GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 27, 2026

Lynda Sallee
The Cortland Holland Meadows
445 104th Avenue
Holland, MI 49423

RE: License #: AH700397994
Investigation #: 2026A1021050
The Cortland Holland Meadows

Dear Lynda 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 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 #:	AH700397994
Investigation #:	2026A1021050
Complaint Receipt Date:	07/22/2026
Investigation Initiation Date:	07/23/2026
Report Due Date:	09/21/2026
Licensee Name:	AHR Holland MI TRS Sub, LLC
Licensee Address:	Ste 300 18191 Von Karman Ave Irvine, CA 92612
Licensee Telephone #:	(949) 270-9200
Administrator:	Maegan Garlock
Authorized Representative:	Lynda Sallee
Name of Facility:	The Cortland Holland Meadows
Facility Address:	445 104th Avenue Holland, MI 49423
Facility Telephone #:	(616) 795-9693
Original Issuance Date:	06/04/2020
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had long call light response time.	Yes
Residents have passed away due to lack of supervision.	No
Facility is not in good condition.	No
Additional Findings	No

III. METHODOLOGY

07/22/2026	Special Investigation Intake 2026A1021050
07/23/2026	Special Investigation Initiated - Telephone interviewed complainant
07/23/2026	Inspection Completed On-site
07/25/2026	Contact - Document Received received additional documents
08/10/2026	Contact-Document Received Received additional documents
08/27/2026	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing. The complainant identified concerns with staffing levels. This was investigated under SIR2026A1021052.

ALLEGATION:

Resident A had long call light response time.

INVESTIGATION:

On 07/22/2026, the licensing department received a complaint with allegations that Resident A had increased call light response times.

On 07/23/2026, I interviewed the complainant by telephone. The complainant alleged that on 07/17/2026, Resident A called Relative A1 because Resident A felt that she was going to pass out and Relative A1 advised Resident A to press her call button for assistance. The complainant alleged that Relative A1 responded to the facility and met Resident A outside. The complainant alleged that during this process, Resident A pushed the call button again with no response. The complainant alleged that Resident A had difficulty exiting the facility due to multiple doors and code needed. The complainant alleged that Relative A1 attempted to contact the facility to inform them that Resident A was being transferred to the local emergency room, but the call was not answered. The complainant alleged that Relative A1 contacted another resident to have that resident inform care staff where Resident A was. The complainant alleged that when care staff contacted Relative A1, they were not aware that Resident A was not in the facility.

On 07/23/2026, I interviewed Maegan Garlock, the administrator at the facility. The administrator reported that she is new to this role and was not at the facility when these events occurred but that she was informed of this situation. The administrator reported that after hours, the internal doors are locked but that Resident A knows the code to exit. The administrator reported that it appears Resident A had difficulty going through the different doors. The administrator reported that on this evening, there was a fall that required two care staff's attention, and another employee was showering a resident. The administrator reported that the calls are forwarded to the telephone that employees carry. The administrator reported that a ticket was placed regarding the after-hours telephone line. The administrator reported this issue has been resolved. The administrator reported the facility had three staff members present on the night of the incident, which meets their staffing ratios.

I reviewed written statement from staff person 1 (SP1). The statement read,

"On Friday 7/17/26 at about 9pm a resident fell out of bed. I took her vitals & checked for injuries. I called (SP2) who was the med tech in AL to help me get the resident up & back into bed. The resident is not mobile- requires a 2 assist with a Hoyer Lift to move her. It took us a little bit of time to get her back into bed. During this time (SP3) who was a CG float was giving resident in AL a shower. Several call lights were going off including (Resident A). After SP2 was done helping me she returned to AL immediately. I was unable to leave MC to help with calls as I was the only staff back there."

I reviewed the schedule for 07/17/2026. The schedule revealed there were three staff that worked the third shift.

I reviewed Resident A's call light response time for 07/17/2026. The report revealed Resident A requested assistance at 8:59pm and the response time was 21.5

minutes. In addition, Resident A requested assistance at 9:08pm and the response time was 28 minutes.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and review of documentation revealed that on 07/17/2026, Resident A requested assistance on two separate occasions, and the wait time was over 20 minutes. Due to the extended wait time, Resident A was privately transported to a local emergency room, and facility staff were not aware of Resident A's whereabouts until caregivers responded to a different resident call for assistance. The facility failed to ensure the safety and protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents have passed away due to lack of supervision.

INVESTIGATION:

The complainant alleged that there have been a few resident deaths over the past weeks. The complainant alleged that there was a memory care resident that was left outside and unattended for approximately 30 minutes on a very hot day.

On 07/23/2026, I interviewed SP4 at the facility. SP4 reported that not many memory care residents go into the patio. SP4 reported if a resident does go into the patio, typically care staff are able to view the resident from the windows.

While onsite, I observed the memory care employees sitting near the windows. The workers were able to view the memory care courtyard. In addition, the courtyard was locked and secure which would prevent memory care residents entering the courtyard without staff awareness.

On 08/10/2026, I interviewed the authorized representative Lynda Sallee by telephone. The authorized representative reported that Resident B did not pass away from heat exposure. The authorized representative reported that Resident B received adequate protection and safety.

On 08/10/2026, I obtained a written statement from Resident B's hospice company. The company reported that on the hot day Resident B, "*was not outside all day. She would go outside very often, sit for a bit, even nap, but the staff was very good about making sure she was in the shade. She would also come and go independently. They put a hat on her at times as well as making sure she had sunscreen on. She had end stage Alzheimer's disease which followed the normal trajectory which is what caused her demise.*"

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	Interviews conducted and observations made revealed lack of significant evidence to support the allegation that Resident B passed away due to lack of supervision while outside.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility is not in good condition.

INVESTIGATION:

The complainant alleged that the facility is not in good condition. The complainant alleged that the facility washing machine has been broken. The complainant alleged that outside patio has little shade with a broken umbrella.

The administrator reported that there was a broken washing machine at the facility, however, there was still a working washing machine. The administrator reported there was a delivery of two new machines that will be installed on 07/24/2026. The administrator reported that she is aware of the broken umbrella and that a new one will be installed soon.

On 07/23/2026, I walked the facility. I observed the new washing machines that were to be installed. I observed the broken umbrella that the administrator moved from the patio so that it would not harm the residents. I walked around inside the facility, and the facility appeared to be in good condition.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observations made revealed the facility has taken steps to ensure the building and equipment is in good condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

08/11/2026

Kimberly Horst — Date
Licensing Staff

Approved By:

08/27/2026

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