



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 02, 2026

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

RE: License #: AM410403710
Investigation #: 2026A0467048
Brightside Living - Mistywood

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 #:	AM410403710
Investigation #:	2026A0467048
Complaint Receipt Date:	08/13/2026
Investigation Initiation Date:	08/13/2026
Report Due Date:	10/12/2026
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 - Mistywood
Facility Address:	3371 Mistywood St SE Caledonia, MI 49316
Facility Telephone #:	(616) 803-0476
Original Issuance Date:	05/01/2020
License Status:	REGULAR
Effective Date:	11/01/2024
Expiration Date:	10/31/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not follow doctor's orders for Resident A.	Yes

III. METHODOLOGY

08/13/2026	Special Investigation Intake 2026A0467048
08/13/2026	Special Investigation Initiated - Letter Spoke to Recipient Rights Officer, Ashton Byrne via email
08/17/2026	Inspection Completed On-site
08/17/2026	Contact – telephone call made to Beth Young, guardian/sister of Resident A.
08/18/2026	APS Referral – not warranted
09/01/2026	Exit conference with licensee designee, Corey Husted.

ALLEGATION: Staff did not follow doctor's orders for Resident A.

INVESTIGATION: On 08/13/2026, I received a complaint from Kent County Recipient Rights Officer Ashton Byrne. The complaint alleged that Resident A's doctor ordered daily blood pressure and pulse checks due to reported dizziness. In addition to daily checks, the order also directs staff to check Resident A's blood pressure and pulse "whenever the client complains of dizziness."

On 08/13/26, I emailed Mrs. Byrne to confirm that I would follow-up with her after completing my onsite investigation at the home on Monday, 08/17/26. Mrs. Byrne indicated she plans to conduct her onsite review on Wednesday, 08/19/26.

On 08/17/26, I conducted an unannounced onsite investigation at the home. Upon arrival, staff answered the door and allowed entry into the home. Staff member Chelsea Martin escorted me to Resident A's basement bedroom, where introductions were made. Resident A reported living in the home for a few months and stated that things have been going well. He confirmed a history of dizziness but said he has been symptom-free since meeting with his psychiatrist, Dr. Hawkins last week, when his Clozaril dosage was lowered. Resident A also confirmed that his blood pressure and pulse have recently been checked. He reported receiving his medications as prescribed and denied any concerns about his care.

I then met with Ms. Martin in the staff office to discuss the allegation. She explained that sometime last month, Resident A's guardian and sister, Beth Young, provided

staff with written orders from his doctor requiring daily blood pressure and pulse checks and additional checks whenever he complains of dizziness. Ms. Martin provided the paperwork, which was an order written by Resident A's psychiatrist, Dr. Sean Hawkins.

Ms. Martin stated that after receiving the order, she and a colleague contacted Network 180 three times in an attempt to obtain a prescription for the order. According to Ms. Martin, calls were made on 07/08/26 (the day the order was received), 07/14/26, and 07/16/26. However, staff did not receive any response from Network 180. Ms. Martin also noted that their fax machine was not working for a period of time, so it is unclear whether anything was attempted to be faxed. She added that Network 180 staff were aware of the fax issue.

Ms. Martin reported that the official order was not obtained until Resident A was seen on 08/12/26 by Nurse Practitioner (NP) Lindsey Kelly through Home MD. The order was then manually entered into the MAR by AFC staff member Donna Rodriguez, and Resident A has been receiving daily blood pressure and pulse checks since 08/13/26. This was verified by reviewing his August 2026 MAR. Since implementing this order, Resident A has not reported any dizziness.

While onsite, I did not see or receive any additional or alternative order from NP Lindsey Kelly, despite Ms. Martin indicating that she had attempted to obtain one. The only order present was the original one provided on 07/08/26 by Dr. Sean Hawkins. Therefore, there was no reason for this order to not be entered for more than a month before being added to Resident A's MAR and implemented. Additionally, because the order did not involve medication, a prescription was not necessary as blood pressure and pulse checks cannot be filled by a pharmacy.

On 08/17/26, I spoke to Beth Young, guardian/sister of Resident A via phone. Ms. Young confirmed that she brought Resident A to his appointment on 07/08/26 with his psychiatrist, Dr. Sean Hawkins. During that visit, Dr. Hawkins ordered that Resident A's blood pressure and pulse be checked daily and also whenever he reports dizziness. Ms. Young received the written order and delivered it to staff member Chelsea Martin, explaining the need for it. Despite providing staff with the order, it was not implemented for more than a month. Ms. Young stated that when she called the home to inquire about the order being implemented, "staff knew nothing," describing the issue as communication breakdown but also indicating she did not believe staff made sufficient effort to implement the order she physically provided. Prior to ending the call, Ms. Young stated, "bottom line, they didn't take his blood pressure like the doctor ordered."

On 08/19/26, I spoke to staff member Donna Rodriguez regarding the allegations. Ms. Rodriguez reported that she had no knowledge of Chelsea Martin receiving the order on 07/08/26. She stated that the first time she saw the order was on 08/12/26. At that time, Ms. Rodriguez contacted the pharmacy to have the order added to Resident A's MAR but was informed that the order would need to be entered

manually by staff, which she completed. Since the order was added to the MAR on 08/12/26, Resident A's blood pressure and pulse have been checked as ordered. Ms. Rodriguez noted that she works part-time and is not frequently at the home, so 08/12/26 was the first time she became aware of the order. She stated that had she known earlier, she would have addressed it immediately.

Ms. Rodriguez and I discussed the difference between an order and a prescription, noting that blood pressure and pulse checks are not medications and therefore do not require a prescription, as a pharmacy would not be able to fill it. She stated that moving forward, Ms. Martin will notify her immediately upon receiving any orders so she can assist and ensure Resident A and other residents have all required supports in place. We also discussed that the order did not include parameters for responding to abnormal readings. Because the order only states that blood pressure and pulse should be checked daily, Ms. Rodriguez plans to contact Dr. Hawkins and staff at Network 180 to obtain clear instructions on what actions staff should take if Resident A's blood pressure or pulse falls outside expected ranges.

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 CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	An order signed by Dr. Hawkins on 07/08/26 instructs staff to check Resident A's blood pressure and pulse once daily or whenever he complains of dizziness. Despite the order being in place, it was never implemented or added to Resident A's MAR until 08/12/26, more than a month after it was initially ordered. Therefore, there is a preponderance of evidence to support 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 Hendrick

09/02/2026

Jerry Hendrick
Area Manager

Date