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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2021

Renee Kennedy
Covenant Village of the Great Lakes
2520 Lake Michigan Dr. NW
Grand Rapids, MI 49504-4696

RE: License #: AH410236771
Investigation #: 2021A1010026
Covenant Village of the Great Lakes

Dear Ms. Kennedy:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410236771
Investigation #:	2021A1010026
Complaint Receipt Date:	03/25/2021
Investigation Initiation Date:	03/25/2021
Report Due Date:	05/24/2021
Licensee Name:	Covenant Living of the Great Lakes
Licensee Address:	2520 Lake Michigan Dr. NW Grand Rapids, MI 49504
Licensee Telephone #:	(616) 735-4511
Authorized Representative/ Administrator:	Renee Kennedy
Name of Facility:	Covenant Village of the Great Lakes
Facility Address:	2520 Lake Michigan Dr. NW Grand Rapids, MI 49504-4696
Facility Telephone #:	(616) 735-4541
Original Issuance Date:	12/11/2000
License Status:	REGULAR
Effective Date:	04/29/2020
Expiration Date:	04/28/2021
Capacity:	102
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B were assaulted by staff person Jordon Hamilton.	No

III. METHODOLOGY

03/25/2021	Special Investigation Intake 2021A1010026
03/25/2021	Special Investigation Initiated - On Site
03/25/2021	Inspection Completed On-site
03/25/2021	Contact - Document Received Received staff training documents
03/30/2021	Contact – Document Received Received Mr. Hamilton's training documents
4/27/2021	Exit Conference Completed with licensee authorized representative Renee Kennedy

ALLEGATION:

Resident A and Resident B were assaulted by staff person Jordon Hamilton.

INVESTIGATION:

On 3/19/21, I received an incident report regarding care staff person Jordon Hamilton and Resident A and Resident B. The report read, "Jordon Hamilton, Resident Aide, was providing care when a resident in Memory Care, [Resident A], was asking for help. Sarah states that [Resident A] continued to ask for help for about 5 minutes at which point she went in [Resident A's] room, [Resident A] asked Sarah again to help her. At that time, Jordon was toileting [Resident A] and [Resident A] was upset. Sarah verified that there was nothing that [Resident A] needed and left the room. A few minutes later, Jordon asked Sarah for help to get [Resident A] off from the toilet, stating 'she's being difficult again' when Sarah walked into the room and [Resident A] was still upset. Sarah asked [Resident A] 'what is wrong' to which [Resident A] replied, 'you know what's wrong.' Sarah left the room and Jordon brought [Resident A] to the dining room. [Resident A] was sitting at

the dining room table with her head down and wouldn't eat; Sarah approached her and got on a knee before her and asked her what was wrong and she said 'I was assaulted and you know what happened. He is the master.' Sarah asked [Resident A] 'What do you mean, you were assaulted? Did he hit you? What happened?' [Resident A] responded that he had assaulted her when dressing her.

Later, Sarah was in the dining room and another resident, [Resident B] came up to her and was trying to get Sarah's attention. Sarah asked if she needed to go to the bathroom and [Resident B] said no. [Resident B] was crying and said that Jordon touched her vagina, breasts and wrists. Sarah asked if Jordon gave her a shower, to which [Resident B] responded yes, and that it made her uncomfortable. Sarah stated that she understood and would request that in the future she was showered by a female and [Resident B] stated 'the problem is my wrists,' holding them out to Sarah. 'He hurt me, right here- on my wrists' indicating that Jordon had been aggressive and hurt her while showering her."

The report read the facility's director of human resources Heidi Bedevia interviewed Mr. Hamilton after the incidents were reported to her. Ms. Bedevia wrote, "I explained to Jordon that we had an allegation of abuse that required an investigation and that at this time, we would be asking him to clock out for the day and leave for the remainder of the shift. I explained that if the claims were unsubstantiated, he would be compensated for the time and that we would be in touch with him on Friday morning.

Jordon immediately responded that he had been through this multiple times and that he is aware of his right to understand the allegations that were made against him. I explained that because Renee, Assisted Living Director, was not in the office at this time, that we would review the allegations with him on Friday morning and that he needed to wrap up his work for the day.

Jordon began yelling multiple irrational thoughts such as 'this always happens to me.' 'I never make it through my 90 days.' 'I am always targeted.' And then he responded 'I want to make a complaint about harassment. I am being harassed by people that don't want me here. My privacy is never respected. I want to make a complaint.' At that point, I assured Jordon that he would have the opportunity to present his view points and we would address any concerns that he may have on Friday, when Renee was back and we were able to follow up with him."

The report read Resident A and Resident B were assessed for injuries and none were present. Ms. Kennedy notified Adult Protective Services (APS) of Resident A and Resident B's statements.

On 3/25/21, the Bureau received the allegations from APS. The complaint read, "Last week on 03/17/2021, a male employee, Jordan [sic] Hamilton, was giving [Resident B] a shower. When the shower was finished, [Resident B] was crying and stated that Jordan [sic] Hamilton staff touched her all over and that her wrists hurt.

[Resident B] was checked out and no signs of abuse were found. Jordan [sic] Hamilton was terminated from employment on grounds not associated with this incident related to attendance." The complaint was not assigned for APS investigation.

On 3/25/21, I interviewed administrator Renee Kennedy at the facility. Ms. Kennedy's statements were consistent with the incident report that was dated 3/17. Ms. Kennedy said Mr. Hamilton was terminated for attendance issues and poor work performance. Ms. Kennedy reported she did not receive any previous complaints from residents or staff regarding Mr. Hamilton physically or sexually abusing residents. Ms. Kennedy stated Mr. Hamilton received resident rights and working with residents with dementia training when he started at the facility.

On 3/25/21, I interviewed medication technician (med tech) Sarah Sobczak at the facility. Ms. Sobczak's statements were consistent with the incident report and Ms. Kennedy. Ms. Sobczak reported she received resident rights and working with residents with dementia training when she started at the facility.

Ms. Sobczak said Mr. Hamilton provided care to Resident A and Resident B in the past without incident. Ms. Sobczak stated there were issues with Mr. Hamilton using his phone too much and not completing job tasks, however residents never previously made complaints of physical or sexual abuse against him.

On 3/25/21, I interviewed shift supervisor Pam Stebbins at the facility. Ms. Stebbins reported she worked the day Resident A and Resident B complained about Mr. Hamilton. Ms. Stebbins stated Ms. Sobczak came to her and reported what Resident A and Resident B said about Mr. Hamilton. Ms. Stebbins statements were consistent with the incident report and Ms. Sobczak. Ms. Stebbins said she reported the information to the facility's registered nurse Sarah Sharp.

Ms. Stebbins said she received resident rights training when she started at the facility.

On 3/25/21, I interviewed Resident A at the facility. Resident A resided in the secured memory care unit in the facility. I was unable to engage Resident A in meaningful conversation. Resident A denied concerns regarding staff at the facility. Resident A did not have any bruises on the visible parts of her body.

On 3/25/21, I interviewed Resident B at the facility. Resident B also resided in the secured memory care unit in the facility. I was unable to engage Resident B in meaningful conversation. Resident B denied concerns regarding staff at the facility. Resident B did not have any bruises on the visible parts of her body.

On 3/30/21, I received a copy of Mr. Hamilton's staff training *Transcript* for my review. The document read Mr. Hamilton received *Communicating with People with Dementia* training on 2/25, *Dementia Care: Understanding Alzheimer's Disease*

training on 1/28, *Preventing Recognizing, and Reporting Abuse* training on 1/28, *Prevention, Identification, and Reporting of Dependent Adult Abuse* training on 1/28, and *Protecting Resident Rights in Nursing Facilities* training on 1/28.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
FOR REFERENCE: MCL 333.20201	**(2) (l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	The interviews with Ms. Kennedy, Ms. Sobczak, Ms. Stebbins, along with review of the incident report revealed there was insufficient evidence to suggest Mr. Hamilton physically or sexually assaulted Resident A and Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with licensee authorized representative Renee Kennedy by telephone on 4/27.

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

4/5/21

Lauren Wohlfert — Date
Licensing Staff

Approved By:

4/21/21

Russell B. Misiak — Date
Area Manager