GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2026

Lynda Sallee
AHR Northview Grand Rapids MI TRS Sub, LLC
Ste. 300
18191 Von Karman Ave.
Irvine, CA 92612

RE: License #: AL410418268
Investigation #: 2026A0583034
The Cortland Lodge

Dear Ms. Sallee:

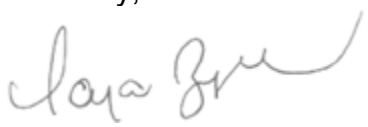
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0100.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410418268
Investigation #:	2026A0583034
Complaint Receipt Date:	04/22/2026
Investigation Initiation Date:	04/22/2026
Report Due Date:	05/22/2026
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:	Lynda Sallee
Licensee Designee:	Lynda Sallee
Name of Facility:	The Cortland Lodge
Facility Address:	3736 Vista Springs Ave NE Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	09/27/2024
License Status:	REGULAR
Effective Date:	03/27/2025
Expiration Date:	03/26/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff failed to seek timely medical treatment for Resident A's fractured hip.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/22/2026	Special Investigation Intake 2026A0583034
04/22/2026	APS Referral APS Kevin Souser
04/22/2026	Special Investigation Initiated - Letter APS Kevin Souser
04/27/2026	Inspection Completed On-site
05/07/2026	Exit Conference Licensee Designee Lynda Sallee

ALLEGATION: Staff failed to secure timely medical treatment for Resident A's fractured hip.

INVESTIGATION: On 04/22/2026 complaint allegations were received from Adult Protective Services (APS) and stated the following, *"(Resident A) (88) resides at the Cortland nursing home (memory care unit). (Resident A) is diagnosed with dementia, arthritis, high blood pressure, congestive heart failure, and anemia. (Resident A) uses a walker to ambulate"* and alleged that *"on 04/20/2026 at 8:00pm, (Resident A) had a ground level fall where she broke her left hip. (Resident A) yelled and screamed in her room for two hours trying to get someone to help her. (Resident A) got herself onto her bed and contacted her son. The facility eventually contacted 911".*

On 04/22/2026 I interviewed APS staff Kevin Souser via telephone. He confirmed that he is assigned to investigate the allegation and attempted to interview Resident A in person at the hospital. He stated that Resident A was unable to complete an interview due to her advanced dementia symptoms.

On 04/27/2026 I completed an unannounced onsite investigation and interviewed administrator Lesa Vandermeer and director of nursing Celina Wilson.

Ms. Vandermeer confirmed that Resident A is currently hospitalized due to a

fractured left hip sustained at the facility on 04/20/2026. She stated that staff Tiana Patterson and Amiyah McGowan were working during the incident. She explained that the facility utilizes the “Safely You” video monitoring system which alerts staff to resident falls by telephoning staff. She stated that according to the monitoring system transcript and video, Ms. Patterson assisted Resident A into bed at 8:04 PM and Resident A fell in her private bedroom at 8:14 PM. She stated that Ms. Patterson was alerted of the fall and located Resident A on the floor at 8:16 PM. She stated that Ms. Patterson left Resident A’s bedroom to obtain assistance from Ms. McGowan who was working at an adjacent facility (AH410400149) and they both transferred Resident A from the floor and into a chair at 8:20 AM. She stated that Ms. Patterson telephoned Ms. Wilson, “Home MD”, and Resident A’s DPOA. She stated that Home MD staff advised Ms. Patterson to send Resident A to the hospital for evaluation and Resident A was diagnosed with a hip fracture. She stated that Resident A also utilizes a “pendant” to alert staff of her needs but failed to use the pendant the night of the incident.

Ms. Wilson stated that she received a telephone call from Ms. Patterson on 04/20/2026 at approximately 8:30 PM indicating Resident A had fallen in her bedroom and was complaining of hip pain. Ms. Wilson stated that she directed Ms. Patterson to contact Resident A’s medical provider “Home MD” and follow their directions.

On 04/28/2026 I received an email from Ms. Vandermeer which contained Resident A’s Assessment Plan, Incident Report, and “Safety You” video transcript.

Resident A’s Assessment Plan, signed 02/27/2026, indicates Resident A requires the assistance of one staff for transfers and bathing.

The Incident Report, dated 04/20/2026, indicates Resident A was located “on the ground” in her bedroom, “yelling” at 8:15 PM by Ms. Patterson. The IR states that Resident A was assessed to have sustained a “small skin tear to left elbow” and expressed level 10 pain in the hip area. The IR indicates Resident A was “wanting to sit up” and was “assisted x2”. The IR indicates that Resident A’s vitals were taken, “provider called”, and “family notified”. The IR indicates Resident A’s “provider” and “family” requested Resident A be sent to “Corewell” for treatment and Resident A was sent via EMS to “Corewell” for treatment. The IR indicated Andrea Sylvester NP was notified at 9:20 PM, Relative 1 was notified at 10:00 PM, Relative 2 was notified at 10:00 PM, and Ms. Wilson was notified at 8:45 PM. The IR indicated that Resident A was sent to Corewell Health for treatment at 10:00 PM.

I observed the “Safely You” video transcript indicates that on 04/20/2026 8:04 PM Resident A was assisted into her bed and staff exited the bedroom. Per the document, 8:14 PM Resident A fell in her private bedroom, 8:16 PM staff enter the bedroom, and 8:20 PM Resident A is transferred off the floor.

On 04/29/2026 I observed “Safely You” video footage of the 04/20/2026 incident. I

observed at 8:14 PM Resident A got out of her bed, walked across her bedroom, and fell onto the floor. I observed Ms. Patterson enter the bedroom at 8:16 PM and Ms. Patterson and Ms. McGowan transferred Resident A into her chair at 8:20 PM.

On 04/30/2026 I interviewed Ms. Patterson via telephone. She stated that she worked independently at the facility 04/20/2026 7:00 PM until 04/21/2026 7:00 AM. She stated that at approximately 8:00 PM she assisted Resident A in her bed and exited the room thereafter. She stated that at approximately 8:14 PM she heard Resident A yelling “help” and immediately found her on the floor of her bedroom complaining of hip pain and bleeding from her arm. She stated she heard Resident A yelling before being alerted of the fall by “Safely You”. She stated that she did not want to move Resident A without assistance. She stated that she left the building, walked outside to The Courtland Rediscovery (AH410400149), and requested assistance from Ms. McGowan. She stated that she and Ms. McGowan re-entered the facility and jointly transferred Resident A from the floor and into her chair at 8:20 PM. Ms. Patterson stated that Ms. McGowan left after the transfer. Ms. Patterson stated that shortly after, she assisted Resident A in her bed. She stated that Resident A continued to complain of hip pain. Ms. Patterson stated that she had “messed up” because she should have called Resident A’s medical provider “right away” but instead allowed Resident A to remain in her bed complaining multiple times of pain while Ms. Patterson “finished med pass”. Ms. Patterson stated that she should have sent Resident A to the hospital sooner given the level of pain and discomfort Resident A verbalized. Ms. Patterson stated that she telephoned Andrea Sylvester N.P. at 10:02 PM, Ms. Wilson at 10:08 PM, “family” at 10:13 PM, and “911” at 10:20 PM. She stated that Ms. Sylvester advised Ms. Patterson to send Resident A to the hospital during the 10:02 PM contact and EMS arrived at 10:30 PM.

On 04/30/2026 I interviewed staff Amiyah McGowan via telephone. She stated that on 04/20/2026 she worked at The Courtland Rediscovery (AH410400149). She stated around 8:00 PM she received a telephone call from “Safely You” indicating Resident A had fallen in her bedroom. Ms. McGowan stated that she immediately facetimed Ms. Patterson who was already aware of the fall and assessing Resident A. Ms. McGowan stated that while on facetime, Ms. Patterson asked her to come to the facility and help transfer Resident A off the floor. Ms. McGowan stated that she walked over to the facility and assisted Ms. Patterson with transferring Resident A into a chair. She stated that Resident A voiced that she was suffering from hip pain. Ms. McGowan stated that she left right after Resident A was seated in her bedroom chair.

On 05/07/2026 I completed an exit conference via telephone with licensee designee Lynda Sallee. She stated that she had nothing to add to the investigation and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.689	**Resident health care.**

	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	I observed “Safely You” video footage of the 04/20/2026 incident. I observed at 8:14 PM got out of her bed, walked across her bedroom, and fell onto the floor. Ms. Patterson entered the bedroom at 8:16 PM and Ms. Patterson and Ms. McGowan transferred Resident A into her chair at 8:20 PM. Ms. Patterson stated that she had “messed up” because she should have called Resident A’s medical provider right away but instead allowed Resident A to remain in her bed complaining multiple times of pain while Ms. Patterson finished passing resident medications. Ms. Patterson stated that she should have sent Resident A to the hospital sooner given the level of pain and discomfort Resident A verbalized. Ms. Patterson stated that she telephoned Andrea Sylvester N.P. at 10:02 PM, Ms. Wilson at 10:08 PM, “family” at 10:13 PM, and “911” at 10:20 PM. She stated that Ms. Sylvester advised Ms. Patterson to send Resident A to the hospital during the 10:02 PM contact and EMS arrived at 10:30 PM. A preponderance does support violation of the applicable rule occurred. Ms. Patterson found Resident A on the floor of her bedroom complaining of pain at 8:16 PM but did not contact her medical provider until 10:02 PM. Resident A was subsequently hospitalized with a hip fracture.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Finding: The facility is insufficiently staffed.

INVESTIGATION: While onsite on 04/27/2026, Ms. Vandermeer stated that 04/20/2026 7:00 AM until 04/21/2026 7:00 PM, staff Tiana Patterson worked at the facility independently with nineteen residents. She stated that all residents require one staff member for all care needs. She stated that staff Amiyah McGowan worked at The Courtland Rediscovery (AH410400149) during the same time frame and The Courtland Rediscovery is located on the same campus. She explained that the facility utilizes the “Safely You” video monitoring system which alerts staff to resident falls by telephoning staff. She stated that according to the monitoring system transcript and video, Resident A fell in her private bedroom at 8:14 PM. She stated that Ms. Patterson located Resident A on the floor at 8:16 PM. She stated that Ms. Patterson requested Ms. McGowan’s assistance transferring Resident A off the floor. She stated that the two staff jointly transferred Resident A from the floor at 8:20 AM.

On 04/28/2026 I received an email from Ms. Vandermeer which contained Resident A's Assessment Plan. I observed Resident A's Assessment Plan, signed 02/27/2026, indicates Resident A requires the assistance of one staff for transfers and bathing.

On 04/30/2026 I received an email from Ms. Vandermeer which indicated that on 04/20/2026 the facility provided care to 19 residents.

On 04/30/2026 I interviewed Ms. Patterson via telephone. She stated that she worked independently at the facility 04/20/2026 7:00 PM until 04/21/2026 7:00 AM. She stated that at approximately 8:14 PM she heard Resident A "yelling help" and immediately found her on the floor of her bedroom complaining of pain. She stated that she observed Resident A was bleeding from her arm and complained of hip pain. She stated that she did not want to move Resident A without assistance. She stated that she left the facility, walked outside to The Courtland Rediscovery (AH410400149), and requested assistance from Ms. McGowan. She stated that she and Ms. McGowan reentered the facility and jointly transferred Resident A from the ground and into her chair at 8:20 PM.

On 04/30/2026 I interviewed staff Amiyah McGowan via telephone. She stated that on 04/20/2026 she worked at The Courtland Rediscovery (AH410400149). She stated around 8:00 PM she received a telephone call from "Safely You" indicating Resident A had fallen in her bedroom. Ms. McGowan stated that she immediately facetimed Ms. Patterson who was already aware of the fall and assessing Resident A. Ms. McGowan stated that while on facetime, Ms. Patterson asked her to come to the facility and help transfer Resident A off the ground. Ms. McGowan stated that she walked over to the facility and assisted Ms. Patterson with transferring Resident A into a chair. She stated that Resident A voiced that she was suffering from hip pain. Ms. McGowan stated that it is common practice for staff to leave their assigned facilities to assist staff at other facilities with transfers and personal care.

On 04/30/2026 I completed a LARA file review and observed that per SI 2025A0357040 10/30/2025, the facility was found to be in violation of R 400.15206 (1) because the facility was insufficiently staffed. A CAP was received and approved on 11/06/2025.

On 05/07/2026 I completed an exit conference via telephone with licensee designee Lynda Sallee. She stated that she had nothing additional to add to the investigation and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a

	resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.**
ANALYSIS:	Ms. Patterson stated that she worked independently at the facility 04/20/2026 7:00 PM until 04/21/2026 7:00 AM. She stated that at approximately 8:14 PM she heard Resident A "yelling help" and immediately found her on the floor of her bedroom complaining of pain. She stated that she observed Resident A was bleeding from her arm and complained of hip pain. She stated that she did not want to move Resident A without assistance. She stated that she left the facility, walked outside to The Courtland Rediscovery (AH410400149), and requested assistance from Ms. McGowan. She stated that she and Ms. McGowan reentered the facility and jointly transferred Resident A from the ground and into her chair at 8:20 PM. Ms. McGowan stated that on 04/20/2026 she worked at The Courtland Rediscovery (AH410400149). She stated around 8:00 PM Ms. Patterson asked her to come to the facility and help transfer Resident A off the ground. Ms. McGowan stated that she walked over to the facility and assisted Ms. Patterson with transferring Resident A into a chair. Ms. McGowan stated that it is common practice for staff to leave their assigned facilities to assist staff at other facilities with transfers and personal care. A preponderance does indicate that a violation of the applicable rule occurred. The facility appeared to be staffed to meet the minimum standards according to this rule. However, when there are incidents such as Resident A's 04/20/2026 fall, staff reported that staff assistance is sought from another facility on the campus, which demonstrates there are not sufficient staff on duty to provide adequate protection to the residents and therefore, a violation of this applicable rule is established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** (SPECIAL INVESTIGATION 2025A0357040)

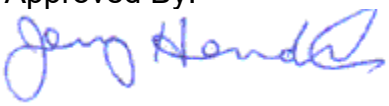
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

05/07/2026

Toya Zylstra — Date
Licensing Consultant

Approved By:



05/07/2026

Jerry Hendrick — Date
Area Manager