GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 16, 2024

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

RE: License #: AH410236771
Investigation #: 2024A1028077
Covenant Village of the Great Lakes

Dear Andrea Smith:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH410236771
Investigation #:	2024A1028077
Complaint Receipt Date:	09/10/2024
Investigation Initiation Date:	09/12/2024
Report Due Date:	11/10/2024
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:	Andrea Smith
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:	05/15/2024
Expiration Date:	07/31/2024
Capacity:	102
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive timely emergency care when Resident A demonstrated a change in condition.	No
Resident A's room smelled of urine and multiple soiled briefs were found in the bathroom.	No
Resident A was not provided a shower for three weeks in August in 2024.	Yes
Resident A did not receive fresh meals from 8/15/2024 to 8/17/2024 and a meal tray was left in Resident A's room for two days.	No
Additional Findings	No

III. METHODOLOGY

09/10/2024	Special Investigation Intake 2024A1028077
09/12/2024	Special Investigation Initiated - Letter
09/12/2024	APS Referral
09/23/2024	Contact - Face to Face Interviewed AR/Admin/Andrea Smith at the facility.
09/23/2024	Contact - Face to Face Interviewed Employee A at the facility.
09/23/2024	Contact - Face to Face Interviewed Employee B at the facility.
09/23/2024	Contact - Face to Face Interviewed Employee C at the facility.
09/23/2024	Contact - Document Received Received requested documentation from staff.

ALLEGATION:

Resident A did not receive timely care when Resident A demonstrated a change in condition.

INVESTIGATION:

On 9/10/2024, the Bureau received the allegations through the online complaint system.

On 9/23/2024, I interviewed facility administrator, Andrea Smith, who reported Resident A demonstrated a decline in condition on 8/17/2024 and was sent to the hospital. Ms. Smith reported Resident A did not return to assisted living upon discharge from the hospital, but instead entered skilled physical rehabilitation due to decline in condition. Ms. Smith reported Resident A moved out of the facility after completing skilled physical rehabilitation. Ms. Smith reported facility staff were re-educated on identifying resident change in conditions and reporting protocols to ensure and review staff competency. Ms. Smith provided me the requested documentation for my review.

On 9/23/2024, Employee A's statement, Employee B's statement, and Employee C's statement was consistent with Ms. Smith's statement.

On 9/23/2024, I reviewed the requested documentation which revealed the following:

- On 8/15/204, Resident A reported to staff [they] felt tired and decided not to eat dinner in the dining room. Resident A reported [they] were not hungry and was assisted back to [their] room by staff.
- Resident A was provided a meal in [their] room due to not want to eat in the dining room.
- It was noted in the documentation that Resident A had recently has Covid-19 and was still recovering.

- On 8/17/2024, Resident A demonstrated weakness, requiring increased assistance from staff with staff obtaining vitals. Resident A's blood pressure was 100/74, pulse was 84, and respirations were 20. Resident A's oxygen fluctuated between 85% and 91%.
- Due to fluctuation in Resident A's oxygen levels, family was contacted and requested Resident A be sent to the hospital.
- Emergency services arrived and took Resident A to the hospital.

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.**
ANALYSIS:	It was alleged Resident A did not receive timely care when Resident A demonstrated a change in condition. Interviews, on-site investigation, and review of documentation reveal that while Resident A demonstrated a change in condition on 8/17/2024, the facility contacted Resident A's authorized representatives and emergency services to ensure timely evaluation, treatment and care. There is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's room smelled of urine and multiple soiled briefs were found in the bathroom in August 2024.

INVESTIGATION:

On 9/23/2024, Ms. Smith reported no knowledge of Resident A's room smelling of urine or soiled briefs being found in the bathroom. Ms. Smith reported housekeeping services regularly cleaned Resident A's room.

On 9/23/2024, Employee A and Employee B statements are consistent with Ms. Smith's statement.

On 9/23/2024, Employee C reported no knowledge of Resident A's room smelling of urine or soiled briefs being found in the bathroom. Employee C confirmed all resident rooms are cleaned weekly by housekeeping and that facility staff will spot clean as needed. Employee C also reported if a resident's room were to smell of urine, it would be reported to management and to housekeeping to ensure the resident's health and cleanliness of the resident and the room as well.

On 9/23/2024, I reviewed Resident A's service plan which revealed the following:

- Facility launders sheets and towels. Family launders Resident A's personal clothing.
- Housekeeping is completed weekly or daily as needed.
- Staff to notify housekeeping if room requires extra cleaning.

An inspection of Resident A's room was not completed, as Resident A no longer resides in the facility and the room was cleaned after Resident A's exit from the facility.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	It was alleged Resident A's room smelled of urine and multiple soiled briefs were found in the bathroom in August 2024. Interviews, on-site investigation, and review of documentation reveal there is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not provided a shower for three weeks in August in 2024.

INVESTIGATION:

On 9/23/2024, Ms. Smith reported Resident A received showers in accordance with the service plan.

On 9/23/2024, Employee A reported Resident A received showers in accordance with service plan but would refuse showers intermittently due to still recovering from Covid-19 in August 2024. Employee A reported Resident A would be too tired at times to participate in care routines. Employee A reported Resident A required supervision to stand by assist from facility staff to complete showers.

On 9/23/2024, Employee B's statement was consistent with Ms. Smith's statement and Employee A's statement. Employee B reported due to Resident A no longer residing at the facility, Resident A's shower sheets are no longer available.

On 9/23/2024, Employee C's statement was consistent with Ms. Smith's, Employee A's statement, and Employee B's statement.

On 9/23/2024, I reviewed Resident A's service plan which revealed the following:

- Resident A requires stand by assist and step by step cueing from facility staff during showers.
- Resident A's showers were scheduled every Wednesday and Saturday during second shift.

I reviewed the requested documentation which revealed the following:

- Resident A was marked independent by facility staff for multiple personal hygiene routines from 8/1/2024 to 8/16/2024.
- There is no evidence Resident A refused showers.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	It was alleged Resident A was not provided a shower for three weeks in August in 2024. Interviews, on-site investigation, and review of documentation reveal there is a discrepancy between facility staff interviews and the provided documentation. While facility staff confirm Resident A required stand by assist and cueing during showers, Resident A was marked independent on care routine worksheets with personal hygiene. It can also not be determined if the category of personal hygiene on the care routine worksheets completed by facility staff included showers. During staff interviews, it was alleged that if Resident A missed showers, it was because Resident A refused showers, but review of documentation reveals there is no evidence to support this. Due to the discrepancies, it cannot be determined if Resident A received showers consistent with the service plan, therefore the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive fresh meals from 8/15/2024 to 8/17/2024 and a meal tray was left in Resident A's room for two days.

INVESTIGATION:

On 9/23/2024, Ms. Smith reported Resident A's family brought concerns about a meal tray dated 8/15/2024 being left in Resident A's room until 8/17/2024 and concerns about Resident A not receiving fresh meals. Ms. Smith reported she completed an investigation, and it was determined that a tray dated 8/15/2024 was found in Resident A's room and that it was removed by staff on 8/17/2024. Ms. Smith reported facility staff and kitchen staff were conferenced with due to the tray being left in Resident A's room for two days. Ms. Smith reported she confirmed with kitchen staff that Resident A was delivered three fresh meals each day to [their] room. Ms. Smith provided me the requested documentation for my review.

On 9/23/2024, Employee A's statement and Employee B's statement was consistent with Ms. Smith's statement.

On 9/23/2024, Employee C confirmed knowledge of a meal tray being left in Resident A's room for almost two days. Employee C reported Resident A was still revering from Covid-19 during this time and required encouragement to eat and drink intermittently, so meals were delivered to Resident A's room. Employee C confirmed facility staff were conferenced with on protocols concerning meal delivery and pick-up to resident rooms.

On 9/23/2024, I reviewed the requested documentation which revealed the following:

- On 8/15/2024, Resident A had meal delivered to room due to not feeling well.
- On 8/17/2024, meal tray dated 8/15/2024 was allegedly found in Resident A's room.
- On 8/17/2024, Resident A was sent to the hospital.
- Evidence meals were delivered to Resident A's room.
- Evidence staff were provided re-education on meal delivery protocols.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular mealtimes. A home shall make snacks and beverages available to residents.
ANALYSIS:	It was alleged Resident A did not receive fresh meals from 8/15/2024 to 8/17/2024 and a meal tray was left in Resident A's room for two days. Interviews, on-site investigation, and review of documentation reveal that while it was confirmed a meal tray was left in Resident A's room from 8/15/2024 to 8/17/2024, the facility immediately addressed the concern and provided all staff re-education on correct meal delivery protocols. It was also alleged that Resident A did not receive fresh meals for two days, but there is no evidence to support Resident A did not receive fresh meals in accordance with the rule. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.

9/23/2024

Julie Viviano Date
Licensing Staff

Approved By:

10/14/2024

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