GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

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

September 6, 2023

RE: License #: AH460361737
Investigation #: 2022A1022024
Gaslight Village Assisted

Dear Sara 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.
- 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 #:** | 2022A1022024 |
| | |
| **Complaint Receipt Date:** | 08/24/2022 |
| | |
| **Investigation Initiation Date:** | 08/24/2022 |
| | |
| **Report Due Date:** | 10/23/2022 |
| | |
| **Licensee Name:** | Gaslight Village Assisted Living, LLC |
| | |
| **Licensee Address:** | Suite 200<br>3196 Kraft Avenue<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 464-1564 |
| | |
| **Administrator:** | Guinevere DeBerry |
| | |
| **Authorized Representative:** | Sara Dickendesher |
| | |
| **Name of Facility:** | Gaslight Village Assisted |
| | |
| **Facility Address:** | 2625 N. Adrian Highway<br>Adrian, MI 49221 |
| | |
| **Facility Telephone #:** | (517) 264-2284 |
| | |
| **Original Issuance Date:** | 09/08/2015 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 11/22/2022 |
| | |
| **Expiration Date:** | 11/21/2023 |
| | |
| **Capacity:** | 51 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| The facility did not provide interventions to prevent resident-to-resident altercations between the Resident of Concern (ROC) and Resident B. | Yes |
| The facility's director spoke about the ROC's problematic toileting behaviors in front of individuals not authorized to know that information. | No |
| Care staff members did not seem to be able to deal with aggressive residents living in the memory care unit. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/24/2022 | Special Investigation Intake<br>2022A1022024 |
| 08/24/2022 | Special Investigation Initiated - Telephone<br>Spoke with complainant by phone |
| 09/15/2022 | APS Referral |
| 09/15/2022 | Inspection Completed On-site |
| 09/06/2023 | Exit Conference |
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## ALLEGATION:

**The facility did not provide interventions to prevent resident-to-resident altercations between the Resident of Concern (ROC) and Resident B.**

**INVESTIGATION:**

On 8/23/2022, the complainant called the Bureau of Community and Health Systems complainant hotline with allegations regarding her mother, the Resident of Concern (ROC). According to the intake unit's interview, "her mother has been in 3 different alterations with a gentleman who is a resident at [facility name]. She was hit in the face (resulting in) broken (eye) glasses; the first time she was hit she was not sent to the ER (emergency room). They must have deemed it like she was okay. They did call [name of complainant] to let her know. The 2nd time she was hit she was sent to the hospital because she was hit in the face hard. They also wanted to do a psych evaluation that day she was agitated. And the gentleman was agitated as well."

On 8/24/2022, I interviewed the complainant by phone. The complainant reiterated that her mother had been in altercations with another resident, Resident B, on three different occasions in the Memory Care (MC) unit. The complainant went on to say that she did not think that the care staff knew what to do when residents with dementia are involved in an altercation with another resident.

On 9/15/2022, a referral was made to Adult Protective Services.

On 9/15/2022, during the onsite visit, the administrator described the ROC, who lived in the MC unit, as being mainly independent for activities of daily living (ADLs) but needing assistance with dressing and showers as well as encouragement for using the toilet. The administrator went on to say the biggest concern for the ROC was her "intrusive" behaviors with other residents as well as with care staff members, including with both Resident A and Resident B. The ROC was known to follow other residents around the common area of the facility as well as to enter other residents' rooms and try to take their belongings. When care staff went to redirect the ROC, she would first become upset, then agitated and aggressive.

Although the ROC displayed intrusive behaviors with Resident B, mainly following him around, the administrator had been more concerned with the ROC's interactions with Resident A. The ROC would "hover" over Resident A, as Resident A sat in her wheelchair. Resident A stated she was "afraid" of the ROC.

When the administrator was asked about altercations that involved the ROC, she provided the following incident reports (IRs).

> On 7/26/2022, "[Name of the ROC] was sitting in the chair when [Name of Resident B] walked up to her and slapped her in the head. No Noted injuries. [Name of the ROC] is alert to self and independent with transfers." The IR did not indicate if there were any precipitating factors to this altercation and did not indicate what steps were taken to prevent a recurrence of this type of incident. Written on the IR under heading "Corrective measures taken to prevent recurrence of this incident," the individual completing the report had written "Monitor resident for signs of injury." The complainant alleged that the ROC's

glasses had been broken as a result of this altercation, but facility records did not contain any mention of the glasses and the administrator stated she did not have any knowledge of broken personal equipment.

On 8/20/2022, “Resident [name of the ROC] smacked resident [name of Resident A] on the back of the head. [Name of Resident A] was sitting in the chair and [name of the ROC] walked up behind her and smacked her. [Name of the ROC] is independent with transfers. [Name of the ROC] is alert to self.” Written on the IR under heading “Corrective measures taken to prevent recurrence of this incident,” the individual completing the report had written “Work with physician and family to support in aggressive behaviors.”

On 8/21/2022, “Staff doing care with another resident when they came out to the room they witnessed yelling. Resident [name of Resident B] was standing over [name of the ROC]. [Name of the ROC] was sitting on the couch and [name of Resident B] hit her. Staff re-directed [name of Resident B]. [Name of the ROC] had been following [name of Resident A] during shift pointing at him and calling him names. Staff attempted to re-direct often during shift. [Name of Resident B] stated "she smacked me." [Name of the ROC] is independent with transfers. [Name of the ROC] is alert to self.” Written on the IR under heading “Corrective measures taken to prevent recurrence of this incident,” the individual completing the report had written “Follow discharge instructions from ED.”

When the administrator was asked if the facility had identified any precipitating events or factors that would have preceded these altercations and to describe the follow-up steps that were taken by the facility to prevent a reoccurrence, the administrator had no answer.

Review of the ROC’s service plan, dated 7/1/2022, indicated the following:

- For orientation, the ROC “Requires regular prompting due to confusion and disorientation. Provide orientation as appropriate.”
- For wandering behavior, the ROC “wanders in public areas, but not intrusive… Redirect as needed.”
- For delusions, suspiciousness, hallucinations, the ROC “exhibits delusions, suspiciousness, or hallucinations occasionally but not daily and requires intervention. Acknowledge the feelings the resident is having with it and try to find out what it means to the resident. Try a statement such as it sounds as if you are worried then offer to help. If it is not upsetting the resident or others, let the resident continue with the belief.”

The service plan indicated that the ROC did not exhibit present or past resistive/uncooperative behavioral issues; did not have verbal disruptive behaviors and did not exhibit social disruptive behaviors. There service did not identify that the ROC may have negative interactions with any residents or staff members.

The service plan for Resident A indicated that she did not have disruptive behaviors, that she was cooperative with care, was incontinent, but otherwise mainly needed only moderate physical assistance of 1 person to complete activities of daily living. The service plan for Resident A did not identify that she had the potential to have negative interactions with other residents.

The service plan for Resident B indicated that he required regular prompting due to confusion and disorientation, that he wandered within the common areas of the facility, but that he did have less than daily uncooperativeness with staff and less than daily verbal disruptions. Resident B also exhibited less than daily delusions, suspiciousness, or hallucinations, with the same service/assistance provisions written for the ROC. Neither the service plan for the ROC nor the service plan for Resident B indicated if these behaviors were directed to others, either staff or other residents. Resident A was mainly independent with activities of daily living. The service plan for Resident B did not identify that he had the potential to have negative interactions with other residents.

Review of the ROC's health record charting notes revealed the following:

- On 7/2/2022, at 12:12 pm, "resident has not slept. Walking around going into other residents' rooms. Follows staff."
- On 7/7/2022, at 4:12 am, "resident was up most of the night…resident was getting very rude to staff the later it got. Tried several things nothing worked."
- On 7/13/2022, at 1:06 am, "resident has gotten up several times throughout the night and will not stay in bed."
- On 7/14/2022, at 5:33 am, "resident continues to get up and out of bed throughout the night. She was wandering into other residents' rooms while they were resting."
- On 7/23/2022, at 12:48 pm, "resident was trying to get staff to lay down in bed with her and got very upset when staff would not lay down with her. Resident also kept going into other residents' rooms when they were changing and stating she wanted to watch them change and also went into another resident's room and tried to pull down their pants. Staff redirected resident…"
- On 7/25/2022, at 1:19 pm, "Resident stayed in bed most of shift. She is very upset and did not want to get out of bed…She screamed (and) kicked staff and yelled at them. Staff remained calm and tried several times (to) reassure her…"
- On 7/26/2022, at 10:24 pm, "resident was hit by another resident, but appears to be free of injury…"
- On 7/27/2022, at 10:29 pm, "started to get irritated and tried to hit staff…"
- On 7/30/2022, at 4:52 am, "Resident was up all night. She was hard to redirect and went into other residents' rooms waking them up. She got very angry with staff and yelled at them several times."
- On 7/30/2022, at 11:12 am, "Resident was walking around the memory care common area…she followed staff in(to) laundry room and care station…She thought staff was going to hit her. She was very upset with staff yelling at them and other residents."

- On 7/30/2022, at 10:07 pm, “Resident was agitated and upset mostly all day.”
- On 8/2/2022, “resident would become highly agitated and upset and push the doors open.”
- On 8/4/2022, at 8:40 pm, “Agitated…did my (care staff writer) best to keep her calm.”
- On 8/4/2022, at 2:22 am, “resident was very aggressive last night. Went to bed around 2 am.”
- On 8/4/2022, at 4:16 am, “resident got up at 4 am turning lights on in other residents’ rooms. (Care staff) tried several times to distract her. Nothing worked and (resident) was getting aggressive.”
- On 8/4/2022, at 1:34 pm, “Resident was agitated and confrontational with residents that were awake during 6 am shift change. Staff tried to redirect but resident was not redirecting. Throughout first shift she became angry and aggressive towards other residents without warning and would say things to them that were mean and other residents were appearing upset and became defensive by it.”
- On 8/5/2022, at 9:59 pm, “resident started to get agitated and tries to get in other residents’ rooms at night.”
- On 8/7/2022, at 1:58 pm, “The last hour of first shift resident has become upset, defensive, and confrontational with staff and residents. Has also started to demand to go in residents’ apartment during resident care, getting mad at staff for not being with her during that time.”
- On 8/8/2022, at 4:26 am, “[Name of the ROC] has been up all night trying to get into other residents’ rooms…Staff was able to talk her into going to bed…about 3 am.”
- On 8/9/2022, at 9:53 pm, “resident keeps trying to go in other residents’ rooms and will get agitated if you ask her to/ sit down.”
- On 8/12/2022, at 10:19 am “Late Entry. On 8/11 after dinner resident was following other residents around and pointing her finger in the face calling them stupid over and over again. Resident was entering other people’s rooms at bedtime scaring them to the point they wanted a lock on their door. Staff finally was able to redirect resident not before most other residents were on edge.”
- On 8/15/2022, at 1:33 am, “resident has been very verbally abusive to resident and staff was going around turning lights on while residents are sleeping and is not wanting to cooperate with staff.”
- On 8/16/2022, at 2:30 pm, “Resident was agitated and interacting with another resident by hovering over her and speaking to her in anger.”
- On 8/19/2022, at 1:37 pm, “Resident…best mood until about 1:30 pm when another resident started (singing) she started to get upset and started telling him that she is going to slap him…”
- On 8/19/2022, at 9:48 pm, “resident seemed to get agitated after dinner leading to her tapping another resident on the back of head.”
- On 8/20/2022, at 9:14 pm, “Resident was very agitated…Resident was also in other residents’ faces pointing her finger at them and telling them to shut up. Was verbally aggressive with other residents.”
- On 8/21/2022, at 1:07 pm, “Resident…intrusive to other residents’ rooms and privacy. She would become defensive when residents wanted their distance…”

• On 8/21/2022, at 10 pm, “Resident was really aggressive all day towards staff…Staff tried to redirect her. Staff took her outside on a walk and gave her snacks. It did not work. Resident’s daughter was called…Daughter had come in also tried to redirect her. Resident got more aggressive after her daughter had left. She was pointing fingers in peoples’ faces during the whole shift…continuously making remarks about harming others and herself…Also followed staff around the whole shift and when staff was doing resident care, resident was trying to open the door and got angry when she couldn’t come in…Resident also punched the door when she couldn’t get it opened. Staff was in another resident’s room doing resident care, came out and heard screaming. She had gotten into an altercation with another resident and gotten hit. Resident was sent out to the hospital for further evaluation.”

| **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:**<br><br>**(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:** | Charting notes for the ROC indicated the resident’s increasing agitation and aggressiveness, but there was no change to her service plan to indicate that the care staff were given any direction on how to decrease or better deal with her behavior. Likewise, there was no evidence that facility staff had a plan to provide appropriate interventions for either Resident A or Resident B. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

## The facility’s director spoke about the ROC’s problematic toileting behaviors in front of individuals not authorized to know that information.

**INVESTIGATION:**

According to the intake unit’s interview with the complainant, the complainant stated “HIPAA (Health Insurance Portability and Accountability Act, a federal statute

intended to assure an individual's health information privacy) was violated by the director because another resident's wife was in the room and they were talking about her mom and some of the things that were going on with her in front of the resident's wife, it was not something that should have been stated in front of other people." When asked about this statement, the complainant stated this referred to a conversation that she had with the administrator about the ROC's problematic toileting behaviors, including defecating in inappropriate locations while other individuals were in the room.

When the administrator was asked about this incident, the administrator acknowledged that she had a conversation with the complainant on the day the complaint moved the ROC out of the facility. The administrator stated that the conversation occurred in the ROC's apartment and not in a common area where staff, visitors, or other residents could overhear the conversation. In addition to the complainant, both the ROC and the complainant's husband were present during the conversation.

| **APPLICABLE RULE** | |
|---|---|
| **MCL 333.20201** | **Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.** |
| | **(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:**<br>**(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.** |
| **ANALYSIS:** | There is not sufficient evidence to establish that the ROC's privacy not respected. The complainant has one version of events, and the administrator has another. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Care staff members did not seem to be able to deal with aggressive residents living in the memory care unit.**

**INVESTIGATION:**

The complainant stated that she questioned if the care staff in the facility's memory care unit had been given adequate training in how to deal with aggressive residents with dementia.

When the administrator was asked about the training provided to staff working in the memory care unit that would help them care for aggressive, agitated or combative residents, the facility submitted training outlines for the following computer module-based training titles: A Day in the Life of Henry: A Dementia Experience; Care of Residents with Dementia in Assisted Living; Dementia Care: Challenging Behaviors; Dementia Care: Challenging Behaviors and Direct Care Staff; Improving Communications in Dementia Care; Teepa Snow's Dementia 101; and Teepa Snow's Challenging Behaviors.

Review of charting notes for the ROC revealed that caregiver #1, caregiver #2, caregiver #3 and caregiver #4 all provided care to the ROC at times when she displayed episodes of aggression and agitation. Caregiver #1) did not complete any of the modules. Caregiver #2 completed A Day in the Life of Henry: A Dementia Experience; Care of Residents with Dementia in Assisted Living; Dementia Care: Challenging Behaviors; Dementia Care: Challenging Behaviors and Direct Care Staff; Improving Communications in Dementia Care; Teepa Snow's Dementia 101; and Teepa Snow's Challenging Behaviors, plus additional modules on dealing with residents with dementia not included in the training outlines. Caregiver #3 completed Dementia Care: Challenging Behaviors and Direct Care Staff; Teepa Snow's Dementia 101; and Teepa Snow's Challenging Behaviors. Caregiver #4 completed A Day in the Life of Henry: A Dementia Experience; Improving Communications in Dementia Care; Teepa Snow's Dementia 101; and Teepa Snow's Challenging Behaviors plus 1 additional module on dealing with residents with dementia not included in the training outlines.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:**<br>**(a) Reporting requirements and documentation.** |

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|---|---|
| | **(b) First aid and/or medication, if any.**<br>**(c) Personal care.**<br>**(d) Resident rights and responsibilities.**<br>**(e) Safety and fire prevention.**<br>**(f) Containment of infectious disease and standard precautions.**<br>**(g) Medication administration, if applicable.** |
| **ANALYSIS:** | Only 1 of four randomly chosen caregivers who made entries on the ROC charting notes had completed all of the dementia training that the administrator reported was how their caregivers were trained to deal with residents with dementia-related behaviors. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I reviewed the findings of this investigation with the authorized representative (AR) on 09/06/2023. 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 the status of the license remain unchanged.

09/06/2023

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

08/30/2023

_____

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