupervised in the home while Ms. Sanders was working, and the other two incidents occurred maybe a week or two apart.

Introductions were made with Resident B and he agreed to discuss the allegation briefly. Resident B stated that he has lived in the home for approximately three years and things are going well for him. Resident B had no knowledge of staff leaving him or other residents unsupervised in the home.

I then spoke to staff member, Katie Estlund regarding the allegation. Ms. Estlund primarily works at another home and picks-up at this home occasionally. Ms. Estlund stated that she did not work at the home on 11/25/24 and she did not have any knowledge of the residents being left unsupervised on that day. However, Ms. Estlund stated that she worked on Saturday, 10/26/24, and when she arrived at the home, Resident C told her that staff member Kayla Sanders left the residents unsupervised in the home to go to the gas station to get tampons. Ms. Estlund stated that Resident C also told her that Ms. Sanders has left residents unsupervised in the home previously. Ms. Estlund stated that when she arrived at the home on 10/26/24, Ms. Sanders was in the shower. When Ms. Sanders finished her shower, she told her that she had to shower due to starting her menstrual cycle. This led Ms. Estlund to believe Resident C when he told her that Ms. Sanders left the residents unsupervised for a period of time.

Resident C was interviewed at the dining room table. Resident C stated that he has lived at the home for approximately 6 to 7 months. Resident C confirmed that he and other residents were left unsupervised in the home last week Monday, 11/25/24. Resident C stated that staff member, Kayla Sanders was working during this time. Resident C stated that Ms. Sanders reportedly went to the gas station down the street. Resident C also stated that Ms. Sanders left residents unsupervised in the home a week or two prior to this incident. Resident C stated that each time Ms. Sanders has left the residents unsupervised in the home, she was gone for approximately 30 minutes.

On 12/4/24, I made my way to Hope Network Day Program on 36th street in Wyoming to interview Resident D and E. Upon entry into the building, staff introduced me to Resident D and assisted us to a conference room to speak. Staff stated that Resident D has been diagnosed with Autism, so it will likely be difficult to obtain information from him. Resident D stated that his last name was “whatever you want to call me” and that he has lived in the AFC home for “a little while.” Resident D stated that he is unsure if he has ever been left unsupervised in the home. Resident D did not have any additional information to add.

Introductions were made with Resident E and he stated that he has lived at the home for a long time. Resident E stated that he comes to Day Program Monday through Thursday and enjoys it. Resident E denied being left unsupervised at the home by any staff member. It should be noted that it was difficult to understand Resident E at times as there is likely a speech impairment. Resident E was also

fixated on asking me if I were working the following day. Resident E was thanked for his time as this interview concluded.

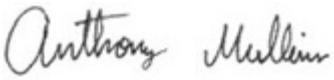
On 12/4/24, I spoke to staff member, Kayla Sanders via phone to discuss the allegation. Ms. Sanders was asked about leaving residents at the home last week Monday (11/25/24). Ms. Sanders shared that on the day in question, she took Resident B and Resident D to the gas station down the street from the home. Ms. Sanders confirmed that she left Resident C at the home while she went to the gas station “because he’s his own guardian.” I informed Ms. Sanders that regardless of Resident A being his own guardian, staff are required to be in the home when residents are present. Ms. Sanders stated that she understands. I also informed Ms. Sanders that resident’s stated that she has left them unsupervised in the home on other occasions. Ms. Sanders was adamant that 11/25/24 was the only time she left a resident unsupervised.

On 12/4/24, I conducted an exit conference with licensee designee, Kalia Greenhoe. She 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 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Resident A and Resident C both confirmed that they were left unsupervised on 11/25/24 while Ms. Sanders was working. They also shared that Ms. Sanders has left them unsupervised in the home in the past. Ms. Sanders admitted to leaving Resident C unsupervised in the home on 11/25/24. Ms. Sanders denied leaving residents unsupervised on any other occasions. Based on the information provide, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

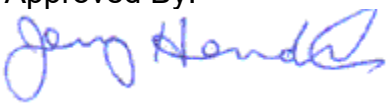
Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.



12/05/2024

Anthony Mullins Date
Licensing Consultant

Approved By:



12/05/2024

Jerry Hendrick Date
Area Manager