STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235614	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Village of the Great Lakes	2520 Lake Michigan Drive NW Grand Rapids, MI 49504

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility.Findings include: On 3/24/26 at 1:14 PM, a review of the facility provided document entitled Legionella Policy, dated 12/21/2022, found that the the Water Management Program will be reviewed at least once a year . The document also states that, .our facility has a water management program, which is overseen by the water management team. A review of the provided document entitled Water Management Program, dated September 2020, found multiple Water Management Plan Team members that are former employees of the facility. A further review of the program found under the heading Control Measures - Domestic Water, found control measure DWM06 is to Monitor disinfectant level in the water supply and distal faucets. On 3/24/26 at 3:30 PM, an interview with Maintenance Supervisor (MS) JJ found the control limits are completed as they come up in their maintenance system, but the vendor is the one who takes the samples and would have the updated documents. MS JJ stated he would reach out to the vendor for additional documentation.On 3/26/26 at 7:32 AM, an email was sent to MS JJ requesting additional documentation.On 3/26/26 at 8:17 AM, a reply email from MS JJ found the facility would be educating staff and reinstituting the free chlorine monitoring.On 3/26/25 at 12:35 PM, a reply email from the Nursing Home Administrator (NHA) was received with documents showing work orders on maintaining the chlorine residual in the cooling towers, but no documentation showing tests done for free chlorine residual from the domestic water supply used by residents. A review of the updated document entitled Water Management Plan dated March 24th, 2026, found only two team members listed (one vendor contact and one facility staff) when their Legionella Policy states that: The water management team will consist of the following personnel: a. Facilities Maintenance Co-Lead, b. Infection Preventionist Co-Lead, c. Healthcare Administrator, d. Director of Nursing, e. Medical Director (or designee);.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop a person-centered baseline care plan for 1 (Resident #46) of 12 residents reviewed for person-centered baseline care plan resulting in the potential for unmet care needs.Findings include:Resident #46Review of a Face Sheet revealed Resident #46 was a female who was admitted to the facility on [DATE] and had pertinent diagnoses which included: centrilobular emphysema (a chronic condition that causes shortness of breath), chronic respiratory failure, and dependence on oxygen.On 3/24/26 at 1:24 PM, Resident #46 was observed sitting in her bed, with a nasal cannula (a device that delivers extra oxygen through a tube into the nose) present in her nose, with an oxygen concentrator (machine that draws in air, filters out nitrogen, and delivers a steady stream of oxygen-enriched air) running at 2L (liters). Resident #46 appeared to be short of breath.In an interview on 3/25/26 at 10:41 AM, Resident #46 was sitting in her bed with a nasal cannula present in her nose and the oxygen concentrator running at 2L. Resident #46 reported she always wore oxygen, even in the shower. Resident #46 reported when she did not have the oxygen, she was very winded and was not able to do anything until she caught her breath again.On 3/25/26 at 9:00 AM, Resident #46 was observed sitting in her bed with a nasal cannula present in her nose and the oxygen concentrator running at 2L. Resident #46 reported she had a chronic lung condition, and she had to always wear oxygen. Resident #46 reported she had her machine (oxygen concentrator) set at 2L at home, but she would adjust the dial if she needed more when she was moving around. Review of March 2026 Physician Order Sheet for Resident #46 revealed .Oxygen (O2) at 2 L/min (liters per minute) per nasal cannula Notes 2L continues, 4 L with activity, titrate (continuously measure and adjust the balance) to 1 L. with an order date of 3/20/2026.Review of Nursing admission Evaluation-Respiratory for Resident #46 dated 3/20/26 revealed Rhythm: labored; oxygen therapy: yes.In an interview on 3/25/26 at 1:35 PM, Certified Nurse Assistant (CNA) R reported each resident has a resident care summary that the CNAs can review that provides specific instructions for providing resident care. CNA R reported Resident #46 does wear oxygen, but she was unsure of the liter flow rate. CNA R reported the information would be in the resident care summary. When queried, CNA R reported she did not have access to review physician orders for residents.Review of Resident Care-Touchscreen Summary for Resident #46 reviewed on 3/26/26 revealed .Toileting -care oxygen @ (at) 4L for activity & (and) 2L at rest. Review of Baseline Care Plan for Resident #46 reviewed on 3/25/26 revealed .Resident receives the following services: Oxygen. There were no interventions noted.Review of Care Plan for Resident #46 reviewed on 3/25/26 revealed Problem.Nursing - Respiratory Status: No noted problem was listed. Goals: Resident #46 will be free of respiratory distress: Active. There were no interventions noted.In an interview on 3/26/26 at 10:41 AM, Registered Nurse (RN) G reported baseline care plans are within the admission assessment section of the medical records. RN G reported oxygen use was not part of the baseline care plan. RN G reported baseline care plan topics were pre-determined within the computer program and did not include a respiratory specific care plan. RN G reported the admitting nurse would enter a physician order for oxygen use for a resident, but CNAs do not have access to review physician orders. RN G reported if a resident's needs were not on the resident care summary, a CNA would not have access to the information. RN G reported CNAs would need specific information regarding a resident's oxygen needs because CNAs exchange portable oxygen tanks, and the liter flow rate would need to be set. In an interview on 3/26/26 at 11:39 AM, Clinical Reimbursement Manager/Registered Nurse (CRM/RN) M reported baseline care plans have 4 main topics ADLs (activity of daily living), fall risk, pain, and nutrition and should be created by the admitting nurse. CRM/RN M reported she added additional information to the baseline care plan to create the comprehensive care plan, and she had 14 days to complete the care plan. CRM/RN M reported respiratory status and oxygen use would need to (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be put directly on the resident care summary. CMR/RN M reported a resident's oxygen use would be important information for the nursing team to know; it would be part of the resident's daily needed care. CMR/RN M reported she was out of the office when Resident #46 admitted to the facility and the team was ?still learning that piece' when queried about who covered her role in her absence. CMR/RN M reported Resident #46's care summary indicated she used oxygen, but no specifics were mentioned. Additionally, CMR/RN M confirmed Resident #46's respiratory care plan did not have any interventions listed.In an interview on 3/26/26 at 12:32 PM, Director of Nursing (DON) B reported CRM/RN M was responsible to create a baseline care plan for a resident within 48 hours of admitting to the facility, and the baseline care plan would include basic information about how to care for a resident. DON B reported oxygen use would be a physician order and added to the resident care summary.In an interview on 3/26/26 at 12:36 PM, Assistant Director of Nursing (ADON) S reviewed the care plan for Resident #46 and confirmed there were no interventions related to her oxygen use. ADON S reviewed Resident #46's resident care summary and reported she had added .Toileting -care oxygen @ 4L for activity & 2L at rest. and it did appear oxygen use was only during toileting; however, the resident required the adjusted oxygen use at all times.Review of facility policy Care Plans - Baseline with a date of March 2022 revealed .a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident.the baseline care plan includes instructions needed to provide effective, person-centered care of the resident.initial goals based on admission orders.physician orders.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to revise a person-centered care plan for 1 resident (Resident #7) of 12 residents reviewed for care plan revision resulting in an inaccurate reflection of the resident's current care needs. Findings include:Resident #7(R7)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R7 admitted to the facility on [DATE] with pertinent diagnoses including depression, anxiety and history of COVID. Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R7 was cognitively intact.During an observation on 3/24/2026 at 10:02 AM, it was noted that there was no contact precaution signs or enhanced barrier precaution signs outside R7's door or inside the room.During an interview on 3/24/2026 at 10:08 AM, R7 stated that she was sick earlier this month with an infection but she was feeling better now.Review of R7's progress note dated 2/24/2026 revealed .Nurse Practitioner II into eval (evaluate) resident's culture and sensitivity (diagnostic procedure to identify infectious germs from body samples and determine the most effective antibiotic medication to treat it) with new order to d/c (discontinue) previous antibiotic and to start nitrofurantoin for tx (treatment) of UTI (Urinary Tract Infection).Contact precautions initiated.Review of R7's progress note dated 2/28/2026 revealed Resident (R7) continues on antibiotics for UTI without side effects noted. Resident (R7) continues on isolation.Review of R7's progress note dated 3/1/2026 revealed . Resident (R7) continues on contact isolation till (until) tomorrow.Review of R7's Care Plan revealed Problem: Isolation-Contact Isolation-Due to ESBL (Extended spectrum beta lactamase enzymes are produced and can cause severe infection) in urine. Status: Active (Current). Goal: No cross contamination to visitors and employees by March 5. Status: Active (Current). Goal date: 5/25/2026.Intervention: Follow transmission-based precautions. Problem: Infection (R7) has active infection in urine. Status: Active (Current). Interventions.Personal Protective Equipment if indicated. Status: Active (Current).During an interview on 3/26/2026 at 10:10 AM, Assistant Director of Nursing (ADON) who was also the Infection Preventionist (IP) S stated that R7 had ESBL in her urine and was under contact precautions until 3/2/2026. ADON/IP S said that R7 was no longer under contact precautions since her infection was resolved. ADON/IP S also stated that the contact isolation and active infection in urine care plans should have been deleted/resolved. ADON/IP S said that Minimum Data Set (MDS) nurse M was the main one doing nursing care plans and now Director of Nursing (DON) B and her were helping out. During an interview on 3/26/2026 at 10:37 AM, MDS M stated that she initiated nursing care plans and then ADON/IP S and DON B help with updating them. MDS M said she tries to update care plans when changes occur and to resolve care plans but if she didn't catch it right away, she updated them at the quarterly review. During an interview on 3/26/2026 at 10:52 AM, Nursing Home Administrator A was told that the infection care plans for R7 weren't updated and she nodded.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent the development and worsening of pressure ulcers in 2 residents (Resident #13 and Resident #43) of 2 residents reviewed for pressure ulcers resulting in the development of a facility acquired pressure ulcer for Resident #13 and the potential worsening of an existing pressure ulcer for Resident #43.Findings include:Review of a Face Sheet revealed Resident #13 was a female, with pertinent diagnoses which included: other abnormalities of gait and mobility, difficulty in walking not elsewhere specified, other lack of coordination, and pressure area of left buttock stage 3 (full thickness skin injury with exposure of subcutaneous [under all the layers of the skin] fat). Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 2/11/26 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #13 was moderately cognitively impaired. Further review of said MDS revealed Resident #13 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) for Roll left and right (The ability to roll from lying on back to left and right side, and return to lying on back on the bed.) and sit to stand (The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.) Review of a Wound Care note dated 2/24/26 revealed, .Chief Complaint/Nature of Presenting Problem: Wound on left buttock History Of Present Illness: (Resident #13) is seen today because staff noted a new wound on her left buttock. At this time (Resident #13) is sitting in her wheelchair in her room. She admits that the wound is a little painful. She offers no other complaints today.WOUND 1 Type: Pressure Location: Left buttock Size (cm) (centimeter): 0.8x0.9x0.1cm Base: 100% granulation (pink-red moist tissue filling an open wound as it begins to heal) Stage (Pressure): Stage 3.Plan:.Resident has an APM (alternating pressure mattress) mattress and a pressure relieving cushion in her wheelchair, staff to continue to assist resident with frequent turning when in bed, advised resident that she should lay down a couple of times during the day to help get pressure off her bottom. Review of Resident #13's Resident Care – Touchscreen Summary (a document directing the care of the resident for the nursing staff) prior to the development of the stage 3 pressure ulcer on her left buttock on 2/24/26 revealed, .Precautions – Skin Pressure reducing seat cushion Float heals (sic) Heel protectors – Right Heel protectors – Left. Review of Resident #13's Resident Care – Touchscreen Summary after the development of the stage 3 pressure ulcer on her left buttock on 2/24/26 revealed, .Precautions – Skin Pressure reducing seat cushion Special mattress Float heals (sic) Heel protectors – Right Heel protectors – Left Proper positioning Other (describe) turn q (every) 2 hours and lay in bed in between meals. In an interview on 3/25/26 at 10:08 AM, Licensed Practical Nurse (LPN) Q reported prior to the development of Resident #13's stage 3 pressure ulcer on her left buttock, pressure ulcer preventative interventions included 2 hour turns (reposition every 2 hours) and with her incontinence care. LPN Q reported Resident #13 did not want to lay down in her bed and would sit up in her chair a lot of the day. LPN Q reported now we have it so she will lay down after meals. LPN Q did not address how the facility performed offloading from the wheelchair if the resident chose to not lay down. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/25/2026 at 10:12 AM, Certified Nurse Aide (CNA) F reported prior to the development of Resident #13's stage 3 pressure ulcer on her left buttock, pressure ulcer preventative interventions included putting a wedge cushion underneath Resident #13 while in bed to keep her off her bottom. CNA F reported the facility was also using barrier cream on her bottom. CNA F reported sometimes Resident #13 would refuse repositioning and sometimes she didn't want to lay down because she wanted to attend activities. CNA F reported Resident #13 also wears pressure relieving boots while in bed to prevent pressure ulcers on her heels. CNA F did not address how the facility performed offloading from the wheelchair if the resident chose to not lay down. In an interview on 3/25/26 at 10:18 AM, Director of Nursing (DON) B reported Resident #13's stage 3 pressure ulcer on her left buttock was determined to be from pressure and the facility assumed it was from sitting. DON B reported Resident #13 sometimes refused to lay down to get pressure off of her bottom. DON B reported Resident #13 liked to sit in her chair. DON B did not address how the facility performed offloading from the wheelchair if the resident chose to not lay down. In a follow up interview on 3/25/26 at 10:55 AM, DON B was queried as to what interventions were in place prior to the development of Resident #13's stage 3 pressure ulcer on her bottom to prevent a pressure ulcer from developing. DON B reported Resident #13 had a cushion on her wheelchair and staff encouraged her to reposition, which Resident #13 would do. DON B reported other than repositioning and the cushion, that was what the facility was doing when Resident #13 was in her wheelchair. DON B reported the repositioning would be documented in the electronic medical record. In an interview on 3/25/26 at 10:51 AM, Resident #13 reported the staff would come in and offer to reposition her when she was in bed and get her off her bottom. Resident #13 reported she liked to be in her chair after meals. Resident #13 reported she wouldn't refuse to lay back down after meals because it doesn't matter to her where she is. Resident #13 did not report facility staff would help her with removing pressure while seated in her wheelchair. In a follow up interview on 3/25/36 at 2:02 PM, CNA F reported there was not a place in the electronic medical record to document that a resident was turned and repositioned. CNA F was queried as to what interventions the facility implemented to prevent pressure injury for Resident #13 since her preference was to sit in her wheelchair a lot of the time. CNA F reported the facility had put a cushion on her wheelchair, but she would not have been repositioned in her wheelchair because she had a regular wheelchair and queried how could you reposition them in a regular wheelchair? CNA F reported they did remind Resident #13 to shift in her wheelchair. CNA F reported Resident #13's preference was to stay up in her wheelchair in the afternoon after lunch to play BINGO. In an interview on 3/25/26 at 3:23 PM, CNA D reported until Resident #13's stage 3 pressure ulcer on her left buttock appeared, staff were turning and repositioning her every 2 hours but if Resident #13 wanted to be in the wheelchair, she was in the wheelchair. CNA D reported there was nowhere to document turning and repositioning of the resident. CNA D reported sometimes Resident #13 refused to get out of her wheelchair. CNA D did not address how the facility performed offloading from the wheelchair if the resident chose to not lay down. In a follow-up interview on 3/26/26 at 8:38 AM, Resident #13 reported since the stage 3 pressure ulcer developed on her left buttock, staff were making sure that she lay down after meals. Resident #13 also reported they reposition her in bed every 2 hours and they put pillows underneath her to keep pressure off her bottom. Resident #13 was queried as to what other options of treatment or what education did staff provide when she would refuse to lay down to get out of her wheelchair. Resident (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#13 reported she would never refuse to lay down or anything even before her wound developed. In an interview on 3/26/26 at 8:57 AM, CNA O reported they try and lay Resident #13 down after meals and put her on her side to get her off her bottom. CNA O reported when Resident #13 refused to lay down, she tried to educate her that it is important to get off her bottom. CNA O reported Resident #13 is one of the residents that likes to stay up in her wheelchair all day. CNA O reported when Resident #13 would refuse to lay down, she would tell the nurse that she had refused and then the nurse would go and educate Resident #13 and the nurse could then document the refusal in the progress notes. In an interview on 3/26/26 at 9:48 AM, Registered Nurse RN G reported if a resident was at risk for pressure ulcers and they refused to lay down, she would reapproach the resident, but they did have the option to refuse. RN G reported she would educate the resident of the risk of refusal but if they still refused, staff would have to let them stay up and just make sure the documentation was in place in the progress notes to support the refusal. RN G did not address how the facility performed offloading from the wheelchair if the resident chose to not lay down. In a follow-up interview on 3/26/26 at 9:19 AM, CNA F reported that the intervention to lay Resident #13 down after meals happened after she developed the stage 3 pressure ulcer on her left buttock. CNA F reported in the medical field, everybody gets busy and the resident may be up for 3 or 4 hours. CNA F reported she thought Resident #13's pressure ulcer developed because she was staying in her chair too long and being in her wheelchair all day. CNA F reported CNAs did not document refusals of the resident to lay down. In an interview on 3/26/26 at 10:28 AM, Physician's Assistant (PA) GG reported by the time she was made aware of Resident #13's pressure ulcer on her left buttock, it was a stage 3. PA GG reported any event where the resident has pressure to the area, even more than a couple hours, could lead to a pressure injury. PA GG reported even one event when Resident #13 was up in her wheelchair longer than a couple hours could lead to a pressure ulcer. PA GG reported she knew Resident #13 had been reluctant to lay down during the day in the past and had been refusing to lay down. PA GG reported if Resident #13 did refuse, there really is not much the facility could have done. PA GG reported she believed Resident #13's pressure ulcer developed from sitting in her wheelchair. PA GG stated I think it is definitely more of a chair issue and her not wanting to lay down during the day. PA GG did not address how the facility performed offloading from the wheelchair if the resident chose to not lay down. In a follow-up interview on 3/26/26 at 12:18 PM, CNA D reported prior to Resident #13 developing the stage 3 pressure ulcer on her bottom, she did not believe she was encouraged to lay down after meals. CNA D reported Resident #13 sits in the wheelchair so there was not much they could really do. CNA D reported Resident #13 would refuse to lay down when staff encouraged her to lay down and she would just tell the nurse because there was nowhere for CNAs to document the refusal. In an interview on 3/26/26 at 12:35 PM, Former CNA (FCNA) HH reported she did not ever recall that Resident #13 refused to get into bed to get out of the wheelchair. In a follow-up interview on 3/26/26 at 12:49 PM, CNA F was queried what would she do if Resident #13 refused to get out of her wheelchair and lay down. CNA F stated, what else can you do, it is her choice, we leave her in the chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/26/26 at 1:03 PM, Assistant Director of Nursing ADON S reported when a resident refused to get out of their wheelchair and lay down, she would expect staff to reapproach the resident, ask someone else to ask her, and to help the resident to reposition in their wheelchair or stand in the bathroom to take pressure off their bottom. In a follow-up interview on 3/25/26 at 3:18 PM, ADON S was asked for documentation of turning and repositioning for Resident #13 and ADON S reported there was not anything specific in the charting and documentation for CNA charting that confirms that Resident #13 was repositioned every 2 hours. On 3/26/26 at 9:57 AM, Nursing Home Administrator A was requested, via electronic mail, to provide this surveyor with any documentation that (Resident #13) was offered to lay down and refused for the period of 1 month prior to the development of the pressure ulcer. In a follow-up interview on 3/26/26 at 11:30 AM, DON B reported refusals (to lay down) should be documented in the medical record. In electronic correspondence on 3/26/26 at 2:43 PM, NHA A responded to this surveyor's request of 3/26/26 at 9:57 AM with the following response, Unfortunately our system is not set up to document refusals if there is not an order in place, which there wasn't at the time frame requested. I do not have documentation when (Resident #13) was offered to lay down in between meals and she refused to lay down. Review of Resident #13's Care Plan prior to the development of the stage 3 pressure ulcer on her left buttock on 2/24/26 and as provided by the facility revealed the focus of, (Resident #13 is at risk for skin breakdown related to occasional incontinence, impaired mobility r/t (related to) dx (diagnosis) of Parkinson (a disorder of the central nervous system that affects movement, often including tremors) & glaucoma (an eye disorder that damages the optic nerve) & chronic back pain which can affect this as well & needs staff assistance for mobility. (no implementation date) and care planned interventions in entirety which included Calculate calorie needs/fluid requirements. Adjust based on weight, tolerance, and hydration status; Check for incontinence: change if wet/soiled. Clean skin with mild soap and water. Apply moisture barrier; Check skin for areas of redness. Report any changes to the nurse; Dietary Consult; Do NOT massage skin over pressure areas; Keep fluids next to (Resident #13) at all times. Provide cues/assist (Resident #13) to drink fluids with medications and between meals; Monitor laboratory results for abnormal findings.; Nutritional supplements as recommended; Perform complete assessment of skin. Note areas of redness; Elevate/float heels off bed or Heel Protector boots while in bed per (Resident #13)'s preferences; Resident to wear a sports bra to protect breasts from gait belt with transfers.; APM mattress for skin injury prevention (no implementation dates). (Note there was no documentation in the care plan that Resident #13 preferred to stay in her wheelchair and there was not adequate interventions in place for Resident #13 who preferred to sit in her wheelchair for extended periods of time to relive pressure to her buttocks.) According to the National Pressure Ulcer Injury Advisory Panel, Pressure Ulcer Prevention (Black, J. PhD, RN, FAAN), (Resources for Faculty on Pressure Ulcer Prevention - National Pressure Injury Advisory Panel) Nursing Interventions: .Instruct the patient to change position in the chair every hour or more, Stand up if possible. For patients who use a wheelchair for mobility: Use a chair cushion, ask physical therapy for suggestions on which one . Instruct the patient to change position every 15 minutes . Reposition the patient in the chair every 1 hour Resident #43 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235614	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Village of the Great Lakes	2520 Lake Michigan Drive NW Grand Rapids, MI 49504

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Face Sheet revealed Resident #43 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: rhabdomyolysis (a rare and life-threatening condition where your muscles break down and release toxins into your blood and kidneys), muscle weakness, and abnormalities of gait (walking pattern) and mobility. On 3/24/26 at 12:12 PM, Resident #43 was observed laying supine (on her back) in bed. Heel protectors (a boot shaped padded device designed to protect the heels by offloading pressure) blue and orange in color were observed in the reclining chair in the room. Resident #43's heels rested directly in contact with the mattress of the bed. When queried, Resident #43 replied I have no idea what is supposed to happen with those boot things. Review of Wound Care provider noted for Resident #43 dated 3/24/26 revealed .Hospital records indicate wounds present on her back, bottom and left elbow.on admission to facility noted wounds to both elbows, her back and her bottom. Wound 1 Type: pressure Location: Left buttock.Wound 2 Type: pressure Location: coccyx. Wound 3 Type: pressure Location Right elbow.Wound 4 Type: pressure Location Left elbow. Additional Wounds Section: Wound 5 pressure left heel 5.0 x 3.0 cm non-blanchable (refers to skin redness that does not fade when pressure is applied, indicating a potential tissue damage and compromised blood flow) purple discoloration DTI (deep tissue injury) no drainage peri-wound (around the wound) skin intact.Wound 6 pressure Right heel 1.5 x 4.0 cm non-blanchable purple discoloration DTI no drainage peri-wound skin intact. On 3/25/26 at 09:10 AM, Resident #43 was observed laying supine in bed. Heel protectors blue and orange in color were observed in the reclining chair in the room, in the same position as observed the day before. Resident #43 was observed sleeping in bed, and her heels rested directly in contact with the mattress of the bed. Review of Nursing admission Evaluation for Resident #43 dated 3/17/26 revealed .Skin color: normal.Pressure injuries to bilateral (both) elbows, left buttock and natal (groove that separates the two buttocks) fold.Wound details: left buttock pressure injury.left elbow pressure injury.right elbow pressure injury.proximal natal fold pressure injury.bilateral heels intact, blanchable, but mushy. Review of Braden Scale Risk Evaluation for Resident #43, authored by Director of Nursing (DON) B dated 3/17/26 revealed .Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitations lead to almost constant friction.Risk level: Very High Risk. Review of Baseline Care Plan for Resident #43 dated 3/19/26 revealed .Resident receives the following services: wound care. There were no interventions noted related to wound care, or pressure injuries. On 3/25/26 at 11:59 AM, Resident #43 was observed laying supine in bed. Assistant Director of Nursing (ADON) S and Registered Nurse (RN) G were observed removing the blanket covering Resident #43, and her heels were noted to be resting directly on the mattress. Heel protectors blue and orange in color were observed in the reclining chair in the room, in the same position as observed earlier that day and the day before. On 3/25/26 at 12:09 PM, RN G removed Resident #43's sock on her right foot, inspected her heel and then applied skin prep wipe (protective wipes used to form a protective barrier that helps preserve (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin integrity). The outer side of Resident #43's right heel was noted to have what appeared to be a large fluid filled blister, purple in color. ADON S was observed visually inspecting Resident #43's right heel, touching and prodding the heel, reapplying her sock and applying the heel protector she retrieved from the reclining chair. RN G then removed the sock from Resident #43's left foot and applied skin prep wipe. Resident #43's left heel was noted to also have what appeared to be a large fluid filled blister purple in color. ADON S was observed also visually inspecting Resident #43's left, heel, touching and prodding the heel, and reapplying her sock and applying the heel protector she retrieved from the reclining chair. Review of Care Plan Report for Resident #43 dated 3/25/26 revealed Resident #43 was admitted with multiple pressure injuries: bilateral heels, elbows, and sacrococcygeal area.Goal.Promote patient's progression of pressure wounds healing.use pillows, pads or wedges to reduce pressure on heals and pressure points. In an interview on 3/25/26 at 1:20 PM, Resident #43 reported she had worn the heel protectors on and off since she was admitted to the facility. Resident #43 stated sometimes they put them on, sometimes they don't. Resident #43 reported she did not wear them that day until the nurse put them on when they looked at her heels, and she did not wear them at all the day before. Resident #43 reported she did not mind wearing the heel protectors, she stated they felt like feet pillows. In an interview on 3/25/26 at 1:35 PM, Certified Nurse Assistant (CNA) R reported she provided morning care to Resident #43 at about 9 am, and she was pretty sure she was wearing her heel protector boots at that time. CNA R reported she applied her heel protectors when she was done with care. In an interview on 3/25/26 at 3:30 PM, CNA K reported Resident #43 did not have any interventions in place for pressure wounds that she was aware of, and she did not wear heel protector boots. In an interview on 3/26/26 at 8:52 AM, CNA O reported she was unsure what interventions were in place for Resident #43 related to pressure wounds, but she did not think she had heel protector boots. CNA O reported if someone had wounds on their heels they would always 'float' them off the bed with a pillow. CNA O reported she had assisted the wound provider on Tuesday, 3/24/26 and knew that purple areas were found on Resident #43's heels that day. In an interview on 3/26/26 at 11:04 AM, RN G reported Resident #43 did not have a baseline care plan related to wounds. RN G reported she was not aware Resident #43 had pressure injuries on both of her heels until she observed them yesterday. RN G reported there should have been interventions in place for prevention of pressure wounds and/or the worsening of existing pressure wounds related to the wounds Resident #43 admitted to the facility with. RN G reported without interventions, the wounds can break down further, could open, and get worse. In an interview on 3/26/26 at 11:39 AM, Clinical Reimbursement Manager/Registered Nurse (CRM/RN) M reported baseline care plans have 4 main topics ADLs (activity of daily living), fall risk, pain, and nutrition and should be created by the admitting nurse. CRM/RN M reported she added additional information to the baseline care plan to create the comprehensive care plan, and she had 14 days to complete the care plan. CRM/RN M reported wound care, or wound prevention was not part of the baseline care plan. CMR/RN M reported a resident's existing wound or wound development risk would be important information for the nursing team to know; if interventions were not in place or staff did not know about a wound, it could get worse. CMR/RN M reported a resident care summary (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would have information regarding a resident's needs for pressure wound interventions. CMR/RN M confirmed Resident #43's care summary indicated she required wound care, but no specific interventions were noted. Additionally, CMR/RN M confirmed she had created Resident #43's that day, and it was a basic pressure injury care plan, and it did not list heel protectors. Review of March 2026 Physician Order Sheet for Resident #43 revealed .Dressing Change, Notes: Pressure injury: Skin prep to bilateral heels, encourage use of heel off loading boots with a start date of 3/25/26.Wound care: Heel Right: Notes Cleanse heel with NS/Wound cleanser, pat dry, apply skin prep to heel, one time daily, ordered on 3/25/26.Wound care: Heel Left: Notes Cleanse heel with NS/Wound cleanser, pat dry, apply skin prep to heel, one time daily, ordered on 3/25/26. Review of Clinical Notes Report revealed .clinical Notes . authored by Director of Nursing (DON) B on 3/17/26. has multiple wounds to bilateral elbows, mid spine, natal fold, and left buttock. Heels are intact, blanchable (refers to skin or tissue that temporarily turns white or pale when pressure is applied and quickly return to its original color once pressure is released; indicating circulation is intact and blood flow is normal to the affected area) but mushy. In an interview on 3/26/26 at 12:42 PM, DON B reported Resident #43's heels were intact but mushy when she admitted to the facility. When asked, DON B reported Resident #43's heels were like 'mashed potatoes with skin over them. DON B reported Resident #43 had heel boots and pillows for offloading. When queried regarding how heel boots were implemented DON B stated we walk down to laundry and grab a pair, we add it to the care summary, the care plan, and we tell the resident what we are doing and why. DON B reported heel boots were put in place for Resident #43 shortly after she arrived. In an interview on 3/26/26 at 12:47 PM, ADON S reported Resident #43's care summary was completed on 3/19/26 and it was noted she had multiple pressure injuries, barrier cream and to be repositioned side to side. ADON S stated there is nothing specific about heels or heel boots. Review of facility policy Prevention of Pressure Injuries with a revision date of April 2020 revealed .review the resident's care plan and identify the risk factors as well s the interventions designed to reduce or eliminate those considered modifiable.Assess the resident on admission.for existing pressure injury risk factors.inspect the skin on a daily basis when performing or assisting with personal care or ADLs (activities of daily living).inspect pressure points.heels.