GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 19, 2026

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

RE: License #: AS410403030
Investigation #: 2026A0467051
Brightside Living - Cedar Springs

Dear Mr. Husted:

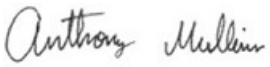
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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 #:	AS410403030
Investigation #:	2026A0467051
Complaint Receipt Date:	09/09/2026
Investigation Initiation Date:	09/10/2026
Report Due Date:	11/08/2026
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 - Cedar Springs
Facility Address:	1880 18 Mile Rd NE Cedar Springs, MI 49319
Facility Telephone #:	(616) 263-9685
Original Issuance Date:	04/21/2020
License Status:	REGULAR
Effective Date:	10/21/2024
Expiration Date:	10/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A and other residents are not being provided with an opportunity to engage in community-based activities.	No
Resident A did not receive his medications as prescribed for at least two weeks in January 2026.	Yes
Staff are not providing transportation services to Resident A per his resident care agreement.	No
Additional Findings	Yes

III. METHODOLOGY

09/09/2026	Special Investigation Intake 2026A0467051
09/10/2026	Special Investigation Initiated - Telephone Spoke to the complainant via phone and confirmed the allegations
09/14/2026	Inspection Completed On-site
09/15/2026	Contact – telephone call made to Lori Marston, Resident A's case manager through Muskegon County CMH (HealthWest). I requested a call back to discuss allegations
09/15/2026	APS Referral – not warranted based on findings.
10/19/2026	Exit conference with Kalia Greenhoe on behalf of licensee designee, Corey Husted.

ALLEGATION: Resident A and other residents are not being provided with an opportunity to engage in community-based activities.

INVESTIGATION: On 09/09/26, I received a complaint alleging that Resident A and other residents were not being provided opportunities to participate in community-based activities.

On 09/10/26, I spoke to the complainant via phone. She reported that for approximately one-year, Resident A and his peers have not been going on outings. She stated that Resident A only recently began going on outings after staff were instructed to do so by his case manager, Lori Marston of HealthWest (Muskegon County CMH).

On 09/14/26, I conducted an unannounced onsite investigation. Upon arrival, staff member Kristina Hill answered the door and allowed entry into the home and introduced me to Resident A. Resident A was interviewed privately on the back patio while smoking a cigarette. Resident A was unable to recall his date of birth or how long he has lived in the home; however, he reported that things are going "good" for

him. He confirmed that staff are responsible for taking him and his peers on outings, which he stated they do. Resident A specifically noted that Ms. Hill takes him on outings, typically to the store to purchase cigarettes at his request. He was unable to recall additional outing locations. Resident A was adamant that his needs are being met and stated that if he wanted to go somewhere specific, he believes that Ms. Hill would accommodate him.

I then spoke to Ms. Hill regarding the allegation. Ms. Hill reported that Resident A is offered monthly outings but frequently refuses. She explained that instead of participating in outings, Resident A often asks her to purchase cigarettes for him. Ms. Hill stated that Resident A's former guardian, who is also his sister, is aware of this. She added that the guardianship lapsed in April 2026, and Resident A no longer has a guardian. Ms. Hill stated that the next scheduled outing is the Apple Fest in Sparta this weekend, and all residents are welcome to participate. She acknowledged that the home's vehicle has been operable for some time but confirmed that she uses her personal vehicle to transport residents when needed.

Prior to concluding my onsite investigation, Ms. Hill provided outing logs dating back to March 2026, documenting that Resident A has been offered multiple outings to locations such as parks, convenience stores, Meijer, the library, restaurants, and shopping areas, most of which he declined. Outing logs for other residents also showed that they were regularly offered community outings.

On 09/15/26, I left a voicemail for Lori Marston at HealthWest requesting a call back to discuss reported transportation concerns. As of the conclusion of this investigation, Ms. Marston has not returned my call.

On 10/19/26, I conducted an exit conference with Kalia Greenhoe on behalf of licensee designee, Corey Husted. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(5) A licensee shall provide the following opportunities for a resident: **(c) Community-based recreational activities.**
ANALYSIS:	Resident A stated that Ms. Hill takes him on community outings. Ms. Hill also confirmed this and reported that Resident A frequently declines these opportunities. A review of Resident A's outing logs dating back to March 2026 shows that he is consistently offered community outings. Based on this information, there is not a preponderance of evidence to support this applicable licensing rule.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A did not receive his medications as prescribed for at least two weeks in January 2026.

INVESTIGATION: On 09/09/26, I received a complaint alleging that Resident A did not receive his medication as prescribed in January 2026.

On 09/10/26, I spoke to the complaint via phone. She reported that Resident A missed his antipsychotic medications for approximately two weeks in January due to staff failing to notify Resident A's physician that the pharmacy would not refill the prescription until a medication review was completed.

On 9/14/26, I conducted an unannounced onsite investigation at the home. Staff Kristina Hill allowed entry into the home and introduced me to Resident A. When asked about medications, Resident A confirmed that he receives all prescribed medications daily and denied having any concerns about his care in the home.

I then spoke with Ms. Hill in her office regarding the allegation. Ms. Hill confirmed that in January 2026, Resident A missed at least one week of medications because the pharmacy would not dispense them without a completed medication review. Ms. Hill stated that she informed Lori Marston, Resident A's case manager through HealthWest, and requested a bridge prescription to provide enough medication until the review was completed, which she states happened.

Ms. Hill provided a copy of Resident A's January 2026 Medication Administration Record (MAR), which documented from 01/02/26 through 01/16/26, Resident A missed multiple doses of Olanzapine 10MG Tab, Risperidone 2MG Tab, and Divalproex 500MG TAB. The MAR notes indicate that some missed doses were a result of Resident A refusing, while other entries reflect that the medications were not available to administer to Resident A.

On 10/19/26, I conducted an exit conference with Kalia Greenhoe on behalf of licensee designee, Corey Husted. 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 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Staff member Ms. Hill confirmed that Resident A missed doses of his medications because a medication review was required before the pharmacy would refill it. A review of Resident A's MAR confirmed that multiple doses were missed for this reason.

	Based on the information provided, there is a preponderance of evidence to support a violation of this applicable licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff are not providing transportation services to Resident A per his resident care agreement.

INVESTIGATION: On 09/09/26, I received a complaint alleging that staff are not providing Resident A transportation services as indicated in his resident care agreement.

On 09/10/26, I spoke to the complainant via phone. She confirmed the allegations and stated that staff are responsible for transporting Resident A to his medical appointments. However, she reported that she has been transporting Resident A herself for the past year because the home's vehicle has been inoperable. She added that as a result of her providing transportation, Resident A has not missed any medical appointments.

On 09/14/26, I conducted an unannounced onsite investigation at the home. Staff Kristina Hill answered the door and introduced me to Resident A. Resident A reported that his sister transports him to his medical appointments as opposed to staff. He was unsure if this arrangement was agreed upon between his staff and sister. He stated that all of his needs are being met and denied having any concerns about living in the home.

I then spoke to Ms. Hill regarding the allegation. Ms. Hill explained that according to the resident care agreement, the home is responsible for transporting residents to one medical appointment per month, and this expectation is communicated to residents and guardians prior to admission. She confirmed that the home's vehicle is currently in need of repair, resulting in her using her personal vehicle to transport residents when necessary. Ms. Hill also stated that Resident A's sister has transported him to appointments "when she's supposed to" and that she has not been required to transport him beyond what is outlined in the care agreement.

While onsite, Ms. Hill provided me with a copy of Resident A's resident care agreement. I noted that his monthly fee includes room and board, home maintenance, cleaning supplies, personal hygiene products, transportation for community outings, and laundry supplies. The agreement does not state that the home is responsible for additional transportation services.

On 10/19/26, I conducted an exit conference with Kalia Greenhoe on behalf of licensee designee, Corey Husted. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following: **(f) Transportation services provided for a basic fee and services that are provided at an extra cost.**
ANALYSIS:	Resident A's resident care agreement indicates that his basic fee includes transportation only for community outings and does not cover additional transportation services. Resident A confirmed that his sister transports him to medical appointments, and Ms. Hill also reported that Resident A's sister provides this transportation. Based on the information provided, there is not a preponderance of evidence to support a licensing rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegations listed above, I reviewed Resident A's assessment plan, which was last signed by his former guardian on 07/29/25. The form is required to be signed by the licensee designee, which was not completed. The form is also required to be completed annually and this form is more than two and a half months overdue.

On 10/19/26, I conducted an exit conference with Kalia Greenhoe on behalf of licensee designee, Corey Husted. 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 400.685	**Resident admission; resident assessment plan; resident care agreement; resident health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.

ANALYSIS:	Resident A's assessment plan was last signed on 07/29/25, making it overdue. Therefore, there is a preponderance of evidence to support a licensing rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED.**

INVESTIGATION: While investigating the allegations listed above, I reviewed Resident A's resident care agreement, which was last signed by his former guardian on 07/29/25. The form is also required to be signed by the licensee designee, which was not completed. This form is more than two and a half months overdue.

On 10/19/26, I conducted an exit conference with Kalia Greenhoe on behalf of licensee designee, Corey Husted. 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 400.685	**Resident admission; resident assessment plan; resident care agreement; resident health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident, resident's designated representative, or responsible agency at least annually or more often if necessary. Any changes to the resident care agreement must be re-signed by all applicable parties. If the annual review results in no changes to the resident care agreement the resident care agreement does not need to be re-signed but the licensee shall document that all applicable parties were contacted and agreed that no changes were necessary.
ANALYSIS:	Resident A's resident care agreement was last signed on 07/29/25, making it more than two and a half months overdue. Therefore, there is a preponderance of evidence to support this applicable licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

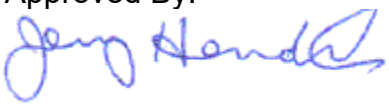
Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.



10/19/2026

Anthony Mullins Date
Licensing Consultant

Approved By:



10/19/2026

Jerry Hendrick Date
Area Manager