STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235614	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COVENANT VILLAGE OF THE GREAT LAKES	2520 LAKE MICHIGAN DRIVE NW GRAND RAPIDS, MI 49504

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 688 Based on interview and record review the facility failed to notify the physician of medication errors for 4 of 9 residents (Resident #110, #108, #109, and #107) reviewed for notification of changes, resulting in the lack of assessment, monitoring, and documentation and the potential for worsening of condition and delay in treatment. Findings include: Review of Registered Nurse (RN) Q's Employee Action Form dated 2/6/20 revealed, Please thoroughly explain details .On the afternoon of 02/03/2020, Nurse (RN Q) was observed discarding a narcotic ([MEDICATION NAME]) (antianxiety medication) for (Resident #108) which she had documented on the narcotics sign-out sheet as administered that morning. She documented in the Electronic Health Record (E.H.R.) that resident refused the medication (which had not been offered,) and did not notify the physician that the medication was not administered. On the afternoon of 02/05/2020, the narcotics count was did (sic) not reconciled during shift-change count. Two medications for (Resident #109)-[MEDICATION NAME] (stimulant medication) and [MEDICATION NAME] (pain medication)-were documented by (RN Q) as administered that morning but had not been removed from their cards. (RN Q) was observed to remove both medications from their respective cards, put them into a medication cup, and discard them. She did not document or notify the physician that the medications were not administered. On the morning of 02/06/2020, (RN Q) documented the administration of [MEDICATION NAME] (antianxiety medication) to (Resident #110), but then stated in report that resident had refused all meds. She did not document his refusal and did not notify the physician .Action Taken .Termination. Resident #110 Review of a Face Sheet revealed Resident #110 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #110's February 2020 Medication Administration Record [REDACTED].Three Times Daily . In the box for February 6th for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #110's Narcotic Sheet revealed, [MEDICATION NAME] 0.25 MG TABLET .TAKE 1 TABLET BY MOUTH THREE TIMES DAILY . (Date) 2/6/20 (Time) 0830 (8:30 A.M.) (Amount Given) one. Review of Resident #110's Progress Notes revealed no documentation that the physician and/or family were notified of the medication error. Review of Resident #110's Occurrence Report revealed no report was completed. Resident #108 Review of a Face Sheet revealed Resident #108 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #108's February 2020 Medication Administration Record [REDACTED].Two Times Daily . In the box for February 3rd for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #108's Narcotic Sheet revealed [MEDICATION NAME] 0.5 MG TABLET .GIVE 1/2 TAB BY MOUTH TWICE DAILY . (Date) 2/3/20 (Time) 0754 (7:54 A.M.) (Amount Given) one. Review of Resident #108's Progress Notes revealed no documentation that the physician and/or family were notified of the medication error. Review of Resident #108's Occurrence Report revealed no report was completed. Resident #109 Review of a Face Sheet revealed Resident #109 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #109's February 2020 Medication Administration Record [REDACTED].Three Times Daily . In the box for February 5th for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #109's February 2020 Medication Administration Record [REDACTED].One Time Daily . In the box for February 5th for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #109's February Narcotic Sheet revealed [MEDICATION NAME] HCL 50 MG TABLET .TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AND TWICE DAILY AS NEEDED . (Date) 2/5/20 (Time) 0740 (7:40 A.M.) (Amount Given) one. Review of Resident #109's February Narcotic Sheet revealed MODAFINIL ([MEDICATION NAME]) 200 MG TABLET .TAKE 1 TABLET BY MOUTH DAILY . (Date) 2/5/20 (Time) 0740 (7:40 A.M.) (Amount Given) one. Review of Resident #109's Progress Notes revealed no documentation that the physician and/or family were notified of the medication error. Review of Resident #109's Occurrence Report revealed no report was completed. Review of an email dated 2/6/20 at 12:17 A.M. revealed, From: (Licensed Practical Nurse (LPN) Y) .To: (Previous Director of Nursing PDON C) Subject: 2/5/20 .I was counting the narcotics with (RN Q) and when got to room (Resident #109's room) the count was off on the residents [MEDICATION NAME]. (RN Q) punched it out into a med cup, then the next med was room (Resident #109's room) [MEDICATION NAME] ([MEDICATION NAME]) and that was off. (RN Q) punched it out into the med cup that the [MEDICATION NAME] was in. We continued counting the narcotics and when we finished (RN Q) crumpled the med cup up and threw it in the trash. Review of an email dated 2/6/20 at 12:15 A.M. revealed, From: (RN M) .To: (PDON C) Subject: Med statement .Per our discussion, I have also witnessed the discussed nurse (RN Q) pop meds out, including a narcotic-a [MEDICATION NAME] for (Resident #108) for Monday morning and simply throw it in the trash. She signed it out for the correct time but never actually gave it and it was found during count .This is a common occurrence as she did it today with (LPN Y) for (Resident #109) morning narcotics. During an interview on 6/25/20 at 1:33 P.M., RN M reported that she observed the narcotic count between RN Q and LPN Y on 2/5/20. RN M reported that the narcotic count was off and RN Q stated she forgot to administer the medications to Resident #109 but had signed Resident #109's medical chart as though she had administered the medication. RN Q then disposed of the narcotics into the trash. RN M reported that narcotics cannot be disposed of in the trash, so RN M and another nurse disposed of them following the facility policy and procedure. RN M reported it was not the first time RN Q had documented a narcotic was administered and disposed of the narcotic. RN M reported that she notified the PDON C of the concerns but did not know if any incident reports were completed. During an interview on 6/25/20 at 1:33 P.M., LPN Y reported that on 2/5/20, while counting narcotics with RN Q, a narcotic count error was identified. Resident #109's [MEDICATION NAME] and [MEDICATION NAME] were still in the blister medication pack but had been signed out as though they had been administered. At that time, RN Q popped the medications into a medication cup and disposed of them in the garbage. LPN Y reported she notified PDON C of the incident immediately. LPN Y reported that PDON C stated she would complete the incident report and notify the physician. During an interview on 6/25/20 at 11:18 A.M., PDON C reported that she believed incident reports were completed. To complete an incident report, it requires the writer to notify the physician and/or family of the concern identified. If a physician is notified of a concern it is documented in the progress notes. During an interview on 6/25/20 at 8:39 A.M., Nursing Home Administrator (NHA) A reported that there were no incident reports pertaining to medication errors for Resident #108, #109, and #110. Resident #107 Review of a Face Sheet revealed Resident #107 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #107's Physician order [REDACTED]. Review of Resident #107's Narcotic Sheet revealed [MEDICATION NAME] 100MG CAPSULE TAKE 1 CAPSULE BY MOUTH TWICE DAILY . (Date) 6/12/20 (Time) 7:35 P(M) (Amount Given) 2 (capsules). Review of Resident #107's Progress Notes revealed no documentation that the physician and/or family were notified of the medication error/wrong dose. Review of Resident #107's Occurrence Report on 6/23/20 revealed no report was completed. During an interview on 06/24/2020 at 2:00 P.M., RN O reported that she did not report the medication error to the physician or complete an incident report at the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) time of the medication error. RN O reported she was notified by DON B that she had not completed an incident report and was at the facility at that time to write up the incident. Review of Resident #107's Occurrence Report revealed, Dr. (name omitted) was notified on 6/24/2020 .I (RN O) was called by DON (Director of Nursing) and was told about a medication error that I made on June 12, 2020 at 1935 (7:35 P.M.) which I had totally forgot about until I was reminded. At the time of the call I recalled that I administered [MEDICATION NAME] 100mg x2 tabs and the order stated [MEDICATION NAME] 100 mg Error observed during survey and this writer (DON B) reviewed occurrence with nurse who made medication error. Incident report completed. MD (physician) notified 6/24/20 .Nurse discussed the medication error with surveyor at time of survey. Contributing factor to error was misreading the order and administering wrong dose.
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 688 Based on interview and record review, the facility failed to provide an environment free from neglect for 3 of 9 sampled residents (Resident #110, # 108, and #109) reviewed for abuse, resulting in the potential for a decline in physical, mental, and psychosocial well-being and the potential for narcotic diversion. Findings include: Review of the facility policy Abuse Prevention Program last revised 11/22/19 revealed, Policy .The policy of the (facility) is zero tolerance of any forms of abuse, neglect, or exploitation .Supervise staff in such a manner as to identify inappropriate behaviors such as rough handling of residents, identifying escalating aggressive behavior from residents, or imposed seclusion .Ensure that each employee understands that he or she is obligated to report knowledge of potential abuse or neglect of a resident to his or her immediate supervisor. vi. Ensure that each employee understands that individuals who fail to report abuse may be subject to penalties by the state .Occurrence Reports will be reviewed by the Administrator and Director of Nursing or designee to identify possible occurrences of abuse. iii. All occurrences/accidents of unknown origin will be investigated. iv. Employees are required to report all occurrences of possible abuse, mistreatment, or neglect of any resident and crimes against a resident or misappropriation of a resident's property immediately to their supervisor or Senior Staff Member .v. The supervisor or Senior Staff Member shall immediately report to the Administrator or person on call .G. Reporting of Abuse .Neglect-the failure to provide goods and services necessary to avoid physical harm or mental anguish. Neglect is the failure to provide the necessary treatment .or medical services by a caregiver . Review of Registered Nurse (RN) Q's Employee Action Form dated 2/6/20 revealed, Please thoroughly explain details .On the afternoon of 02/03/2020, Nurse (RN Q) was observed discarding a narcotic ([MEDICATION NAME]) (antianxiety medication) for (Resident #108) which she had documented on the narcotics sign-out sheet as administered that morning. She documented in the Electronic Health Record (E.H.R.) that resident refused the medication (which had not been offered,) and did not notify the physician that the medication was not administered. On the afternoon of 02/05/2020, the narcotics count was did (sic) not reconciled during shift-change count. Two medications for (Resident #109)-[MEDICATION NAME] (stimulant medication) and [MEDICATION NAME] (pain medication)-were documented by (RN Q) as administered that morning but had not been removed from their cards. (RN Q) was observed to remove both medications from their respective cards, put them into a medication cup, and discard them. She did not document or notify the physician that the medications were not administered. On the morning of 02/06/2020, (RN Q) documented the administration of [MEDICATION NAME] (antianxiety medication) to (Resident #110), but then stated in report that resident had refused all meds. She did not document his refusal and did not notify the physician .Action Taken .Termination. Resident #110 Review of a Face Sheet revealed Resident #110 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #110's February 2020 Medication Administration Record [REDACTED].Three Times Daily . In the box for February 6th for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #110's Narcotic Sheet revealed, [MEDICATION NAME] 0.25 MG TABLET .TAKE 1 TABLET BY MOUTH THREE TIMES DAILY . (Date) 2/6/20 (Time) 0830 (8:30 A.M.) (Amount Given) one. Resident #108 Review of a Face Sheet revealed Resident #108 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #108's February 2020 Medication Administration Record [REDACTED].Two Times Daily . In the box for February 3rd for 8:00 A.M. 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We continued counting the narcotics and when we finished (RN Q) crumpled the med cup up and threw it in the trash. Review of an email dated 2/6/20 at 12:15 A.M. revealed, From: (RN M) .To: (PDON C) Subject: Med statement .Per our discussion, I have also witnessed the discussed nurse (RN Q) pop meds out, including a narcotic-a [MEDICATION NAME] for (Resident #108) for Monday morning and simply throw it in the trash. She signed it out for the correct time but never actually gave it and it was found during count .This is a common occurrence as she did it today with (LPN Y) for (Resident #109) morning narcotics. During an interview on 6/25/20 at 1:33 P.M., RN M reported that she observed the narcotic count between RN Q and LPN Y on 2/5/20. RN M reported that the narcotic count was off and RN Q stated she forgot to administer the medications to Resident #109 but had signed Resident #109's medical chart as though she had administered the medication. RN Q then disposed of the narcotics into the trash. RN M reported that narcotics cannot be disposed of in the trash, so RN M and another nurse disposed of them following the facility policy and procedure. RN M reported it was not the first time RN Q had documented a narcotic was administered and disposed of the narcotic. RN M reported that she notified the PDON C of the concerns but did not know if any incident reports were completed. During an interview on 6/25/20 at 1:33 P.M., LPN Y reported that on 2/5/20, while counting narcotics with RN Q, a narcotic count error was identified. Resident #109's [MEDICATION NAME] and [MEDICATION NAME] were still in the blister medication pack but had been signed out as though they had been administered. At that time, RN Q popped the medications into a medication cup and disposed of them in the garbage. LPN Y reported she notified PDON C of the incident immediately. LPN Y reported that PDON C stated she would complete the incident report and notify the physician. During an interview on 6/25/20 at 10:53 P.M., LPN R reported that if medications and narcotics are not administered to a resident it would be reported immediately to the DON or Administrator along with any other type of abuse. Indicating LPN R identified narcotics not being administered to a resident as the possibility for abuse/neglect.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 688, MI 660, MI 738 Based on interview and record review, the facility failed to 1.) identify neglect and immediately report neglect to the State Agency for 3 residents (Resident #110, #108, and #109) and 2.) report suspected abuse within 2 hours for 1 resident (Resident #101) out of a sample of 9 residents reviewed for abuse, resulting in the potential for continued violations involving mistreatment, neglect, or abuse going undetected, unreported, or without thorough investigation. Findings include: Review of the facility policy Abuse Prevention Program last revised 11/22/19 revealed, Policy .The policy of the (facility) is zero tolerance of any forms of abuse, neglect, or exploitation

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F 0609

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)
.Supervise staff in such a manner as to identify inappropriate behaviors such as rough handling of residents, identifying escalating aggressive behavior from residents, or imposed seclusion .Ensure that each employee understands that he or she is obligated to report knowledge of potential abuse or neglect of a resident to his or her immediate supervisor. vi. Ensure that each employee understands that individuals who fail to report abuse may be subject to penalties by the state .Occurrence Reports will be reviewed by the Administrator and Director of Nursing or designee to identify possible occurrences of abuse. iii. All occurrences/accidents of unknown origin will be investigated. iv. Employees are required to report all occurrences of possible abuse, mistreatment, or neglect of any resident and crimes against a resident or misappropriation of a resident's property immediately to their supervisor or Senior Staff Member .v. The supervisor or Senior Staff Member shall immediately report to the Administrator or person on call .G. Reporting of Abuse .Neglect-the failure to provide goods and services necessary to avoid physical harm or mental anguish. Neglect is the failure to provide the necessary treatment .or medical services by a caregiver . Review of Registered Nurse (RN) Q's Employee Action Form dated 2/6/20 revealed, Please thoroughly explain details .On the afternoon of 02/03/2020, Nurse (RN Q) was observed discarding a narcotic ([MEDICATION NAME]) (antianxiety medication) for (Resident #108) which she had documented on the narcotics sign-out sheet as administered that morning. She documented in the Electronic Health Record (E.H.R.) that resident refused the medication (which had not been offered,) and did not notify the physician that the medication was not administered. On the afternoon of 02/05/2020, the narcotics count was did (sic) not reconciled during shift-change count. Two medications for (Resident #109)-[MEDICATION NAME] (stimulant medication) and [MEDICATION NAME] (pain medication)-were documented by (RN Q) as administered that morning but had not been removed from their cards. (RN Q) was observed to remove both medications from their respective cards, put them into a medication cup, and discard them. She did not document or notify the physician that the medications were not administered. On the morning of 02/06/2020, (RN Q) documented the administration of [MEDICATION NAME] (antianxiety medication) to (Resident #110), but then stated in report that resident had refused all meds. She did not document his refusal and did not notify the physician .Action Taken .Termination. Resident #110 Review of a Face Sheet revealed Resident #110 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #110's February 2020 Medication Administration Record [REDACTED].Three Times Daily . In the box for February 6th for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #110's Narcotic Sheet revealed, [MEDICATION NAME] 0.25 MG TABLET .TAKE 1 TABLET BY MOUTH THREE TIMES DAILY . (Date) 2/6/20 (Time) 0830 (8:30 A.M.) (Amount Given) one. Resident #108 Review of a Face Sheet revealed Resident #108 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #108's February 2020 Medication Administration Record [REDACTED].Two Times Daily . In the box for February 3rd for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #108's Narcotic Sheet revealed [MEDICATION NAME] 0.5 MG TABLET .GIVE 1/2 TAB BY MOUTH TWICE DAILY . (Date) 2/3/20 (Time) 0754 (7:54 A.M.) (Amount Given) one. Resident #109 Review of a Face Sheet revealed Resident #109 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #109's February 2020 Medication Administration Record [REDACTED].Three Times Daily . In the box for February 5th for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #109's February 2020 Medication Administration Record [REDACTED].One Time Daily . In the box for February 5th for 8:00 A.M. RN Q's initials were documented indicating that she had administered the medication. Review of Resident #109's February Narcotic Sheet revealed [MEDICATION NAME] HCL 50 MG TABLET .TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AND TWICE DAILY AS NEEDED . (Date) 2/5/20 (Time) 0740 (7:40 A.M.) (Amount Given) one. Review of Resident #109's February Narcotic Sheet revealed MODAFINIL ([MEDICATION NAME]) 200 MG TABLET .TAKE 1 TABLET BY MOUTH DAILY . 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She signed it out for the correct time but never actually gave it and it was found during count .This is a common occurrence as she did it today with (LPN Y) for (Resident #109) morning narcotics. During an interview on 6/25/20 at 1:33 P.M., RN M reported that she observed the narcotic count between RN Q and LPN Y on 2/5/20. RN M reported that the narcotic count was off and RN Q stated she forgot to administer the medications to Resident #109 but had signed Resident #109's medical chart as though she had administered the medication. RN Q then disposed of the narcotics into the trash. RN M reported that narcotics cannot be disposed of in the trash, so RN M and another nurse disposed of them following the facility policy and procedure. RN M reported it was not the first time RN Q had documented a narcotic was administered and disposed of the narcotic. RN M reported that she notified the PDON C of the concerns but did not know if any incident reports were completed. During an interview on 6/25/20 at 1:33 P.M., LPN Y reported that on 2/5/20, while counting narcotics with RN Q, a narcotic count error was identified. Resident #109's [MEDICATION NAME] and [MEDICATION NAME] were still in the blister medication pack but had been signed out as though they had been administered. At that time, RN Q popped the medications into a medication cup and disposed of them in the garbage. LPN Y reported she notified PDON C of the incident immediately. LPN Y reported that PDON C stated she would complete the incident report and notify the physician. During an interview on 6/25/20 at 8:39 A.M., Nursing Home Administrator (NHA) A reported that after reviewing RN Q's write up dated 2/6/20 she would have reported it to the State Agency. NHA A reported that the incident involving RN Q in February of 2020 was not reported to the State of Michigan by the previous Nursing Home Administrator. During an interview on 6/25/20 at 11:18 A.M., PDON C reported that the incident with RN Q not administering narcotic medications should have been reported to the State Agency. PDON C reported the incident to Previous Nursing Home Administrator (PNHA D) at the time RN Q was written up on 2/6/20. PDON C reported that at that time the only person who had access to turn Facility Reported Incidents to the State Agency was PNHA D. During an interview on 6/25/20 at 10:53 A.M., PNHA D reported if there was an issue with RN Q in February she was not made aware of it. PNHA D reported that if a resident did not receive their prescribed narcotics, she would have reported that to the State of Michigan as misappropriation. Resident #101 Review of a Face Sheet revealed Resident #101 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of an email dated 12/10/19 from LPN I to PDON Z revealed, Here is the statement for (Resident #101). On Thursday 12/5/19, after a care conference, (Resident #101's) daughter (Family Member FM V) reported that (Resident #101) had a complaint about the nightshift CNA (Certified Nursing Assistant). She reported that the CNA told (Resident #101) that she could only use the restroom once at night .On 12/09/19, during a BS (Blood Sugar) (at) 0700 (7:00 A.M.), res(ident) was weepy and upset. Res(ident) stated her complaint unprompted. She reported to CN (nurse) that she was left on the toilet for a long period of time and called for help but no one came .She said that the girl had told her she was only allowed to go once during the night, and she did not understand the rule .CN reported to DON and completed morning med pass and returned (at) 0935 (9:30 A.M.) to get more information. Review of an email dated 12/10/19 from FM V to PDON Z revealed, According to my recollection, when I .visited her (Resident #101) on Wednesday December 4, 2019, she told me about a bathroom issue that she had the previous night .The same aide came but refused to take her indicating to (Resident #101) that she could only go once. On December 5, there was a conference concerning (Resident #101), attended by the social worker, physical therapist, and nurse. I mentioned this incident to the nurse, (LPN I), in the hallway after the conference. She said that she would investigate it . Review of Phone Interview with (FM V), Daughter of (Resident #101) dated 12/11/19 revealed, At 6:43pm, (FM V), daughter of (Resident #101), contacted (PNHA AA) regarding concern. (FM V) stated she was confused when she spoke to (PDON Z) regarding the date of the concern. She initially thought it was December 4th when (Resident #101) shared to (FM V) her concern regarding care. After thinking it over more, she now believes the concern was brought forward initially on Monday, December 2nd .(FM V) believes it was December 2nd because she repeated the concern on December 4th prior to the care conference .Writer asked (FM V) if she had reported this concern to any staff and she stated yes, she told a certified nurse aide on 12/2/19 .FM V also stated that she shared the concern to nurse (LPN I) on Thursday, December 5th after the care conference . During an interview on 6/25/20 at 1:39 P.M., FM V reported that early in December (she could not remember the exact date) she notified a CNA of the concerns and also a Nurse that Resident #101 had regarding being told she could only use the bathroom [ROOM NUMBER] time a night. FM V reported that at that time there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235614	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COVENANT VILLAGE OF THE GREAT LAKES	**2520 LAKE MICHIGAN DRIVE NW GRAND RAPIDS, MI 49504**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) was no further follow up. FM V reported that she sent an email on 12/10/19 regarding the concern that Resident #101 had reported. FM V reported that after the facility staff was notified the second time of Resident #101's concern they took action. Review of the Facility Reported Incident dated 12/9/19 revealed, Resident Name: (Resident #101) .Cognitive Status: Independent .BIMS Score: (Brief Interview for Mental Status) 13 (Indicating Resident #101 was cognitively intact .(PDON Z) and and (sic) HR (Human Resources) Director (name omitted) provided a written disciplines to nurse (LPN I) and certified nurse aide (CNA J) for not following the Abuse Prevention and Reporting Policy. Staff re-educated on Abuse Prevention and Reporting policy on 12/12/19. Staff will continue to receive re-education on the abuse prevention and reporting policy. During an interview on 6/24/20 at 9:58 A.M., RN T reported that any allegation of abuse is immediately reported to the Administrator and/or the Director of Nursing. During an interview on 6/25/20 at 10:53 P.M., LPN R reported that any form of abuse is immediately reported to the Administrator.