STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 10, 2022

Sara Dickendesher
Gaslight Village Assisted Living, LLC
Suite 200
3196 Kraft Avenue
Grand Rapids, MI 49512

RE: License #: AH460361737
Investigation #: 2022A1027018
Gaslight Village Assisted

Dear Ms. Dickendesher:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the licensee authorized representative and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. 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 (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH460361737
Investigation #:	2022A1027018
Complaint Receipt Date:	12/08/2021
Investigation Initiation Date:	12/09/2021
Report Due Date:	02/07/2022
Licensee Name:	Gaslight Village Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 914-0045
Administrator:	Guinevere DeBerry
Authorized Representative:	Sara Dickendesher
Name of Facility:	Gaslight Village Assisted
Facility Address:	2625 N. Adrian Highway Adrian, MI 49221
Facility Telephone #:	(517) 264-2284
Original Issuance Date:	09/08/2015
License Status:	REGULAR
Effective Date:	11/22/2020
Expiration Date:	11/21/2021
Capacity:	51
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A’s authorized representative was not notified she fell and went to the hospital.	Yes
Additional Findings	No

III. METHODOLOGY

12/08/2021	Special Investigation Intake 2022A1027018
12/09/2021	Special Investigation Initiated - Telephone Voicemail left with complainant
12/09/2021	Contact - Telephone call received Telephone interview conducted with the complainant
12/09/2021	Contact - Telephone call made Telephone call conducted with Resident A's DPOA
12/09/2021	Contact - Document Received Received text message with copy of phone records from Resident A's DPOA
01/05/2022	Contact - Document Sent Email sent to Ms. DeBerry requesting Resident A's facesheet, service plan and employee contact information.
01/05/2022	Contact - Telephone call made Voicemail left with medication technician Cathy Montalvo
01/05/2022	Contact - Telephone call received Telephone interview conducted with medication technician Cathy Montalvo
01/06/2022	Contact - Document Sent Email sent to Administrator Guinevere DeBerry requesting facility's telephone records from 12/6/21
01/07/2022	Contact - Telephone call made Telephone interview conducted with shift supervisor Jennifer Washburn
01/07/2022	Contact - Telephone call received

	Telephone interview conducted with Administrator Guinevere DeBerry
01/07/2022	Inspection Completed-BCAL Sub. Compliance
01/31/2022	Exit Conference Conducted with Authorized Representative Sara Dickendesher

ALLEGATION:

Resident A's authorized representative was not notified she fell and went to the hospital.

INVESTIGATION:

On 12/8/21, the department received a complaint which read Resident A fell, went to the hospital and her family was not notified. The complaint read Resident A had Alzheimer's and could not answer questions on her own at the hospital.

On 12/9/21, I conducted at telephone interview with the complainant. The complainant stated Resident A has resided at the facility for approximately six or seven years with great care until recently. The complainant stated Resident A has Alzheimer's dementia. The complainant stated Resident A had a fall in the early morning on 12/6 around 4:00 or 5:00 am. The complainant stated the facility never notified Resident A's Durable Power of Attorney (DPOA). The complainant stated Resident A was taken to Hickman Hospital, a CAT scan was completed, and she was returned to the facility on 12/6. The facility called Resident A's DPOA on 12/7 at 2:30 PM to notify him that Resident A was in extreme pain, and they wanted to order hospice services. The complainant stated Resident A's family decided it would be best to obtain an x-ray first prior to starting hospice services. The facility staff stated they would coordinate ordering an x-ay and she would have one done on 12/7. The complainant stated Resident A's DPOA went to the facility on 12/8 and the x-ray had not been completed yet. The complainant stated the x-ray was completed on 12/8 and the facility called results to Resident A's DPOA on 12/8 at 10:00 pm to notify him that Resident A had a broken femur. The complainant stated Resident A's family decided they wanted Resident A to go to Chelsea Hospital for treatment and the facility staff was supposed to call her DPOA when the ambulance picked her up. The complainant stated Resident A's DPOA did not receive a call from the facility when they picked her up and received a call from Chelsea emergency room staff once she arrived. The complainant stated Chelsea emergency room stated Resident A had broken her hip.

On 12/9/21, I conducted a telephone interview with Resident A's DPOA, Gary Adams. Mr. Adams statements were consistent with the complainant. Mr. Adams stated his mother resides in memory care at the facility. Mr. Adams stated facility

staff have called him throughout the five years she has resided at the facility regarding any issues or concerns. Mr. Adams stated once facility staff notified him of Resident A’s fall on 12/7 at 2:30 pm, he asked why he was not notified on 12/6 when it happened. Mr. Adamas stated facility director Guinevere DeBerry stated she thought the midnight staff person notified him. Mr. Adams stated Ms. DeBerry also stated the midnight shift staff person had not had an event like this happen before and did not know what to do. Mr. Adams stated he visited Resident A on 12/7 after receiving the call from the facility to ask for the hospital paperwork in which he reviewed it then determined he would like an x-ray completed as well. Mr. Adams stated Ms. DeBerry was going to obtain an order for the x-ray and it would be completed on 12/7. Mr. Adams stated he visited Resident A on 12/8 around 3:00 PM and facility staff informed him the x-ray had not been ordered. Mr. Adams stated the facility staff spoke with Ms. DeBerry who stated the x-ray was ordered and called the x-ray company who stated they were running late. Mr. Adams stated the x-ray was completed on 12/8 in which he received a call from facility staff Sara Smith who stated Resident A had a “broken leg.” Mr. Adams stated Ms. Smith was planning to send Resident A to the hospital. Mr. Adams stated when he spoke with Ms. Smith that he requested she be transfer to Chelsea Hospital and he be called from facility staff to let him know when the ambulance picked her up. Mr. Adams stated he never received a call that the ambulance picked up Resident A and received a call from the Chelsea emergency room staff. Mr. Adams stated Resident A had a broken hip in which she required surgery.

On 1/5/22, I conducted a telephone interview with facility caregiver Cathy Montalvo. Ms. Montalvo stated she was assigned to the memory care unit on 12/6/21 but was not on the memory care unit at the time of Resident A’s fall, because she was assisting another staff member. Ms. Montalvo stated staff member Louise was covering the memory care unit when Resident A fell. Ms. Montalvo stated she returned to the memory care unit and observed Resident A on the floor in the dining area. Ms. Montalvo stated she called the facility’s administrator Ms. DeBerry, the ambulance, Resident A’s physician and Resident A’s family. Ms. Montalvo stated she was “99% sure” she had contacted Resident A’s DPOA and left a voicemail but could not remember who she called and stated the voicemail was “generic.”

On 1/7/22, I conducted a telephone interview with shift supervisor Jennifer Washburn. Ms. Washburn stated she was coming onto her shift at 6:00 AM. Ms. Washburn stated the ambulance had just arrived to pick Resident A up from the facility to take her to the hospital. Ms. Washburn stated she advised Ms. Montalvo to call the emergency room to provide a report immediately. Ms. Washburn stated Resident A’s DPOA is her emergency contact, and she has called him in the past in which she has been required to leave a voicemail on his phone and he returned her call.

On 1/7/22, I conducted a telephone interview with administrator Guinevere DeBerry. Ms. DeBerry stated Ms. Montalvo contacted her when Resident A’s fall occurred. Ms. DeBerry stated she called Resident A’s DPOA on 12/7/21 and he reported he

had not known she fell nor went to the hospital on 12/6. Ms. DeBerry stated she questioned Ms. Montalvo regarding her notification to Resident A's DPOA. Ms. DeBerry stated Ms. Montalvo stated Resident A's DPOA phone rang numerous times, and his voicemail did not pick up. Ms. DeBerry questioned Ms. Montalvo a second time in which Ms. Montalvo stated she could not leave a voicemail on Resident A's DPOA phone. Ms. DeBerry stated she had recently left a voicemail on Resident A's DPOA phone. Ms. DeBerry stated the facility does not have a written policy to reach out to second emergency contact and/or DPOA if the first person appointed does not answer or staff are unable to leave a voicemail. Ms. DeBerry requested the 12/6 phone records from their phone company, but the phone company was not tracking outgoing calls for the facility. Ms. DeBerry stated she educated her staff to call the second emergency contact listed.

I reviewed Resident A's facesheet which read consistent with statements from the complainant and Resident A's DPOA.

I reviewed the incident report for Resident A which read consistent with the complainant and staff interviews. The report read Resident A's Authorized Representative was contacted on 12/6/21 at 6:15 am.

I reviewed a text message from Resident A's DPOA which included images of Resident A's DPOA phone call records which read consistent with his statements.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Complainant, Resident A's DPOA, and staff interviews along with review of facility documentation revealed staff attempted to contact Resident A's DPOA regarding her fall and subsequent hospitalization. Although it cannot be determined if Resident A's DPOA was contacted or not, the facility did not have an organized program to contact Resident A's alternate contact.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/31/2022, I shared the findings of this report with Authorized Representative Sara Dickendesher. Ms. Dickendesher verbalized understanding of the citation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

1/10/2022

Jessica Rogers — Date
Licensing Staff

Approved By:

01/31/2022

Andrea L. Moore, Manager — Date
Long-Term-Care State Licensing Section