



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2026

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

RE: License #: AH410236771
Investigation #: 2026A1041002
Covenant Village of the Great Lakes

Dear Licensee:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Tammie Daniels".

Tammie Daniels, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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

I. IDENTIFYING INFORMATION

License #:	AH410236771
Investigation #:	2026A1041002
Complaint Receipt Date:	03/25/2026
Investigation Initiation Date:	03/30/2026
Report Due Date:	05/24/2026
Licensee Name:	Covenant Living of the Great Lakes
Licensee Address:	2520 Lake Michigan Dr. NW Grand Rapids, MI 49504
Licensee Telephone #:	(616) 735-4511
Administrator:	Andrea Smith
Authorized Representative:	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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	102
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive prescribed blood pressure medication for 8 days.	No
Additional Findings	Yes

III. METHODOLOGY

03/25/2026	Special Investigation Intake 2026A1041002
03/30/2026	Special Investigation Initiated - Telephone Interview and document request with Administrator
04/06/2026	Contact - Document Received Received requested documentation from the administrator
04/20/2026	Contact - Telephone call made Interview with Administrator and Employee 1
04/23/2026	Contact - Telephone call made Interview with Employee 4 and Employee 5
04/27/2026	Contact - Document Received Received requested documentation from Employee 1
04/28/2026	Contact - Face to Face Interview with Administrator and Employee 1
5/14/26	Exit Conference

ALLEGATION:

Resident A did not receive prescribed blood pressure medication for 8 days.

INVESTIGATION:

On 03/26/2026, the Department received a complaint alleging that when emergency services were called on 03/18/2026 due to Resident A having a bloody nose, Resident A's blood pressure was checked and found to be 199/170. The complainant alleged that when facility staff were asked if Resident A had received

blood pressure medication, staff revealed that the medication had not been given for the past 8 days. The complaint was made anonymously.

On 03/30/2026, a telephone interview was conducted with the Administrator, Andrea Smith. During the interview, the Administrator was notified of the investigation and agreed to provide Resident A's service plan; progress notes; and medication administration records for February and March of 2026 for review.

On 04/06/2026, I reviewed Resident A's most recent service plan and medication administration records (MAR's) for February and March 2026. It was noted in the service plan that the home was responsible for administering Resident A's medications. The MAR for March 2026 revealed Resident A had an order for one blood pressure medication (Metoprolol Tartrate) to be given daily and that it was not administered for 8 days beginning 03/09/2026 through 03/16/2026. The same reason was entered in the notes each day the medication was not given and each read: "*Not Administered (Medication Unavailable)*". Resident A also did not receive a multivitamin tablet on 9 days including 03/01/2026; 03/03/2026 through 03/06/2026; and 03/09/2026 through 03/12/2026 for the reason "*Not Administered (Medication Unavailable)*".

On 04/06/2026, a telephone interview was conducted with Employee 1. Employee 1 acknowledged that the facility failed to ensure Resident A's blood pressure medication was administered as ordered by the physician for 8 days as noted in the MAR for March 2026. Employee 1 acknowledged the multivitamin findings also. Employee 1 explained that she found out Resident A did not receive the blood pressure medication because of a call from Resident A's family after emergency services were requested for Resident A on 03/17/2026. Employee 1 reported that as a result, she immediately began an investigation to determine the root cause for why Resident A did not get the blood pressure medication. Employee 1 reported that the first issue was that staff did not request a refill for the blood pressure medication until it was gone on 03/09/2026. Employee 1 reported that medication reorder sheets with Resident A's blood pressure medication and multivitamin refill requests were completed multiple times during the time that the medications were found to be gone, however, they were not faxed to the pharmacy or physician. Employee 1 reported that it was the responsibility of nursing staff to fax the medication reorder sheets once completed. Employee 1 reported that in this case, it was Employee 2 working on each of the days that reorder sheets were not faxed. Employee 1 reported that she interviewed Employee 2 and Employee 2 said that she called and reported the refill need to the physician's office, but otherwise Employee 2's recollection was "cloudy". Employee 1 reported that she reviewed Resident A's progress notes after talking to Employee 2 and there was no documentation entered regarding a verbal refill request to the physician's office. Employee 1 reported that immediate action was taken to ensure this did not occur again and included medication audits to be completed each week for all resident medications and one-on-one education with the staff.

On 04/20/2026, a telephone interview was conducted with Employee 1. Employee 1 reported that an in-service regarding a new process for monitoring and reordering medications was scheduled with all staff who manage resident medication on 04/22/2026. Employee 1 reported that re-education as well as disciplinary action would be provided to Employee 2 however, Employee 2 had been off work since Employee 1 interviewed her regarding this incident. Employee 1 reported that an incident report was opened on 03/17/2026 because of the medication error and would be used for ongoing facility quality assurance purposes and tracking.

On 04/20/2026, I reviewed Resident A's medication audit reports. It was noted that a medication audit was completed by staff for Resident A's medications weekly since 03/18/2026.

On 04/23/2026, a telephone interview was conducted with Employee 4. Employee 4 could not recall receiving one-on-one education in March but remembered that a new process was put in place right after the incident for completing the medication reorder sheets. Employee 4 reported attending an in-service on 04/22/2026 detailing the new process for ensuring medications were ordered timely for all facility residents.

On 04/23/2026, a telephone interview was conducted with Employee 5. Employee 5 could recall having one-on-one education regarding how to reorder medications following this incident in March. Employee 5 reported that in addition to education, the facility immediately implemented the use of a different pharmacy book to keep track of medication reordering and make it easier for staff.

On 04/27/2026, I reviewed the facility incident report regarding Resident A's medication error of not receiving blood pressure medication for several days in a row and it was dated 03/17/2026. The report included what areas of breakdown led to the medication error and that a written plan of correction was initiated on 03/26/2026.

On 04/28/2026, I reviewed the in-service completed on 04/22/2026 with all staff who manage any aspect of resident medications. The in-service included the plan of correction and gave instruction for weekly medication audits; reordering medications seven days prior to the last dose; specific instruction for nursing staff related to the reorder and faxing of refill requests; and how non-nursing staff complete the reorder form. An in-service attendance record was signed by staff members who attended.

On 04/28/2026, an interview was conducted with Employee 1. Employee 1 reported that Employee 2 had still not been back to work since the interview following the incident. Employee 1 reported that any staff member who did not attend the in-service on 04/22/2026 would receive a copy of the education for review.

APPLICABLE RULE	
R 325.1932	Resident medications.
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	<p>Reviews of records and interviews revealed there is sufficient evidence to determine that Resident A did not receive the prescribed blood pressure medication and multivitamin as ordered due to failure of the facility to ensure the medication refill process was completed appropriately. After the discovery of this medication error, Employee 1 took the following actions:</p> <ul style="list-style-type: none"> • Immediately implemented weekly medication audits. • One on one verbal staff education following identification of the medication error. • Incident report was completed for ongoing facility quality assurance purposes and tracking. • Formal in-service was completed for staff who manage any aspect of resident medications. • Re-education and written disciplinary action will be taken for Employee 2 upon returning to work. <p>Although the error occurred, the facility initiated corrective actions taken after discovery of the medication error that should ensure that this will not occur again for Resident A, and the other residents residing at this facility.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/06/2026, I reviewed Resident A’s most recent service plan, and it was noted that the home was responsible for administering Resident A’s medications.

On 04/06/2026 during review of Resident A’s March 2026 MAR, it revealed that Resident A did not receive the prescribed multivitamin tablet from 03/20/2026 through 03/22/2026 for the reason “*Not Administered (Resident Self-Administers)*”.

APPLICABLE RULE	
R 325.1932	Resident medications.
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	Based on review of Resident A's records, it was determined that three daily doses of the multivitamin were documented as not administered by the home for the reason given that Resident A self-administered. Resident A does not self-administer medications according to the service plan and therefore, the medication was not administered as ordered.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Tammie Daniels

04/29/2026

Tammie Daniels
Licensing Staff

Date

Approved By:

Andrea Moore

05/13/2026

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

Date