GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2026

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

RE: License #: AH730338689
Investigation #: 2026A0627050
Covenant Glen of Frankenmuth

Dear Donna Bacigalupo:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

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

I. IDENTIFYING INFORMATION

License #:	AH730338689
Investigation #:	2026A0627050
Complaint Receipt Date:	06/04/2026
Investigation Initiation Date:	07/07/2026
Report Due Date:	08/04/2026
Licensee Name:	Frankenmuth Glen ALC, LLC
Licensee Address:	3520 Davenport Avenue Saginaw, MI 48602
Licensee Telephone #:	(989) 892-0658
Administrator:	Andrea Flood, Administrator
Authorized Representative/	Donna Bacigalupo, Authorized Repr.
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:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	77
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
It was alleged that Resident A was given 2 doses of Xanax on 5/12/26 and 5/19/26 and had to go to the hospital multiple times.	Yes
Additional Findings	No

III. METHODOLOGY

06/04/2026	Special Investigation Intake 2026A0627050
07/07/2026	Special Investigation Initiated - On Site
07/07/2026	Exit Conference

ALLEGATION: It was alleged that Resident A was given 2 doses of Xanax on 5/12/26 and 5/19/26 and had to go to the hospital multiple times.

INVESTIGATION: On 6/4/26 the Bureau of Community and Health Systems received a complaint alleging that Resident A was given 2 doses of Xanax on 5/12/26 and 5/19/26, had to go to the hospital multiple times and afterward became bedridden.

On 7/7/26, I went onsite to investigate the allegation and interviewed Michelle Ziemer, Executive Director (ED) and SP1. SP1 described Resident A as very anxious and sometimes difficult to manage.

Review of Progress Notes dated from 5/4/26 through 5/15/26 documented Resident A's agitation 5 times over the course of 11 days. On 5/20/2026, Resident A complained of back pain and did not eat her lunch. Resident A was seen lying sideways in the bed and later that day at 4:00pm was found by her husband laying on the floor. The incident report documented that she was assessed for injuries that were negative. Resident A was transported to the hospital as a precaution. On 5/21/26 Resident A was walking around and a caregiver noted she almost fell backward and was caught. Later Resident A was found on the floor again, assessed for injury that was negative. Her POA (Power of Attorney) was present and declined

to have her return to the hospital. 5/22/26 documented that she was very lethargic, having continued back pain and did not go to the dining room for any meals. On 5/25/26, fell and hit the back of her head and was transferred out of the facility to the hospital.

Review of the Medication Administration Record (MAR) noted that Alprazolam, 0.5mg by mouth at bedtime, if needed. Review of the MAR documentation presented noted that on 5/12/26 Resident A had received Alprazolam 0.5mg by mouth at 3:00pm and again at 7:48 pm. Further review of the MAR also noted that on 5/19/26 Resident A received Alprazolam 0.5mg by mouth at 2:38pm and again at 4:08pm. The medication order as written is only to be given once a day at bedtime.

On 7/7/26 I interviewed SP1 about the medications being given twice on 2 different dates, SP1 replied that the medications were given twice as a result of the Primary Care Provider giving a verbal order for the medication to be repeated for Resident A's behaviors. On 5/12/26 at 3:06pm Resident A tried to escape from the Memory Care Unit and at 8:00pm pulled the fire alarm causing Fire Emergency personnel to come to the facility. On 5/19/26 Alprazolam was given twice for MAR documented Agitation/Restlessness. There was no documentation noting a PCP's order to double the medication on 5/12/26 or 5/19/26. I inquired about the facility's expectation for documenting verbal orders and SP1 replied that it is expected that verbal orders be documented for all residents in their individual records.

It was noted that on 5/21/26 that Resident A's Alprazolam was reduced on 5/21/26 to 0.5mg ½ tablet (0.25 mg) by mouth at bedtime if needed. On 5/25/26 Resident fell, hit her head and was transferred to the hospital. Resident A did not return to the facility after this date.

APPLICABLE RULE	
R 325.1932	**Resident's 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:	The facility failed to ensure that the extra doses of Alprazolam that were administered had been given as ordered by a PCP and documented appropriately.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



7/20/2026

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Rick Brummette Date
Licensing Staff

Approved By:



07/30/2026

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