GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

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

RE: License #: AH410236771
Investigation #: 2025A1028079
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

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 #:	2025A1028079
Complaint Receipt Date:	08/11/2025
Investigation Initiation Date:	08/12/2025
Report Due Date:	10/10/2025
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	102
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell and incurred multiple fractures to [their] pelvis due to Resident A's anti-seizure being stopped abruptly by facility staff.	Yes
Staff did not provide care in accordance with Resident A's service plan.	Yes
Resident A's call lights were not answered in a timely manner.	Yes
Additional Findings	No

III. METHODOLOGY

08/11/2025	Special Investigation Intake 2025A1028079
08/12/2025	Special Investigation Initiated - Letter
08/12/2025	Contact - Document Sent Interviewed complainant via email.
08/19/2025	Contact - Face to Face Interviewed the facility authorized representative/administrator at the facility.
08/19/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
08/19/2025	Contact - Face to Face Interviewed Employee 2 at the facility.
08/19/2025	Contact - Document Received Received requested documentation from Employee 2.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA).

ALLEGATION:

Resident A fell and incurred multiple fractures to [their] pelvis due to Resident A's anti-seizure being stopped abruptly by facility staff.

INVESTIGATION:

On 8/11/2025, the Bureau received the allegations through the online complaint system.

On 8/12/2025, I emailed the complaint requesting additional identifying information with the complaint providing the requested information via email the same day.

On 8/19/2025, I interviewed the facility authorized representative/administrator at the facility who reported knowledge that Resident A's medication required a new physician order prior to the pharmacy filling the prescription. The facility reached out to the physician ahead of time to request the medication re-fill and the physician did not respond to requests until a few days later. Resident A was without the medication for a few days due to the facility waiting on a new physician order to be issued for the medication.

On 8/19/2025, I interviewed Employee 1 at the facility who confirmed Resident A's medication required a new physician's order prior to the pharmacy filling the prescription. The facility requested a new physician's order and called to check because the medication was not being refilled by the pharmacy. Employee 1 reported there was gap in which Resident A went without the medication. Employee 1 provided me with the requested documentation for my review.

On 8/19/2025, I interviewed Employee 2 at the facility whose statement was consistent with the authorized representative/administrator statement and Employee 2's statement. Employee 2 provided me with additional documentation for my review.

On 8/26/2025, I reviewed the requested information that the facility provided, which revealed the following:

- Resident A was to receive 1 tablet of 750 mg of Levetiracetam orally two times daily (morning and evening).
- Resident A received the medication as prescribed and without interruption from the morning of 6/1/2025 to evening of 6/14/2025. The medication was then placed on HOLD in the medication administration system due to not being available.
- On 6/17/2025, the facility made a request for the prescription to be refilled.
- On 6/20/2025, Resident A presented as shaky and not feeling well. Staff called management with staff informing management that Resident A has been out of Levetiracetam.
- On 6/20/2025, management made an inquiry about the medication and advised Resident A's family that the on-call physician was notified about the medication refill. The physician called-in the refill with the family being notified it could be picked up at the pharmacy immediately. However, Resident A had complaints of pain in the tailbone area due to a fall on 6/19/2025. At that time,

Resident had refused to go to the hospital, but the family convinced Resident A to go to the hospital on 6/20/2025. Resident A did not return to the hospital.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged that Resident A fell and incurred multiple fractures to [their] pelvis due to Resident A's anti-seizure medication being stopped abruptly by facility staff. Interviews, onsite investigation, and review of documentation reveal the following: • Resident A prescription of 1 tablet of 750 mg of Levetiracetam was last administered in the evening on 6/14/2025. • From the morning of 6/15/2025 to the morning of 6/21/2025, the facility marked the medication in the medication administration record as 'not available'. • Facility staff requested a new prescription refill order from the physician on 6/17/2025. • There is additional documentation that facility staff followed up with the physician on the prescription refill request on 6/20/2025. The new prescription was ordered by the on-call physician and filled by the pharmacy on 6/20/2025. Resident A was to be administered 1 tablet of 750 mg of Levetiracetam orally two times daily, but the prescription was exhausted on the evening of 6/14/2025. There is evidence that the facility requested a new physician order for the medication refill, however, the documentation shows that the request was not made until 6/17/2025. Further review of documentation revealed Resident A was without the medication from the morning of 6/15/2025 until Resident A went to the hospital on 6/20/2025. The facility did not act in a timely manner or take the necessary steps to ensure Resident A's medication was refilled prior to becoming exhausted on 6/14/2025, which may have contributed to Resident A's fall with injury on 6/19/2025. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION

Staff did not provide care in accordance with Resident A's service plan.

INVESTIGATION:

On 8/12/2025, the complainant provided me with additional information via email. The complainant reported that facility staff did not check on Resident A routinely, Resident A slept in the same clothes for several days, Resident A did not get showers, and staff would drop off breakfast with Resident A's medication left on the tray.

On 8/19/2025, Employee 1 reported Resident A resided in the assisted living area for 6-8 weeks before entering another facility in June 2025 because it was determined that Resident A would require a more skilled setting and services after a fall on 6/19/2025. Resident A was [their] own person and made [their] own decisions and there was not an active authorized representative in place for Resident A, but the facility communicated regularly with Resident A's children about Resident A's care. Employee 1 reported the family wanted staff to get Resident A up in the morning and assist Resident A to bed by 8pm. However, Resident A often did not want to get up in the morning and the family was informed that Resident A has the right to refuse to get up, to refuse care, and to refuse participation in activities etc. The family was also reminded that staff encourage Resident A to get up in the morning, participate in activities and care, but Resident A is [their] own person and makes [their] own decisions and staff cannot force Resident A to do anything [they] do not agree to. Employee 1 reported Resident A would refuse care at times to include changing clothes or showers. Employee 1 also reported Resident A would choose to sleep in the recliner instead of the bed at times and that Resident A had the right to do so, but the family had some difficulty understanding the parameters of resident rights. Employee 1 reported no knowledge of staff leaving pills on the meal tray when serving Resident A and that Resident A received care and showers in accordance with the service plan and Resident A's preferences. Employee 1 provided me with requested documentation for my review.

On 8/19/2025, Employee 2 reported no knowledge that pills were ever left on Resident A's meal trays and that medications are not administered in that manner in the facility. Employee 2 reported that facility staff provided care in accordance with the service plan and that Resident A could refuse care such as showers or the changing of clothes intermittently. Employee 2 reported Resident A would choose to remain in the recliner at times or chose to sleep in the bed and that staff followed Resident A's preferences. Employee 2 confirmed that family wanted Resident A up in the morning and in bed by 8pm, but family was informed that it is Resident A's right to choose when to get up and when to go to bed, that staff cannot force Resident A to participate in any activity or family request. Employee 2 provided me with the requested documentation for my review.

On 8/26/2025, I reviewed the requested information that the facility provided, which revealed the following:

- Resident A was [their] own person and made [their] own decisions. There is not an active durable power of attorney or authorized representative in place for Resident A, but there are a patient advocate document and a contact person list in place.
- Resident A required assistance with hearing aids, dressing, bowel and bladder management, and showers.
- Resident A required standby assistance and cueing for grooming.
- Resident A was to receive a shower two times per week on Monday and Thursday on first shift.
- The facility managed housekeeping, meals, and medication management.
- The family managed Resident A's laundry.
- There is documentation the *family requested [Resident A] to be up in the mornings at 8am when at all possible.*
- The care task documentation shows that from 6/1/2025 to 6/20/2025 there are only 3 showers marked as completed for Resident A. Other care tasks such as dressing, personal hygiene, and toileting are marked as *independent, staff, min assist, mod assist, and max assist.*

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 staff did not provide Resident A care in accordance with the service plan. Interviews, onsite investigation, and review of documentation revealed the following: • There is a lack of documentation to determine if Resident A received showers 2 times per week in accordance with the service plan. Only 3 showers were documented as completed from 6/1/2025 to 6/20/2025. • There are several discrepancies between the service plan and the care task documentation. The levels of staff assistance that was to be provided to Resident A per the service plan for dressing, personal hygiene, and toileting did not match the level of staff assistance that was documented on the care task log. For example, dressing, personal hygiene, and toileting are marked as 'independent' by staff on varying days throughout the care task documentation but the service plan dictates Resident A is to receive 1 person staff assistance with these specific tasks. • There are blank entries on the care task documentation. Due to the lack of documentation, blank entries on the care task documentation, and the discrepancies between the service plan and care task documentation, it cannot be determined if Resident A received care and/or staff assistance in accordance with the service plan. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's call lights were not answered in a timely manner.

INVESTIGATION:

On 8/12/2025, the complainant reported Resident A's call lights were not answered in a timely manner and that call lights were sometimes not answered for 45-50 minutes or longer. No dates were provided as to when the call lights were not allegedly answered in a timely manner.

On 8/19/2025, the authorized representative/administrator reported call lights are expected to be answered by staff in a timely manner and reported no knowledge that Resident A's call lights were not answered in a timely manner or not answered for

45-50 minutes. The authorized representative/administrator reported the call lights are reviewed routinely to ensure they are being answered in a timely manner.

On 8/19/2025, Employee 1's reported call lights are answered in a timely manner and to [their] knowledge Resident A's call lights were answered in a timely manner when Resident A used it. Employee 1 reported the average call light answer time is currently between 6-7 minutes, but staff are not always consistent about resetting the call light because staff provide care first and then reset the call light after care completion. Employee 1 reported staff sometimes forget to reset the call light after providing care, so the call light response times may look longer than the call light response time really was. Employee 1 provided me with Resident A's call light log.

On 8/19/2025, Employee 2's statement was consistent with the authorized representative/administrator's statement and Employee 1's statement.

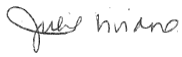
On 8/27/2025, I reviewed Resident A's call light log which revealed the following:

- From 5/2/2025 to 6/20/2025, Resident A used the call light 30 times total.
- On 5/15/2025, the call light response time was 21.8 minutes.
- On 5/16/2025, the call light response time was 41.9 minutes.
- On 5/17/2025, the call light response time was 61.3 minutes.
- On 6/01/2025, the call light response time was 58.4 minutes.
- On 6/17/2025, the call light response time was 99.3 minutes.
- On 6/18/2025, the call light response time was 34.5 minutes.
- On 6/20/2025, the call light response time was 20.2 minutes.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	It was alleged that Resident A's call lights were not answered in a timely manner. Interviews, onsite investigation, and review of documentation revealed that Resident A had multiple call light response times over 20 minutes and up to 99.3 minutes. Due to the multiple call light times that are 20 minutes or longer, it cannot be determined that staff responded to Resident A's call lights in a timely manner. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



8/27/2025

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Julie Viviano Date
Licensing Staff

Approved By:

09/30/2025

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