GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2025

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

RE: License #: AH410400149
Investigation #: 2025A1021054
The Cortland Memory Care & Rediscovery

Dear Diana Billow:

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 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) 335-5985.

Sincerely,
Kimberly Horst

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410400149
Investigation #:	2025A1021054
Complaint Receipt Date:	05/03/2025
Investigation Initiation Date:	05/06/2025
Report Due Date:	07/02/2025
Licensee Name:	AHR Northview Grand Rapids MI TRS Sub, LLC
Licensee Address:	Ste. 300 18191 Von Karman Ave. Irvine, CA 92612
Licensee Telephone #:	(810) 923-4742
Administrator/ Authorized Representative:	Diana Billow
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 had a fall, and responsible parties were not notified.	Yes
Additional Findings	No

III. METHODOLOGY

05/03/2025	Special Investigation Intake 2025A1021054
05/06/2025	Special Investigation Initiated - Telephone interviewed administrator by telephone
05/06/2025	Contact - Document Sent email sent to complainant to inform them of LARA investigation
05/15/2025	Contact - Telephone call made interviewed SP1
07/01/2025	Exit Conference

ALLEGATION:

Resident A had a fall, and responsible parties were not notified.

INVESTIGATION:

On 05/03/2025, the licensing department received a complaint with allegations Resident A had a fall and Resident A's family nor hospice was contacted regarding the fall. The complainant alleged Resident A had a stroke two days later and then passed away. The complainant alleged if the fall had been documented and reported properly, Resident A's family could have had the opportunity to make the choice to have Resident A taken to the hospital for an evaluation.

On 05/06/2025, I interviewed the administrator Diana Billow by telephone. The administrator reported she was not employed at the facility when this event occurred but would obtain Resident A records.

On 05/15/2025, I interviewed staff person 1 (SP1) by telephone. SP1 reported Resident A had an unwitnessed fall on 03/28/2025. SP1 reported the fall occurred on the night shift. SP1 reported Resident A was found on the floor, complained of no pain, and had no injuries. SP1 reported Resident A was assisted back to bed. SP1

reported an internal incident report was completed but there was no documentation that hospice or the family were contacted. SP1 reported that if an incident occurs on night shift, employees will not contact the family because they do not want to wake them up, especially if there are no injuries. SP1 reported the information is to be passed along to first shift for the first shift to contact family. SP1 reported there is no documentation that this information was passed along to first shift or that hospice or the family was contacted. SP1 reported she spoke with Relative A1 on 03/28/2025 regarding this fall. SP1 reported Relative A1 inquired about facility policy after a fall as the family had viewed the fall on the video cameras located in Resident A's room. SP1 reported that the facility policy is to contact the hospice company and family at the appropriate time. SP1 reported Relative A1 reported this did not occur and family contacted hospice regarding the fall. SP1 reported she spoke with Relative A1 soon after this fall and after Resident A had a stroke which was around 04/01/2025. SP1 reported Resident A's family observed Resident A to be standing by her bed, have a physical reaction, and then fall onto the bed. SP1 reported Relative A1 reported understanding that this cardiac event or stroke was not a result of the fall that occurred on 03/28/2025.

I reviewed the facility incident report for fall on 03/28/2025. For notifications there was no documentation that hospice or family was notified. The narrative of the report read,

"Med tech and aid went into residents room for 2 hour check and changes and noticed she as well as her blankets were all on the ground next to her bed. Med tech grabbed vitals and checked her as she was good she seemed fine just wouldn't get up as she continued sleeping the whole observation process. Resident then was assisted with getting into bed."

I reviewed Priority Life Care Incident Reporting Policy and Procedure. The policy read,

It is the policy of Priority Life Care that any incident or occurrence involving a resident, worker, visitor, or vendor, or physical damage to the community property, and/or vehicles is reported in full.
Incident
Any happening or unusual occurrence, which is not consistent with a routine operation of the community or the routine care of a particular resident, resulting in an injury or potential injury to a resident, worker, visitor, or vendor, or physical damage to the community property and/or vehicles. Examples of incident or occurrence which would be reported (not all-inclusive)

- *An incident involving a resident, vendor, or visitor.*
- *Physical damage to community property, or vehicles, including all vehicle accidents.*
- *Any injury or any occurrence which might have a potential adverse effect on any resident, including exit seeking behavior; resident-to-resident contact; a fall; fracture, skin tear, burn or laceration, choking; missed or inaccurate*

medication; suspected abuse; outbreaks of communicable illness; and other similar events.

- *Serious event which are defined as unanticipated death or incident that could have resulted in death or major permanent loss of function, not relating to the natural course of the residence, illness or underlying condition.*

Procedures

- *The staff person who witnesses the event or is first upon the event, is to report to the executive director or the community as soon as possible. The Executive Director will direct and delegate responsibilities to designees as needed for the reports and reporting to Corporate Leaders.*
- *Resident incidents: Complete all information and make appropriate contacts; complete and reports required in the community*
- *Incident Reports are considered part of the confidential record and will be handled according to HIPAA another privacy guidelines. DO NO release incident reports to the public; unless directed to so by Corporate Leaders*
- *All resident incident should be reported to physician or family as soon as possible.*
- *An investigation must be initiated within 24 hours of the current by the executive director, community nurse, or designee.*

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A had an unwitnessed fall on 03/28/2025. However, the hospice company and Resident A's family were not contacted regarding this fall. Therefore, the facility did not follow their own internal policy or Home for the Aged Licensing Rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

05/16/2025

Kimberly Horst Date
Licensing Staff

Approved By:

06/30/2025

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