GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2026

Donna Bacigalupo
Covenant Glen of Frankenmuth
1040 Covenant Drive
Frankenmuth, MI 48734

RE: License #: AH730338689
Investigation #: 2026A1035023
Covenant Glen of Frankenmuth

Dear Licensee:

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.

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730338689
Investigation #:	2026A1035023
Complaint Receipt Date:	02/03/2026
Investigation Initiation Date:	02/03/2026
Report Due Date:	04/05/2026
Licensee Name:	Frankenmuth Glen ALC, LLC
Licensee Address:	3520 Davenport Avenue Saginaw, MI 48602
Licensee Telephone #:	(989) 892-0658
Administrator/ Authorized Representative	Donna Bacigalupo
Name of Facility:	Covenant Glen of Frankenmuth
Facility Address:	1040 Covenant Drive Frankenmuth, MI 48734
Facility Telephone #:	(989) 262-8340
Original Issuance Date:	06/27/2014
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	77
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was injured. The facility did not follow policy and procedure related to incidents and accidents.	Yes
Additional Findings	No

III. METHODOLOGY

02/03/2026	Special Investigation Intake 2026A1035023
02/03/2026	Special Investigation Initiated - Letter email sent to complainant
02/23/2026	Contact - Face to Face
03/11/2026	Inspection Complete. BCAL Sub – Compliant.
03/11/2026	Exit Conference.

ALLEGATION:

Resident A was injured. The facility did not follow policy and procedure related to incidents and accidents.

INVESTIGATION:

On February 3, 2026, the Department received a complaint through the online complaint system which read:

> "Resident A had a broken hip and extreme bruising in her lower stomach and pelvis area. There is not an incident filed for this injury at the facility. The facility failed to provide any explanation regarding this extreme injury. Lack of care, experience, training and knowledge in this memory care facility was not provided."

On February 23, 2026, an onsite investigation was conducted. While onsite, I interviewed Staff Person (SP)1 who states a caregiver reported to her there was new bruising noted on Resident A's hip/ pelvic area. At this time, staff had been asked if there was a fall or known cause of injury, staff denied knowledge of known injury. SP1 states no formal investigation was conducted, family and hospice were notified of findings. SP1 states the on-call hospice nurse had come out and

completed an assessment. An x-ray was ordered and completed on 1/30/2026. X-ray results concluded “acute fracture medical wall of the right acetabulum with protrusion of the right hip.”

Through record review on 1/29/2026 at 10:10 a.m. SP2 documents “resident looks like she has a freshly new bruise on her right pelvic side, she is in a lot of pain, she would wince at slight touch by it and she seems very frightened today, she is also very leaned and hunched over.”

1/29/2026 at 13:42 p.m. SP1 noted in progress notes “notified by staff of some new bruising on right hip. Residents demo discomfort when palpated. Did notify hospice agency and agency stated they would let resident RN know of this new noted bruise.”

1/29/2026 at 17:20 p.m. hospice nurse arrived and assessed Resident A.

1/30/2026 at 11:45 a.m. placed an ordered STAT x-ray.

1/30/2026 at 22:08 p.m. X-ray results received from Mobile x-ray indicating an acute fracture. Hospice and family notified at this time.

Hospice nurse assessment and notation on 1/29/2026 at 21:10 p.m. states:

> “*ON CALL VST MADE DUE TO HAVING INCREASED BRUISING TO LEFT GROIN AREA EXTENDING DOWN TO PUBIC BONE AND ACROSS LOWER ABDOMEN. A LOT OF DISEASE EDUCATION GIVEN TO FAMILY ABOUT POSSIBLY BEING A CLOT THERE. THERES A HARD "BUMP" IN THE ARTERY THAT IS PALPABLE AND MAY BE THE CAUSE OF THE BRUISING. AT THIS TIME THE FAMILY WISHES TO KEEP HER COMFORTABLE AT THE FACILITY. UPON ARRIVAL PATIENT WAS HUNCHED OVER IN HER CHAIR AND WAS IN OBVIOUS DISTRESS WHEN TOUCHED. HER HANDS WERE CLENCHED TIGHT AND SHE WAS HANGING ONTO THE CHAIR CUSHIONS. TYLENOL GIVEN DURING VISIT WITH POSITIVE RESULTS AS LAUREN CAREGUVER STATED SHE HAD A HARD RIKE GETTING HER TO TAKE IT. WATCHED AS FAMILY FED HER AND SHE ATE ALL OF HER DINNER. ACCORDING TO STAFF SHE DIDN'T EAT LUNCH AS SHE SAID PATIENT REFUSED. FAMILY WAS COAXING HER AND SHE WOULD OPEN HER MOUTH FOR EVERY BITE. LAUREN ALSO STATED THAT PATIENT HAD A HARD TIKE SUCKING OUT OF THE STRAW AND SHE DRANK FINE FOR HER DAUGHTER AND MYSELF. SHE DRANK A WHOLE CUP OF JUICE.”*

Hospice nurse assessment and notation on 1/30/2026 at 23:51p.m. states:

> *“RN FOLLOW UP VISIT DONE TODAY PATIENT FOUND IN HER ROOM IN HER WHEELCHAIR. DAUGHTER PRESENT. NURSE DID ASSESSMENT. VSS. NO PAIN NOTED WITH PT SITTING IN HER BRODA CHAIR. DAUGHTER UPSET ABOUT THE BRUISING TO PATIENT PELVIC AREA. STATED THAT SHE HAD DECIDED TO NOT SEND HER OUT TO ER FOR XRAY OR TREATMENT BECAUSE IT WOULD BE TOO HARD ON HER MOM. NO REPORTED FALL OR INJUY BY FACILITY STAFF YESTERDAY. DAUGHTER STATES HER MOM ATE BACON AND TOAST FOR*

BREAKFAST AND SHE HAS NOT APPEARED PAINFUL AND HAS BEEN SMILING AT HER DAUGHTER. PATIENT ASSISTED BACK TO BED BY FACIILITY CAREGIVER. NOTED THAT PATIENT HAD SCATTERED BRUISING TO PELVIC AREA. SUPERVISOR CAME IN TO CHECK ON PATIENT AND ONLY BRUISING NOTED TO FRONT OF PELVIS BETWEEN HIPS. NO BRUISING ON HIPS ON EITHER SIDE. NO BRUISING ON BUTTOCKS. PATIENT SMILING AND TRYING TO COMMUNICATE. WHEN ATTEMPTED TO MOVE HER BACK INTO WHEELCHAIR, PATIENT GRIMACED. ON RIGHT LEG MOVEMENT. HIP WITH NO SWELLING AND NO SWELLING NOTED IN EITHER LEG. LEGS SOFT AND PEDAL PULSES PRESENT, BUT NO EDEMA. PER DAUGHTER REQUEST CALLED DR. LOCKARD TO REQUEST XRAY FOR RIGHT HIP AND PELVIS. ORDER RECEIVED AND MOBILE XRAY ORDERED. XRAY DONE AND THIS NURSE CALLED BY SP1 WITH RESULT OF ACUTE DISPLACED FRACTURETHROUGH THE MEDIAL WALL OF THE ACETABULUM WITH PROTRUSIO. MILD DJD. DISCUSSED KEEPING PATIENT IN BED. CURRENTLY TAKING TYLENOL EVERY 6 HOUR. PATIENT ALSO HAS O.25 ML MORPHINE SYRINGES IN THE DRAWER FOR HER. UPDATED TEAM AND CALLED AND TALKED TO DAUGHTER. DAUGHTER UPSET ABOUT THE BREAK. WANTED TO KNOW IF HER MOM COULD STILL GET OUT OF BED AND TOLD HER I WOULD BE THE BEST TO KEEP HER IN BED FOR COMFORT. DAUGHTER WORRIED THAT THE PATIENT HAD FALLEN AND IT DID NOT GET REPORTED. EXPLAINED TO DAUGHTER THAT THERE WAS NO EVIDENCE OF FALL. NO BRUISING TO HIP OR BUTTOCKS. DAUGHTER WORRIED ABOUT HER STAYING IN BED EXPLAINED THAT THE STAFF WOULD SIT HER HIGH IN BED WHEN EATING TO PREVENT ASPIRATION. DAUGHTER WONDERED IF IT WOULD HEAL AND SHE COULD GET UP IN TIME. SHE STATED THAT HER NEIGHBOR HAD FALLEN AND THEN DIED. SYMPATHY GIVEN. EXPLAINED THAT WE WOULD CONTINUE THE TYLENOL ATC AND THAT SHE HAD INTERMITTENT MORPHINE. DAUGHTER IN AGREEMENT WITH PT GETTING MORPHINE MEDICATION AS NEEDED BUT DID NOT WANT IT SCHEDULED AT THIS TIME AS SHE WAS WORRIED IT WOULD OVER SEDATE HER. ALSO NOTIFIED HER THAT ELIZABETH WOULD BE IN TO SEE HER SATUDAY AND SUNDAY. PLAN DISCUSSED ALSO WITH SP1. NOTIFIED DR LOCKARD OF PLAN TO KEEP PATIENT IN BED AND USE MORPHINE PRN. PLAN FOR ELIZABETH TO SEE PT SATURDAY AND SUNDAY. DR LOCKARD IN AGREEMENT AND NO FURTHER ORDERS GIVEN. NOTIFIED HOSPICE TIME OF THE FX AND PLAN OF CARE WITH MEDICATIONS. AND THE PLAN FOR VISITS OVER THE WEEKEND. DAUGHTER AND SP1 INSTRUCTED TO CALL COMPASSUS WITH UNMANAGED SYMPTOMS."

Through record review of the facilities "Reporting of Accident, Incident, and Elopement" policy an "accident" is defined as an incident which occurred without design, a mishap misfortune, or misadventure, which may result in harm or injury to a person or property. Immediate investigation on the cause of an accident or incident involving a resident, employee, or visitor shall be initiated by the Administrator and an appropriate accident record or incident report completed. This accident record or incident record shall be maintained in the Administrators office. An accident record or incident record shall be prepared for each accident to a resident, personnel, and visitor and shall include the following information:

- Name of person involved in the accident or incident.
- Date, hour, place, and narrative description of the facts about the incident/ accident which indicates cause if known.

- Effect of accident or incident on person involved extent of injuries.
- Written documentation of the individuals notified.
- The corrective measures taken to prevent measure(s) taken to prevent future incidents/ accidents from occurring.

On 2/25/2026 an email was sent to SP1 and Donna Bacigalupo inquiring about a completed incident accident report. SP1 responded: “There was no "formal investigation" completed due to no "formal incident" being reported by staff, family or hospice.”

On February 25, 2026, a phone interview was conducted with SP3 who states the bruise was observed during 1st rounds, SP2 notified SP1 of observation. SP3 states Resident A was shaking and appeared to be in pain. SP3 is unaware of an occurrence that would have caused the bruising.

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:	Through record review and interview Resident A was observed with a bruise of unknown origin to her right pelvic area. SP1, hospice and family were notified. An x-ray was obtained concluding there was an acute fracture. Facility did not follow policy and procedure related to incidents and accidents, by completing necessary documentation or incident or accident report and did not address Resident A’s change in condition and increase pain. For these reasons, the allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend the status of this license remain unchanged.

02/25/2025

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

03/11/2026

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