GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 13, 2026

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

RE: License #: AS410403033
Investigation #: 2026A0467050
Brightside Living - Heathcliff

Dear Mr. Husted:

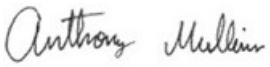
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410403033
Investigation #:	2026A0467050
Complaint Receipt Date:	09/09/2026
Investigation Initiation Date:	09/09/2026
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 - Heathcliff
Facility Address:	2611 Heathcliff Dr SE Grand Rapids, MI 49546
Facility Telephone #:	(614) 329-8428
Original Issuance Date:	04/22/2020
License Status:	REGULAR
Effective Date:	10/22/2024
Expiration Date:	10/21/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff member Areona Hunter is not addressing residents' hygiene and personal care needs appropriately.	Yes

III. METHODOLOGY

09/09/2026	Special Investigation Intake 2026A0467050
09/09/2026	Special Investigation Initiated - Letter Via email with Recipient Rights Officer, Ashton Byrne
09/09/2026	Inspection Completed On-site
09/10/2026	APS Referral Received the same complaint via email from Kent County APS
10/01/2026	Contact – telephone call made to David Dijkstra
10/12/2026	Contact – document received from Kalia Greenhoe
10/12/2026	Exit conference with licensee designee, Corey Husted.

ALLEGATION: Staff member Areona Hunter is not addressing Resident A's hygiene and personal care needs appropriately.

INVESTIGATION: On 09/09/26, I received a complaint from Kent County Recipient Rights Officer Ashton Byrne alleging that staff member Areona Hunter failed to appropriately address Resident A's hygiene and personal care needs. That same day, I conducted an unannounced onsite investigation at the home. Upon arrival, staff member Michelle Carter answered the door and allowed entry into the home. Ms. Carter confirmed that on 09/08/26, Resident A had been left in a soiled brief for an extended period of time by staff member Areona Hunter.

Ms. Carter reported that at approximately 1:30pm on 09/08/26, Ms. Hunter left the home to grab lunch. During this time, a case manager in the home asked whether Ms. Carter could smell urine and/or feces. Ms. Carter stated that she did not smell feces but she did notice the scent of an odor neutralizing room spray that Ms. Hunter had used. This prompted Ms. Carter to check all of the resident's bedrooms, where she did not notice any evidence of urine or feces. However, when Ms. Carter returned to the kitchen, she observed that the chair Resident A had been sitting in was soiled with urine. Ms. Carter noted that earlier in the day she had seen Ms. Hunter place Resident A's linens in the washer, which made her unsure as to why

she didn't also change Resident A's brief. Ms. Carter also added that Resident A does have a history of refusing care needs.

Ms. Carter acknowledged that there had been previous concerns regarding Ms. Hunter not attending to Resident A's needs, specifically leaving her in a soiled brief for extended periods for the next shift to address. However, Ms. Carter believed that "we had turned a corner" in Ms. Hunter's care of the residents. She explained that when she begins her Monday and Friday morning shifts, Resident A typically appears clean and well-groomed, which she attributed to Ms. Hunter. Ms. Carter stated she is unsure why Resident A was not cleaned on the morning on 09/08/26. To ensure Resident A's needs were met on that date, Ms. Carter reported that she cleaned the soiled chair and changed Resident A's brief. She added that when Ms. Hunter noticed her changing Resident A's brief, she approached her and assisted.

Introductions were then made with Resident A on the front porch of the home. Resident A agreed to speak with me as long as Ms. Carter was present. Resident A confirmed that both Ms. Hunter and Ms. Carter worked on 09/08/26. She stated that she woke up around 7:00am and ate breakfast around 7:30am. It should be noted that according to Ms. Carter, Ms. Hunter was working alone until she arrived for her shift at approximately 9:00am.

Resident A stated that her brief was changed by Ms. Carter upon her arrival. She was adamant that Ms. Hunter did not change her, despite asking her to do so. Resident A reported that Ms. Hunter told her that Ms. Carter would change her when she came on shift. She further stated that the chair she had been sitting in was wet due to her sitting in a soiled brief. Resident A added that she does not know why, but she believes Ms. Hunter does not like to change her briefs based on how Ms. Hunter behaves towards her. Resident A explained that she could benefit from Ms. Hunter's assistance while she is working but knows she will receive all the necessary help when Ms. Carter arrives on shift. Resident A stated that she feels safe in the home and aside from Ms. Hunter not addressing her hygiene and personal care needs, she has no additional concerns.

I then spoke to Resident B, who also requested that Ms. Carter be present while speaking to me. Resident B stated that she has lived in the home for approximately two years and confirmed that Ms. Hunter worked the morning of 09/08/26. Resident B explained that she wears briefs but is independent with her care needs. She denied having any knowledge of Resident A's needs not being met by Ms. Hunter, though she did note that when Resident A needs her brief changed, "it sometimes takes a while." Resident B reported feeling safe in the home and had no additional information to provide.

On 10/01/26, I spoke to David Dijkstra, new owner of the AFC home. It should be noted that Mr. Dijkstra is temporarily operating under the former owner (Corey Husted) license for the next few weeks. Therefore, Mr. Husted will remain the

licensee, but Mr. Dijkstra is authorized to discuss concerns and allegations related to the home.

Mr. Dijkstra reported that a recent Recipient Rights investigation had been substantiated, finding that Ms. Hunter left Resident A in a soiled brief. He stated that Ms. Hunter denied the allegation and claimed that Resident A refused to be changed and showered. Despite her explanation, Mr. Dijkstra stated, “there’s been enough things that have happened in the past to where I just don’t have the trust in her.” As a result, he confirmed that Ms. Hunter will not work in the home after 10/02/26.

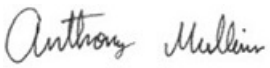
On 10/12/26, I received an email from Kalia Greenhoe that included Resident A’s assessment plan. The assessment plan indicates that Resident A does not need assistance toileting, but she does require prompts and coaching for bathing, grooming, and personal hygiene needs.

On 10/12/26, I conducted an exit conference with licensee designee, Corey Husted. He was informed of the investigative findings and agreed to complete a Corrective Action Plan (CAP) within 15 days of receipt of this report. It should be noted that Mr. Husted’s CAP will include the voluntary closure of his license, as he has sold the home to Mr. Dijkstra, who is expected to be operating under his own license no later than 10/21/26.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Resident A reported that she asked Ms. Hunter for assistance in changing her brief on 09/08/26 and she instructed her to wait for Ms. Carter to arrive to assist her. Although Resident A typically only requires prompting and coaching to attend to her hygiene needs (per her assessment plan), she was not given help when asked. 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.

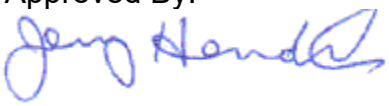


10/12/2026

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Anthony Mullins — Date
Licensing Consultant

Approved By:



10/13/2026

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Jerry Hendrick — Date
Area Manager