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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 #: 2021A1010024
Covenant Village of the Great Lakes

Dear Ms. Kennedy:

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.

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 (616) 356-0100.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	2021A1010024
Complaint Receipt Date:	03/05/2021
Investigation Initiation Date:	03/05/2021
Report Due Date:	05/04/2021
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 C's toenails were long and unkempt, this caused her pain. • Resident C had multiple falls with injury.	Yes
Resident C did not receive her medications as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

03/05/2021	Special Investigation Intake 2021A1010024
03/05/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
03/05/2021	APS Referral APS referral emailed to Centralized Intake
03/25/2021	Contact - Telephone call made Interviewed the complainant by telephone
03/25/2021	Inspection Completed On-site
03/25/2021	Contact - Document Received Received Resident C staff notes, service plan, and MARs
4/27/2021	Exit Conference Completed with licensee authorized representative Renee Kennedy

ALLEGATION:

- **Resident C's toenails were long and unkempt, this caused her pain.**
- **Resident C had multiple falls with injury.**

INVESTIGATION:

On 3/5/21, the Bureau received the allegations from the online complaint system. Regarding Resident C's toenails the complaint read, "[Resident C's] toenails had not

been trimmed since late 2/2020 due to COVID visiting restrictions and [Resident C] was endorsing pain in her toes due to this. The family had been providing nail care prior to this. Podiatry consult was requested by family. Facility never alerted family that service was uncovered and assumed family would not want out of pocket service."

Regarding Resident C's falls the complaint read, "Dates of falls 11/02/2020, 11/29/2020, 12/09/2020, 12/10/2020. 11/02/2020 [Resident C] was seen in ED and diagnosed with C7 fracture by X-ray and placed in a C collar. Overall poor communication when family emailed regarding care concerns with multiple falls resulting in severe pain following the recent fall where [Resident C] sustained a C7 fracture. After several face to face meetings with directors & assistant directors there was no improvement & growing concern for safety. [Resident C] endorsed severe back pain with family on several calls following multiple falls as above. The facility personnel deduced [Resident C] may have a kidney stone despite history of multiple falls with consistent complaints of positional back pain and recommended assessment/care for kidney stones. Family intervened and requested assessment from PCP for back pain and concern for vertebral compression fractures following repetitive falls and consistent complaints of low back pain when [Resident C] did not have a history of back pain. [Resident C] sustained a large L deep facial abrasion with exposure of subcutaneous fat 12/13/2020. Facility reported to family 'No idea how this happened. Maybe she scratched her face on her pillow.'"

On 3/5/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 3/25/21, I interviewed the complainant by telephone. The complainant stated Resident C resided in the secured memory care unit in the facility. The complainant reported emails regarding Resident C's toenails were exchanged with the facility's former administrator. The complainant stated she had not seen Resident C in approximately one year due to COVID-19 visitor restrictions, however Resident C would state her "shoes hurt" because her toenails were long.

The complainant explained prior to the COVID-19 outbreak, Resident C's family members would take Resident C to get a pedicure once a month. The complainant reported Resident C saw a podiatrist "at some point," however an exact date was unknown. The complainant reported Resident C's toenails were supposed to be cut by staff during her "shower times."

The complainant stated there was a podiatrist that the facility contracted with, however Resident C's insurance would not cover the cost. The complainant reported Resident C's family was willing to pay out of pocket for the cost. The complainant said staff reported Resident C was seen by the facility's podiatrist, however Resident C's family did not receive any confirmation that she was seen.

The complainant said Resident C's durable power of attorney (DPOA) was notified when Resident C experienced multiple falls at the facility. The complainant reported there were two incidents when Resident C was transported to the hospital after she fell and sustained injuries. The complainant stated Resident C fell when staff were present and they encouraged her to use her walker. The complainant reported one of the actions taken after Resident C fell was to put her in a wheelchair in a common area where staff could observe her. The complainant said Resident C's family members were told by staff that Resident C would be assessed to determine whether her continued placement in the facility was appropriate. The complainant stated there was no further follow up regarding this.

The complainant reported Resident C cried multiple times when she would "Facetime" with her family because she was in pain. The complainant stated a computed tomography (CT) scan of Resident C's spine was arranged for Resident C. The complainant said old fractures were found in the scan and Resident C had surgery.

The complainant stated staff did not appropriately manage Resident C's pain. The complainant reported staff thought Resident C had a bladder infection or kidney stone because Resident C had pain in her abdomen. The complainant said staff did not attribute Resident C's pain to the multiple falls she had at the facility.

On 3/25/21, I interviewed the facility's administrator Renee Kennedy at the facility. Ms. Kennedy's statements regarding Resident C's family providing Resident C's nail care prior to the COVID-19 outbreak were consistent with the complainant.

Ms. Kennedy stated Resident C did have a "corn" on her toe so her shoes did not fit well as a result. Ms. Kennedy reported this was addressed with Resident C's family and slippers were provided as a result. Ms. Kennedy said at one point during the COVID-19 quarantine, Resident C's family members contacted the facility and reported Resident C's toenails were long. Ms. Kennedy reported she then went to observe Resident C's toenails. Ms. Kennedy stated she observed Resident C's toenails were thick, however they were not excessively long. Ms. Kennedy said she trimmed Resident C's toenails at that time.

Ms. Kennedy reported the facility provides all residents and/or their responsible persons with information regarding their contracted podiatry services. Ms. Kennedy stated the resident and/or their responsible persons can decide whether to sign up for the podiatry services that includes toenail cutting. Ms. Kennedy said she did not know whether Resident C signed up to receive podiatry services. Ms. Kennedy was unsure whether care staff ever cut Resident C's toenails.

Ms. Kennedy said Resident C became weak and would try to ambulate by herself. Ms. Kennedy reported Resident C did have multiple falls at the facility. Ms. Kennedy stated Resident C needed a one-to-one caregiver as she became weaker, however her family refused to pay for it. Ms. Kennedy explained when this intervention failed,

staff began to keep Resident C in common areas where they could see her. Ms. Kennedy reported on 12/11/20, a referral for Faith Hospice was made for Resident C.

Ms. Kennedy provided me with a copy of Resident C's service plan for my review. The *Dressing/Grooming/Hygiene* section of the plan read, "Requires minimal assistance for setup and cueing. Define in comments. Intervention Staff to ensure resident is in clean clothing and assist as needed."

The *Mobility Care Gait and Balance* section of the plan read, "Unsteady balance, uses walker/furniture to maintain standing or walking balance. Intervention Staff to provide x1 assistance to transfer into wheelchair." The *Accidents/Incidents* section of the plan read, "Pattern of ongoing/weekly accidents/incidents. Intervention resident to use commode over toilet for safe toilet transfers – MF 11/9/20 Resident to have reminder signs on walker to cue resident to use walker at all times – MF 11/29/20. Resident has request to MD to review BP medications to [sic] due increased dizzy spells (12/9/21) – MF staff to address need for private duty care giver with family (12/13/20) – MF Resident to be in common areas while awake for close observation (12/12/20) – MF."

The *Fall Risk/Care* section of the plan read, "Staff to ensure that resident is using her walker in order to prevent falls. Keep walker close by." The *Safety Care* section of the plan read, "Aware of call aid system but may or may not use system appropriately. Intervention Staff to monitor. The *Status Checks* section of the plan read, "Benefits from status checks 9-12 times per day. Intervention Staff to check on resident frequently during the day and hourly at HS."

Ms. Kennedy provided me with a copy of the *HyGait Podiatry, P.C.* document for my review. The document read Resident C was seen by HyGait Podiatry on 12/7/20. The document did not outline what services Resident C received.

On 3/25/21, I interviewed medication technician (med tech) Sarah Sobczak at the facility. Ms. Sobczak reported staff cannot cut resident toenails. Ms. Sobczak stated residents either sign up for podiatry services, or their responsible persons coordinate this service. Ms. Sobczak's statements regarding Resident C's family providing Resident C's nail care prior to the COVID-19 outbreak were consistent with the complainant and Ms. Kennedy. Ms. Sobczak denied knowledge regarding whether staff at the facility cut Resident C's toenails during the COVID-19 quarantine.

Ms. Sobczak stated she was not present when Resident C fell at the facility. Ms. Sobczak reported after one fall, Resident C had to wear a neck collar. Ms. Sobczak said after that incident, staff did keep Resident C in common areas so she could be monitored more closely. Ms. Sobczak said she was aware of one fall Resident C had in her bathroom. Ms. Sobczak explained Resident C had a seat riser on the toilet in her bathroom. Ms. Sobczak stated the riser was not sturdy and "was wobbly," however Resident C's family insisted that staff continued to use the device.

On 3/25/21, I interviewed shift supervisor Pam Stebbins at the facility. Ms. Stebbins statements were consistent with Ms. Kennedy and Ms. Sobczak. Ms. Stebbins said Resident C never complained of pain in her feet or having long toenails.

On 3/25/21, I was unable to interview Resident C because she is deceased.

On 4/19/21, I reviewed the facility file. I received Resident C's incident reports that were dated 11/9/20, 12/11/20, and 1/18/21. Resident C was injured after she fell on 11/9/20, 12/11/20, and 1/18/21.

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:	Reviews of Resident C's service plan along with the interviews with Ms. Kennedy, Ms. Sobczak, and Ms. Stebbins revealed it was unclear who was responsible for cutting Resident C's toenails. Resident C's service plan did not clearly outline or provide instruction regarding whether staff, Resident C's family, or podiatry services were responsible for maintaining Resident C's toenails. Review of Resident C's service plan revealed staff were to keep Resident C in common areas as she was identified as a fall risk. The interviews with Ms. Kennedy, Ms. Sobczak, and Ms. Stebbins revealed staff followed this instruction as outlined in Resident C's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C did not receive her medications as prescribed.

INVESTIGATION:

On 3/5/21, the complaint read "07/29/2019 Facility requested Tramadol & Tylenol from PCP for 'body aches' without additional assessment. Tramadol previously was ordered for post op pain after hip replacement surgery & was discontinued in 04/2019 as it was no longer needed. Tylenol order had been sent from PCP to the facility & the pharmacy PRIOR to this repeat request from facility. 12/23/2019 Lasix

was increased BID dosing from daily dosing per PCP orders. Corrected Lasix order was not implemented until 6 days later when family noted the error and [Resident C] continued to have significant lower extremity swelling and decreased mobility due to the need for medication."

On 3/25/21, the complainant reported staff at the facility contacted Resident C's physician to increase her prescribed Tramadol, however Resident C's family felt an increase was not the best option for Resident C.

The complainant reported Resident C continued to have swollen ankles after she was prescribed an increase in her Lasix medication. The complainant stated a staff person informed Resident C's family that her increased Lasix prescription was not started until six days after it was changed to be administered twice daily. The complainant did not know the name of the staff person who informed the family of the error.

On 3/25/21, Ms. Kennedy reported Resident C's medications were administered as prescribed by her physician. Ms. Kennedy denied knowledge regarding Resident C going six days without her prescribed Lasix twice daily.

Ms. Kennedy provided me with a copy of Resident C's *NEW MEDICATION ALERT* document for my review. The document read, "MEDICATION FUROSEMIDE (Lasix) DOSAGE 20 mg 2x a day TIME OF ADMINISTRATION 08001 1400 START DATE 12/20/19 END DATE N/A." Ms. Kennedy provided me with a copy of Resident C's physician orders for "TraMADol (ULTRAM) 50 mg tablet Take one tablet by mouth at bedtime as needed" for my review. One order was dated 11/17/20 and the other dated 1/5/21.

Ms. Kennedy provided me with a copy of a fax cover sheet document for Resident C's physician for my review. The document was dated 12/19/20 and read, "FYI our facility physician provided emergency visit for pain issued (letter was sent to you 12/27/20) orders were obtained from Jennifer Nobert, PA for CBC w/ diff ,CMP, TSH current Tylenol order was D/C. Tylenol was increased to 325mg 2 tabs PO Q6. Please return my message about tramadol. A lumbar x-ray was also completed. Results sent to Dr. Chen neuro surgeon."

Ms. Kennedy provided me with a copy of Resident C's December 2019 medication administration record (MAR) for my review. The MAR read Resident C's Furosemide (Lasix) 20 mg tablet "take 1 tablet by mouth daily" was administered as prescribed from 12/1 until the order was discontinued on 12/19. The MAR read Resident C was administered 20 mg of Lasix twice a day starting on 12/20 through 12/31. The MAR did not reflect a six-day delay in the new Lasix order as reported by the complainant.

Ms. Kennedy provided me with a copy of Resident C's staff notes for my review. A note dated 12/19/19 read, "new order received to change Lasix to 20mg PO BID. Daughter, Pam is aware of change."

A note dated 12/27/20 read, “This nurse faxed the following letter to Dr. MacMillan on 12/27/20: Hello, my name is Heidi Veenstra, I am an RN from Covenant Village Assisted Living in Grand Rapids contacting you regarding a mutual patient, [Resident C] who resided in room 227 here. Staff has been reporting to me that [Resident C] has been complaining of back pain, urinary frequency, burning with urination, and dysuria to the point of her crying and yelling out when on the toilet. She is only voiding small amounts at a time. Her intake has been good as we have been encouraging fluids to her. She has also been experiencing increased confusion and hallucinations. A UA was recently completed 12/14/2020 which showed <10,000 CFU/ML of mixed flora. No ID/Sensitivity due to low colony count. I am wondering if her issues are pain related. It may be painful for her to sit on the toilet, and that may be why she is unable to go to the bathroom? She did have an order for Tramadol 50 mg QHS PRN (DPOA does not want her to take Tramadol during the day. Tylenol during the day, tramadol at night). The Tramadol order was completed 12/7/2020. The Tramadol really seemed to help her. I would like to request to continue Tramadol 50 mg QHS. I am also requesting guidance, do you believe a repeat UA would be beneficial? Any lab work or other orders you would like us to pursue?.”

On 3/25/21, Ms. Sobczak’s statements regarding Resident C’s medications were consistent with Ms. Kennedy.

On 3/25/21, Ms. Stebbins’ statements regarding resident C’s medications were consistent with Ms. Kennedy and Ms. Sobczak.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The interviews with Ms. Kennedy, Ms. Sobczak, and Ms. Stebbins, along with review of Resident C’s MARs and staff notes revealed her medications were administered as prescribed. There is insufficient evidence to suggest there was a six-day delay in the administration of Resident C’s new Lasix order in December 2019.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL INFORMATION:

INVESTIGATION:

On 3/25/21, I reviewed Resident C's staff notes. Notes dated 10/12/20, 5/27/20, 11/29/20, 12/9/20, 12/14/20, 12/30/20 read resident C fell and was not injured. Notes dated 1/12/20, 6/21/20, 12/12/20 read Resident C fell and was injured. I reviewed the facility file and found these incidents were not reported to the department.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Review of the Resident C's staff notes and the facility file, revealed several incidents that met the reporting requirement were not submitted to the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

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

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

4/21/21

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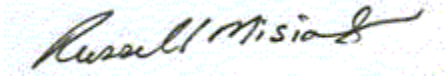
Lauren Wohlfert Date
Licensing Staff

Approved By:



4/21/21

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Russell B. Misiak Date
Area Manager