GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2025

Tara Walton
The Cortland Memory Care & Rediscovery
3736 Vista Springs Ave.
Grand Rapids, MI 49525

RE: License #: AH410400149
Investigation #: 2025A1010028
The Cortland Memory Care & Rediscovery

Dear Licensee:

Attached is the Special Investigation Report for the above-mentioned 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 authorized representative 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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410400149
Investigation #:	2025A1010028
Complaint Receipt Date:	01/23/2025
Investigation Initiation Date:	01/27/2025
Report Due Date:	03/22/2025
Licensee Name:	AHR Northview Grand Rapids MI TRS Sub, LLC
Licensee Address:	Ste. 300 18191 Von Karman Ave. Irvine, CA 92612
Licensee Telephone #:	(949) 270-9200
Administrator/Authorized Representative:	Tara Walton
Name of Facility:	The Cortland Memory Care & Rediscovery
Facility Address:	3736 Vista Springs Ave. Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	03/04/2020
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	56
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not have a service plan when he was admitted to the facility, therefore staff did not know his care needs.	Yes

III. METHODOLOGY

01/23/2025	Special Investigation Intake 2025A1010028
01/27/2025	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
01/27/2025	APS Referral APS referral emailed to Centralized Intake
01/29/2025	Contact - Telephone call made Telephone message left for the complainant, a call back was requested
01/29/2025	Inspection Completed On-site
02/24/2025	Contact - Document Received Received resident service plan and staff progress notes
03/20/2025	Exit Conference

ALLEGATION:

Resident A did not have a service plan when he was admitted to the facility, therefore staff did not know his care needs.

INVESTIGATION:

On 1/23/25, the Bureau received allegations from the online complaint system. The complaint read an unknown male resident did not have a service plan or medications listed in his electronic medication administration record (eMAR). On an unknown date in January 2025, the male resident exhibited physically aggressive behaviors towards staff and attempted to get in a female resident's room. The male resident was transported to the hospital because of his aggressive behavior.

On 1/27/25, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 1/29/25, I left a telephone message for the complainant and requested a call back. As of 3/9/25, I have not received a telephone call back, therefore I was unable to gather additional information.

On 1/29/25, I interviewed the director of nursing (DON) at the facility. The DON reported that on 1/7/25, Resident A was physically and verbally aggressive towards staff and attempted to enter other resident rooms. The DON stated Resident A was transported to the hospital because of the incident that occurred during third shift.

The DON provided me with a copy of Resident A's staff *Progress Notes* for my review. A note dated 1/7/25 read, "resident was heard screaming at 3am, med tech went to go see what was going on, he was found in the next room, med tech tried to redirect resident back to his room but he was unwilling as he started walking down the hall he continued yelling and trying to get intoevery [sic] residents room, he got to room 16 and did not like that I had reached the door handle before him and grabbed my arm and continued to push open the door while still yelling at which point I yelled for help from an RA, resident made his way down to the dining room and kept trying to go out main door when he realized he could not open it he would ram his walker into it, we finally got him to make his way back down toward the rooms while the other behavior started again of the yelling and trying to gointo [sic] rooms, grabbing both med tech and RA arms and hands when he realized he wasnt [sic] hurting us he would squeeze harder. Resident did not have any prns available. Tried reaching out to management calls went unanswered. Finally after over a hour of the behaviors and unsuccessfully redirecting I made the choice to send him out for evaluation as this was very unheard of for him. Notified DON and Family."

The DON explained Resident A transferred from a "sister facility" because he required care and supervision provided in this facility's secured memory care building. The DON reported when Resident A moved to the facility on 1/1/25, a service plan at the time of his admission was not established. The DON reported an "assessment" to develop Resident A's service plan was completed on 1/24/25, several weeks after Resident A admitted to the facility.

The DON stated there was also an issue with Resident A's medications not "transferring over" electronically when he was admitted to the facility on 1/1/25. The DON reported after several attempts to get Resident A's medications "transferred over" from the "sister facility," it was discovered Resident A had to be entered in the facility's eMAR as a new resident. The DON said she was in communication with the facility's contracted pharmacy during this time to resolve the issue. The DON reported the issues was corrected and Resident A's medications were administered as prescribed.

On 1/29/25, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with the DON.

On 1/29/25, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation.

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:	The interview with the DON revealed Resident A was admitted to the facility on 1/1/25. Resident A's service plan was not developed and written until 1/24/25, therefore staff were uninformed regarding his care needs. Resident A exhibited verbally and physically aggressive behaviors on 1/7/25. Staff were unaware of what interventions Resident A required; therefore, he was transported to the hospital. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility's licensee authorized representative on 3/20/25.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

03/10/205

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Lauren Wohlfert Date
Licensing Staff

Approved By:

03/20/2025

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