GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 8, 2023

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

RE: License #: AH460361737
Gaslight Village Assisted
2625 N. Adrian Highway
Adrian, MI 49221

Dear Licensee:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 feel free to contact the local office at 877-458-2757.

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) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH460361737
Licensee Name:	Gaslight Village Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Authorized Representative:	Sara Dickendesher
Administrator/Licensee Designee:	Crystal Smith
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
Capacity:	51
Program Type:	AGED ALZHEIMERS

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 11/07/2023

Date of Bureau of Fire Services Inspection if applicable: 9/20/2023 and 10/23/2023

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 11/08/2023

No. of staff interviewed and/or observed 10
No. of residents interviewed and/or observed 18
No. of others interviewed One Role A resident's hospice nurse

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds held.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Bureau of Fire Services reviews fire drills. Disaster plan reviewed and staff interviewed regarding disaster plan.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s:
- CAP dated 12/19/2021 to Renewal Licensing Study Report (LSR) dated 12/2/2021: R 325.1931(2), R 325.1932(1), R 325.1964(9)(b)
- CAP dated 2/15/2022 to Special Investigation Report (SIR) 2022A1027018: R 325.1921(1)(b)
- CAP dated 9/21/2023 to SIR 2022A1022024 dated 9/6/2023: R 325.1921(1)(b)
- Number of excluded employees followed up? Two N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

R 325.1913 Licenses and permits; general provisions.

(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.

Interview with Sarah Bendele revealed she was appointed administrator on 8/21/2023.

Interview with Jennifer Herald revealed it was assumed the owner appointed Ms. Bendele as administrator and Ms. Herald as authorized representative in which the Department had not received documentation of those changes.

VIOLATION ESTABLISHED.

R 325.1922 Admission and retention of residents.

(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

For Reference:
R 325.1901
Definitions. Rule 1. As used in these rules:

(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.

Review of Resident C's service plan updated on 10/5/2023 revealed it was incomplete and lacked specific care and maintenance.
For example, the plan read in part "*Resident requires assistance with: (specify: ability to get in and out of bed, chair, car, etc.).*"
The plan read in part "*Assurance checks provided (specify frequency) for: (specify reason)*."
The plan read in part "*Resident requires assistance with: (specify: transferring in/out, steadying, washing/drying self, applying lotion, toenail and fingernail care, etc.)*."
The plan read in part "*Resident requires assistance with: (specify: upper/lower body dressing, choosing appropriate seasonal clothing, tying shoes, buttons, snaps, etc.)*."
The plan also read incomplete for the following focus areas respiratory treatments, instrumental ADLs, and laundry.

Review of Resident D's service plan updated on 8/4/2023 revealed it was incomplete in the following focus areas escort/mobility, bathing, and grooming.

VIOLATION ESTABLISHED.

R 325.1931 Employees; general provisions.

(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.

Interview with Employee #1 revealed the "*team lead*" was the designated shift supervisor; however, that staff member was no identified as the shift supervisor on the October 2023 staff schedule. Additionally, Employee #1 stated there was not always a "*team lead*" on second shift.

REPEAT VIOLATION ESTABLISHED.

[For reference, see Licensing Study Report (LSR) dated 12/2/2021, CAP dated 12/19/2021]

R 325.1932 Resident medications.

(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

The medication administration records (MARs) were not always completed per the licensed health care professional orders in which some were left blank. For example, Resident A's October 2023 MAR read one or more doses of medications were left blank for Metronidazole on 10/15/2023 and 10/16/2023, which was prescribed on

10/14/2023. Additionally, Resident A's October 2023 MAR read she was prescribed Morphine every four hours on 10/24/2023 in which 10/25/2023 was left blank, as well as 12:00 AM to 8:00 AM doses were left blank on 10/26/2023.
Resident B's October 2023 MAR read she was prescribed Fluticasone on 10/2/2023; however, it was left blank from 10/3/2023 through 10/6/2023. The October 2023 MAR read she was prescribed Spironolactone on 10/4/2023; however, it was left blank on 10/5/2023 and 10/6/2023.

Resident C's September 2023 MAR read one or more medications were left blank on 9/24/2023, 9/20/2023 and 9/30/2023. The September 2023 MAR read he was prescribed Novolin, hold if his blood sugar was less than 80; however, staff initialed Novolin as administered for a blood sugar of less than 80 on the following dates 9/4/2023, 9/13/2023, 9/17/2023, 9/28/2023. Resident C's October 2023 MAR read he was prescribed Oxycodone in which the 10:00 PM doses on 10/1/2023 and 10/23/2023 were left blank.

Therefore, it could not be determined if Residents A, B and C received their medications as prescribed.

Additionally, Resident B's September 2023 MARs read she was prescribed Fluticasone spray in which staff documented the reason it was not administered was "*awaiting med arrival from pharmacy*" from dates 10/2/2023 through 10/30/2023, except on 10/7/2023, 10/9/2023, 10/13/2023, 10/20/2023 and 10/27/2023 in which staff initialed it was administered.

Medications ordered PRN or "as needed" did not always include written instructions for administration of the medications. For example, Resident B's October 2023 MAR read she was prescribed Acetaminophen, take one or two tablets by mouth every day as needed. There were no specific written instructions for staff describing the circumstances or reasons to necessitate administration of PRN medications to Residents B.

PRN medication orders were duplicated in the September and October 2023 MARs reviewed. For example, Resident A was prescribed Tylenol 325 mg, give two tablets every four hours as needed for pain, discomfort, or fever above 100.4 degrees and Acetaminophen 325 mg, give two tablets every four hours as needed for pain and fever greater than 100.4 degrees. Resident C's September and October 2023 MARs read he was prescribed an as needed Anti-diarrheal twice.

Staff did not always administer PRN medications for the reason prescribed by the licensed healthcare professional. For example, Resident A's October 2023 MAR read she was prescribed Lorazepam for anxiety or restlessness and some staff documented the reason for administration was agitation. The MAR read Resident A was prescribed Haloperidol for agitation or nausea/vomiting. Resident B's September and October 2023 MARs read she was prescribed Alprazolam for anxiety and some staff documented the reason for administration was "agitation" or

“restless.”, Resident C’s October 2023 MAR read staff administered Novolin for “headache.”

Additionally, review of Resident A’s MARs revealed she was prescribed PRN Acetaminophen for pain, Hydrocodone for pain, and Morphine Sulfate for pain and shortness of breath. Review of Resident B’s October 2023 MARs revealed she was prescribed Acetaminophen for pain, discomfort or fever, Morphine Sulfate for pain or dyspnea, and Tramadol for pain. Both Resident A and B’s MARs read there were three medications prescribed for pain which lacked sufficient instructions to determine whether the medications were to be given together, separately, in tandem, or one instead of the other according to the severity of pain.

VIOLATION ESTABLISHED.

R 325.1943 Resident registers.

(1) A home shall maintain a current register of residents which shall include all of the following information for each resident:
(a) Name, date of birth, gender, and room.
(b) Name, address, and telephone number of next of kin or authorized representative, if any.
(c) Name, address, and telephone number of person or agency responsible for resident's maintenance and care in the home.
(d) Date of admission, date of discharge, reason for discharge, and place to which resident was discharged, if known.
(e) Name, address, and telephone number of resident's licensed health care professional, if known.

Review of the resident register, which the facility referred to as the “*Ready Set Go*” binder, revealed it was incomplete. For example, Residents E and F lacked a face sheet in the binder and Resident F’s face sheet lacked the name, address, and telephone number of her licensed health care professional. Thus, the resident register was incomplete, and their face sheets did not always include all information required.

VIOLATION ESTABLISHED.

R 325.1964 Interiors.

(9) Ventilation shall be provided throughout the facility in the following manner:
(b) Bathing rooms, beauty shops, toilet rooms, soiled linen rooms, janitor closets, and trash holding rooms shall be provided with a minimum of 10 air changes per hour of

continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.

Inspection of memory care apartments 2 and 7 revealed they lacked adequate and discernable air flow.

REPEAT VIOLATION ESTABLISHED.

[For reference, see Licensing Study Report (LSR) dated 12/2/2021, CAP dated 12/19/2021]

R 325.1970 Water supply systems.

(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.

Inspection of memory care apartments 2 and 7 revealed the water temperatures were 103.8 degrees Fahrenheit.

VIOLATION ESTABLISHED.

R 325.1976 Kitchen and dietary.

(13) A multi-use utensil used in food storage, preparation, transport, or serving shall be thoroughly cleaned and sanitized after each use and shall be handled and stored in a manner which will protect it from contamination.

Interview with Chef Manager Employee #2 revealed chemical sanitization was utilized and tested daily then recorded to demonstrate the task was completed; however, the October 2023 records were incomplete. For example, the log was left blank on the following dates: 10/2/2023 and 10/7/2023 on evening shifts, 10/21/2023 and 10/22/203 on morning shifts, 10/23/2023 on evening shift, 10/27/2023 on both morning and evening shifts, 10/28/2023 on evening shift, 10/30/2023 on evening shift and 10/31/2023 on both morning and evening shifts.

Interview with Employee #2 revealed the kitchen also utilized a three-compartment sink in which dishes were washed and sanitized three times daily. Inspection of the sanitization log for October 2023 revealed it was incomplete. For example, the following dates were left blank: 10/9/2023 on dinner shift, 10/21/2023 on breakfast and lunch shifts, 10/22/2023 on breakfast and lunch shifts, 10/23/2023 for all three meals, 10/27/2023 for all three meals, 10/30/2023 on dinner shift, and 10/31/2023 for all three meals.
Thus, it could not be confirmed if proper and adequate sanitization of dishware was completed.

VIOLATION ESTABLISHED.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

11/08/2023

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Date

Licensing Consultant