GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 9, 2026

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

RE: License #: AH460361737
Investigation #: 2026A0585023
Gaslight Village Assisted

Dear Ms. 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 responsible party and a date.

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. 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 (517) 335-5985.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664, Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH460361737
Investigation #:	2026A0585023
Complaint Receipt Date:	01/29/2026
Investigation Initiation Date:	02/03/2026
Report Due Date:	03/28/2026
Licensee Name:	Adrian Highway Opco LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	51
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff are engaging in unsafe practices, including neglecting residents, improper diapering of Resident A.	No
Resident B is not getting her medication because she has an aggressive dog, narcotic books are not being signed, and medicine cabinets are being left unlocked.	Yes
Additional Findings	No

III. METHODOLOGY

01/29/2026	Special Investigation Intake 2026A0585023
02/03/2026	Special Investigation Initiated - Face to Face Interviewed administrator and requested resident roster.
02/03/2026	Inspection Completed On-site Completed with observation, interview and record review.
02/03/2026	Inspection Completed-BCAL Sub. Compliance
02/04/2026	APS Referral Allegations sent to Adult Protective Services (APS).
02/10/2026	Exit Conference Conducted via email to authorized representative Jennifer Herald.

ALLEGATION:

Staff are engaging in unsafe practices, including neglecting residents, improper diapering of Resident A.

INVESTIGATION:

On 01/29/2026, the licensing department received an anonymous complaint via BCHS online complaint. The complaint alleged that caregivers were sitting on counters in memory care, laying on the floor, laying on counters and staff are putting

double briefs on Resident A. Due to the anonymous nature of the complaint, no additional information could be obtained.

On 02/03/2025, onsite was completed at the facility. I interviewed the administrator Sarah Bendele who stated that she has not received any report about staff engaging in unsafe practices. She explained that they don't allow double briefing of residents, and don't allow double padding. The administrator shared a copy of the facility pet policy.

During the onsite, I interviewed Employee #1 whose statements were consistent with the administrator. Employee #1 stated that double briefing is not allowed at the facility. She said that staff are reminded of this in their stand-up meetings. She said that she had not seen or heard of staff sitting on counters and laying all on the floor. She said that staff take breaks and eat at different times to ensure that there is enough staff to assist residents when it is time for them to eat or to provide care.

I interviewed Employee #2 who stated that they are not supposed to double brief and they don't do it. Employee #2 stated that she has never seen any staff laying around on the counters or floors.

I interviewed Employee #3 and Employee #4 whose statements were consistent with Employee #2 regarding double briefing.

During the onsite, I observed Resident A sitting in the dining room. Resident A was not able to be interviewed. Resident A was well-groomed and there were no indication that he was wearing a double brief.

During the onsite, I observed other residents in the facility. Residents observed were well groomed and no issues were noted at that time. I did not see any staff laying around at that time. The facility was clean and well maintained.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**

ANALYSIS:	The complaint alleged staff are engaging in unsafe practices, including neglecting residents, improper diapering of Resident A. During the onsite, no unsafe practices were noticed, and residents were well groomed at that time. There is no evidence to support this claim.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B is not getting her medication because she has an aggressive dog; narcotic books are not being signed, and medicine cabinets are being left unlocked.

INVESTIGATION:

The complaint alleged that medicine cabinets are left unlocked in assisted living and narcotic books are not signed.

The administrator stated all medication is locked. She said there are also medicine cabinets locked in residents' rooms. She said that med passers are the only ones with keys to the medicine cabinets. She said narcotic books are in the med cart and they have med passer signatures. She said audits are done once a month on all narcotics. She said there are four med carts with one in memory care and three in assisted living. The administrator stated that there are two residents with dogs and they receive their medication. She said that Resident B has a dog who can be aggressive. She said the dog barks when someone goes to the door. She said Resident B's dog does not have teeth, but he barks a lot at the caregivers. She said that the dog is worst at night because when caregiver goes to Resident B's bed the dog really barks. She said they told Resident B's POA to get the dog a bigger kennel so they can put it in there at night. She said they reached out to Resident B's doctor, and he changed the medication time to day time instead of night. She said that all Resident B's medication is now given in the day.

Employee #1's statements were consistent with the administrator about the medication cabinets being locked. Employee #1 stated that the dog barks a lot at night and they had the doctor change medication from night time to day time. She said care staff do safety checks at night to ensure Resident B's safety. She said Resident B is a new resident to the community and they have asked her to put her dog in a kennel at night to assure the safety of the care staff.

Employee #2 said that all medication is locked. She said Resident B has a dog and it barks all the time. She said they still go into the room to give medication and to assist with her needs.

Employee #3's statements were consistent with Employee #2 regarding medication being locked. She said sometimes the dog is frightening but they go in there anyway because he can't bite because he doesn't have any teeth.

Employee #4 said that she has Resident come out of her room sometimes to give her medication because of the dog.

During the onsite, I attempted to interview Resident B in her room. The dog was very aggressive, and I did not enter the room.

During the onsite, I inspected all four medication carts. The medication carts were all locked. The medication cabinets in the rooms were locked. The narcotic books were all signed by med passers.

The facility pet policy with the implementation date of 08/01/2017 and last reviewed/updated 04/05/2021.

I reviewed Resident B's medication administration record (MAR). The MAR showed the following:

Medication	**Missed Dosage**	**Notes**
Acetamin	01/16 @ 11:32p	Dog prevented entry
Acetamin	01/19 @ 12:28a	Dog wasn't in kennel
Acetamin	01/19 @ 11:21p	Unable to give due to dog
Acetamin	01/20 @ 11:26p	Unable to give due to dog
Acetamin	01/21 @ 11:14 p	Could not give med, dog was aggressive
Acetamin	01/22 @ 11:08p	Could not give 12 am med due to aggressive dog.
Acetamin	01/23 @ 11:45p	Attempt to give but dog was not in kennel
Acetamin	01/24 @ 11:17p	Unable to enter due to dog
Acetamin	01/25 @ 4:52p	Could not give due to aggressive dog
Acetamin	01/25 @11:09p	Unable to give medication due to being out.
Acetamin	01/26 @ 11:06p	Could not give med due to aggressive dog
Acetamin	01/27 @ 11:07p	Resident dog was not in kennel
Acetamin	01/28 @ 11:17p	Unable to enter room due to dog
Acetamin	01/29 @ 11:35p	Cannot give med due to aggressive dog
Acetamin	01/30 @ 11:11p	Unable give due to dog being out.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	The allegations stated that Resident B is not getting her medication because she has an aggressive dog; narcotic books are not being signed, and medicine cabinets are being left unlocked. During the onsite, med carts were inspected and found to be locked, narcotic books were signed by staff. A review of Resident B's MAR showed that she did not receive medication due to an aggressive dog. It is still the responsibility of the facility to ensure that residents are given their medication as prescribed. Therefore, based on Resident B's MAR, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent on the receipt of an acceptable corrective action plan, I recommend no change in the status of this license.

02/09/2026

Brender Howard Date
Licensing Staff

Approved By:

02/09/2026

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