GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Jennifer Herald
Gaslight Village Assisted
2625 N. Adrian Highway
Adrian, MI 49221

March 14, 2024

RE: License #: AH460361737
Investigation #: 2024A1022015
Gaslight Village Assisted

Dear Jennifer Herald:

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 authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH460361737
Investigation #:	2024A1022015
Complaint Receipt Date:	01/10/2024
Investigation Initiation Date:	01/11/2024
Report Due Date:	02/09/2024
Licensee Name:	Gaslight Village Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Sarah Bendele
Authorized Representative:	Jennifer Herald
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:	11/22/2023
Expiration Date:	11/21/2024
Capacity:	51
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) was not provided with appropriate interventions to prevent falls.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/10/2024	Special Investigation Intake 2024A1022015
01/11/2024	Special Investigation Initiated - Letter Complainant was contact by email.
01/17/2024	Contact - Telephone call made. Investigation conducted remotely via videoconference.
03/02/2024	Contact - Document Sent Email exchange with the administrator.
03/14/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) was not provided with appropriate interventions to prevent falls.

INVESTIGATION:

On 01/10/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “My father died rather unexpectedly after a fall at the nursing home. Per the nursing, he fell and (the facility explained that) it was bad this time. His cause of death by the ME (medical examiner) was head trauma related to multiple falls. Per verbal report only I (complainant) have been told (by the facility) your (the complainant) dad fell all of the time. What I (complainant) don’t see is enhanced fall precautions added after his first fall…”

On 01/11/2024, the complainant was contacted by email, but there was no response.

On 01/17/2024, a referral was sent to Adult Protective Services.

On 01/17/2024, I interviewed the administrator remotely, via a videoconference call. According to the administrator, the ROC was a resident in the facility’s memory care (MC) unit, had combative behaviors and severely impaired cognition, that worsened towards the end of his life. The ROC was known to wander around the MC unit using a walker.

The facility supplied the ROC’s chart notes, service plan, and incident reports (IR). Review of these documents revealed the following.

The ROC moved into the facility on 07/06/2023. His charting notes documented that from the time of move-in, the ROC displayed problematic behaviors such as anxiety, restlessness, agitation, and refusals of medication. The service plan developed at the time the ROC moved into the facility indicated that he did not have falls and that he walked independently without any assistive devices.

According to his charting notes, on 07/13/2023, his caregivers suspected that he had sustained a fall because he had a small skin tear on his left arm. The staff did not document this finding on an IR and no changes were made to the ROC’s service plan.

According to an IR, on 07/20/2023, the ROC was found on the floor of the MC dining room. He was sent to the emergency room (ER) of a local hospital after complaining of head pain. Staff observed “a knot” on the back of his head. Subsequently, the ROC complained of pain in his left hip. There were no corrective measures to

prevent reoccurrence listed on the IR. There were no updated care instructions made to the ROC's service plan.

On 07/22/2023, the charting notes documented that the "Resident woke up from sleeping on MC couch, he stood up and started to slowly stumble over and fell on his left side." The staff did not document this finding on an IR and no changes were made to the ROC's service plan.

According to charting notes, on 07/23/2023, when the ROC was displaying agitated behaviors, he was also noted to be "very unstable on his feet." There were no updated care instructions made to the ROC's service plan subsequent to this observation.

According to charting notes, on 07/26/2023, "Resident came into the common area living room using his walker. He let go of his walker and turned around. While turning around, resident fell over." The staff did not document this finding on an IR and no changes were made to the ROC's service plan.

According to an IR, on 07/27/2023, during the caregivers' walk-through, the ROC was found on his back on the floor in his apartment, holding onto a walker. Although the ROC stated that he had pain in his back and his head, emergency medical services (EMS) personnel did not take him to the local ER. There were no corrective measures to prevent reoccurrence listed on the IR. There were no updated care instructions made to the ROC's service plan.

According to charting notes, on 08/07/2023, "Resident was found on floor in front of his room…another resident came and got staff member to help him up." The staff did not document this finding on an IR and no changes were made to the ROC's service plan.

On 08/13/2023, the ROC's service plan was updated to indicate that the ROC was to use a walker. The ROC "can be unsteady. Encourage resident to use walker."

According to charting notes, on 08/14/2023, "Resident was exit-seeking a rushed through the memory care main door when opened by staff. Resident tripped and fell onto his right side…" The staff did not document this finding on an IR and no changes were made to the ROC's service plan.

According to an IR, on 08/15/2023, when caregivers heard the ROC yelling out for help, he was found on the floor in the dining room, holding the back of his head, grimacing, and rocking back and forth. He was noted to have a "bump on back of head and red mark/line on left side of neck and read towards shoulder." The ROC was sent to the ER at the local hospital. Other than a note that the facility "made all appropriate notifications," there were no corrective measures to prevent reoccurrence listed on the IR. There were no updated care instructions made to the ROC's service plan.

According to an IR, on 09/03/2023, the ROC was found in his room laying on the floor in his closet. According to the IR, caregivers determined that the ROC had hit his head on the wall. The ROC was again sent to the local ER. There were no corrective measures to prevent reoccurrence listed on the IR. There were no updated care instructions made to the ROC's service plan.

According to an IR, on 09/09/2023, at 6:25 am, staff again hear yelling from the ROC's room. When they entered, the ROC was again found on the floor, but on this occasion, he was face down with his forehead against the base of his nightstand. The ROC was again sent to the ER. There were no corrective measures to prevent reoccurrence listed on the IR. There were no updated care instructions made to the ROC's service plan.

According to charting notes, on 09/10/2023, (at 6:10 am) "he (the ROC) was up out of bed falling. Staff caught fall called for assistance. We got him back in bed, got him comfortable, told him if he was going to get up to call for us…about 6:27 am we heard a yell. He was on floor (with his) head was on bottom of nightstand…" The charting notes went on (at 3:55 pm) "resident was found belly down on the ground with head against the wall…" The staff did not document this finding on an IR and no changes were made to the ROC's service plan.

According to charting notes, on 09/13/2023, "Staff saw him (the ROC) on his floor in his apartment…" The staff did not document this finding on an IR and no changes were made to the ROC's service plan.

On 09/13/2023, the ROC became a patient of a local hospice agency. His service plan was updated to reflect that he was non-weight bearing and that caregivers were to use a mechanical (Hoyer) lift for transfers. Also, on 09/13/2023 the service plan reflected that the ROC was sleeping on a mattress that had been placed on the floor for resident safety. On 09/23/2023, a "low sitting hospital bed" had been supplied to the ROC and his mattress was no longer on the floor. After the ROC became a hospice benefit recipient, the hospice staff ordered multiple medications for pain, anxiety and behaviors associated with the end of life. While on hospice care, the ROC continued to have falls and to be unsteady on his feet.

On 03/02/2024, via an email exchange with the administrator, the administrator was asked to supply evidence that the facility implemented fall preventions to address the ROC's falls. The administrator stated that a change in the MC unit's caregivers' schedule was made on 07/23/2024. The caregiver who was previously scheduled from 5 pm to 10 pm in the MC unit was changed to 4 pm to 10 pm, so that caregiver would have the time to walk with the ROC around the unit, and to "help decrease his agitation, behaviors, and wandering. Staff hours were increased by 1 hour a day, adding an extra 7 hours of one on one per week." However, there was no evidence provided to support the assertion that the ROC received one to one care from 4 pm to 5 pm daily. This was not indicated on the schedule, not included in his service

plan, and not reflected in his charting notes. The administrator provided the ROC's Supervision Monitoring Log, that the caregiver would "check off" from the medication administration record. This log reflected that the caregiver checked-off on the ROC at 2 am, 6 am, 12 pm, 2:30 pm, 5 pm, and 10:30 pm daily. The administrator acknowledged that she did not know of any other interventions used by the caregivers to decrease the ROC's falls.

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.**
For Reference: R325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The ROC had 11 documented falls between the time he moved into the facility and the time he entered hospice care, including 9 falls after the institution of the extra hour of staff care. There was no evidence that the facility made an effort to find other solutions to help decrease the ROC's falls.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The service plan developed at the time the ROC moved into the facility indicated that he did not have falls and that he walked independently without any assistive devices. The plan showed no modifications until the update on 08/13/2023 when the ROC's

service plan was updated to include the use of a walker. There were no additional service plan updates until the ROC began to receive hospice services.

On 03/02/2024, via an email exchange with the administrator, when the administrator was asked to explain the lack of fall interventions added to the service plan, explained that the service plan provided was “all we have on file. Several hours were put into making sure [name of the ROC] was safe. Obviously, we cannot prevent all falls. The care (service) plan did not include the extra hour of walking of [name of the ROC] due to it being preventative care and not required to be filed within his medical care plan therefore, it was not included. Walking him throughout the community was a preventive measure to possibly reduce his behaviors.”

APPLICABLE RULE	
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: R325.1901	**Definitions.**
	(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.
ANALYSIS:	The ROC developed significant changes in his care needs related to his frequent falling, but no changes were made in his service plan. The service plan did not cover all necessary aspects of care in accordance with the administrative rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 03/14/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

03/14/2024

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Barbara Zabitz Date
Licensing Staff

Approved By:

03/11/2024

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