GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 10, 2024

Emily Gran
The Cortland Wyoming
2708 Meyer Ave SW
Wyoming, MI 49519

RE: License #: AH410397992
Investigation #: 2025A1010005
The Cortland Wyoming

Dear Licensee:

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) 241-1970.

Sincerely,
Lauren Wohlfert

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 #:	AH410397992
Investigation #:	2025A1010005
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/15/2024
Report Due Date:	12/13/2024
Licensee Name:	AHR Wyoming MI TRS Sub, LLC
Licensee Address:	Ste 300 18191 Von Karman Ave Irvine, CA 92612
Licensee Telephone #:	(949) 270-9200
Authorized Representative/Administrator:	Emily Gran
Name of Facility:	The Cortland Wyoming
Facility Address:	2708 Meyer Ave SW Wyoming, MI 49519
Facility Telephone #:	(616) 288-0400
Original Issuance Date:	12/10/2019
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	147
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was unattended outside on 10/7/24 and fell headfirst over the curb.	Yes
Staff at the facility are not trained.	No

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A1010005
10/15/2024	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
10/15/2024	APS Referral APS referral emailed to Centralized Intake
10/15/2024	Contact - Document Sent Emailed complainant for resident's name and DOB
10/22/2025	Inspection Completed On-site
10/22/2025	Contact - Document Received Received resident service plan and incident report
11/15/2024	Contact - Telephone call received Interviewed the complainant by telephone
11/20/2024	Contact - Document Received Letter from complainant received outlining concerns
12/10/2024	Exit Conference

ALLEGATION:

Resident A was unattended outside on 10/7/24 and fell headfirst over the curb.

INVESTIGATION:

On 10/14/24, the Bureau received the allegations from the online complaint system. The complaint read, “October 7, 2024 [Resident A] was let outside unattended and

fell head first in his wheelchair, over the curb head first and died from his injuries. He had a stroke many years prior so had the chair brake been locked he could not have unlocked the brake."

On 10/15/24, I emailed the complainant to obtain additional information.

On 10/15/24, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 10/22/24, I interviewed the administrator at the facility. The administrator reported Resident A used a wheelchair to ambulate. The administrator stated Resident A was able to propel himself in his wheelchair using one foot. The administrator said Resident A did have weakness on one side of his body due to a stroke he had several years ago. The administrator was unable to recall what side of the body Resident A experienced weakness on. The administrator said Resident A required the assistance from two staff persons to transfer.

The administrator stated Resident A like to propel himself throughout the facility. The administrator reported Resident A also liked to go outside often and sit by the door of the main entrance. The administrator said Resident A was able to go outside unsupervised. The administrator reported Resident A was alert and oriented and could communicate his needs to staff.

The administrator explained on 10/7/24, a visitor entering the building informed staff Resident A fell outside. The administrator reported Resident A's wheelchair was not locked and he fell out of it. The administrator explained the facility's contracted nurse practitioner was present in the building at the time of Resident A's fall. The administrator said the nurse practitioner assessed Resident A immediately after he fell. The administrator explained Resident A's nose was bleeding and he sustained cuts on his face because of the fall.

The administrator reported Resident A was on hospice services and hospice staff were also notified after Resident A fell. The administrator said Resident A died at the facility on 10/14/24. The administrator provided me with a copy of Resident A's incident report dated 10/7/24 for my review. The *Incident Description* section of the report read, "Someone came in from outside and stated that someone was outside on the ground. Two med tech [sic] went outside and seen [sic] that it was [Resident A] that had falling [sic] on concrete, the RCC and maintenance helped put the resident back in his chair. Once resident was back in his wheelchair, he was bleeding from his nose and the left side of his head was a cut, left side elbow and shoulder was scraped, his right leg was bruise [sic] black and green. Brought resident back in and had the in-house nurse took [sic] a look at him to make sure that he was alright, the med tech called hospice to inform them about the fall. Resident unable to give description."

The *Immediate Action Taken* section of the plan read, “Keep an eye out on resident if he [sic] trying to go out.” The report read Resident A’s responsible person was notified of the incident at 3:30 pm on 10/7/24. Resident A’s physician was notified of the incident at 3:35 pm on 10/7/24. The incident report was completed by Staff Person 1 (SP1).

The administrator provided me with a copy of Resident A’s service plan for my review. The *TRANSFERRING* section of the plan read, “Will be able to transfer safely with assistance.” The *COGNITION* section of the plan read, “Demonstrates inappropriate judgement related to safety. Displays deficits in judgment.” The *MOBILITY* section of the plan read, “Will be able to move about the community with assistance. Escort needed to/from activities and or dining room.”

On 10/22/24, I interviewed SP1 at the facility. SP1’s statements were consistent with the administrator and the written incident report that she completed. SP1 reported Resident A’s vitals were stable after he fell, and he was put in bed. SP1 said it was determined by the nurse practitioner and hospice staff that Resident A did not need to be sent to the hospital after the incident.

SP1 said when Resident A went to sit outside, he always stayed by the main entrance doors. SP1 reported it was unknown why Resident A went down the sidewalk away from the main doors where he fell. SP1 stated Resident A fell off the curb on was on the ground off the sidewalk.

On 10/22/24, I interviewed SP2 at the facility. SP2 reported she responded outside to assist Resident A and SP1 when he was found outside on the ground. SP2’s statements regarding Resident A were consistent with the administrator and SP1. SP2’s statements regarding Resident A’s fall on 10/7/24 were consistent with the administrator, SP1, and SP1’s written incident report.

On 11/15/24, I interviewed the complainant by telephone. The complainant reported Resident A was paralyzed on his left side due to a stroke he had several years ago. The complainant stated that due to Resident A’s paralysis on his left side, he was unable to lock the wheels on his wheelchair independently. The complainant said that due to Resident A physical limitations, he should not have been permitted to be outside unattended. The complainant reported as a result, Resident A fell out of his unlocked wheelchair and suffered injuries. The complainant expressed concern that Resident A died because of the injuries he suffered after he fell on 10/7/24. The complainant also expressed concern that the injuries from Resident A’s fall were not accurately outlined in Resident A’s death certificate that the medical examiner completed.

On 11/20/24, I received a letter the complainant wrote outlining her concerns regarding Resident A’s fall on 10/7/24. The complainant also provided previous concerns regarding resident A’s care at the facility, such as his room cleanliness and medications, that occurred prior to his death when a change in facility ownership

occurred. The complainant reported these concerns were addressed with the facility and with coordination from the local ombudsman.

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 interviews with the administrator, SP1, SP2, along with review of Resident A's incident report from 10/7/24, revealed he fell out of his wheelchair while he was outside unattended. Review of Resident A's service plan revealed the amount of supervision and assistance he required was not outlined. The complainant and staff reported Resident A had weakness on one side of his body causing him to be unable to fully operate his wheelchair independently. Resident A also required the assistance of two staff persons to transfer. This information was not outlined in his service plan. Resident A's plan did read he, "Demonstrates inappropriate judgement related to safety. Displays deficits in judgment." The *MOBILITY* section of the plan read, "Will be able to move about the community with assistance. Escort needed to/from activities and or dining room." Resident A's care needs that were outlined in his plan were not consistent with allowing him to be left outside unattended without staff assistance. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff at the facility are not trained.

INVESTIGATION:

On 10/14/24, the complaint read that staff at the facility are not trained.

On 10/22/24, the administrator reported all staff hired at the facility receive training regarding how to provide resident care. The administrator provided me with copies of three random staff persons training documents for my review. SP2, SP3, and SP4's training documents read they completed resident care training, such as dressing residents, assisting residents with ambulation (including using gait belts, and transfer assistance), perineal care for male and female residents, bathing

assistance, range of motion, denture care, and hair care. I observed the staffs' *Competency Checklist* training documents were signed and dated.
On 10/22/24, SP1 reported she completed resident care training when she started at the facility. SP1's statements regarding the training she received were consistent with the staff training documents that I reviewed.

On 10/22/24, SP2's statements regarding the resident care training that she received were consistent with her training documents that I reviewed.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(c) Personal care**
ANALYSIS:	The interviews with the administrator, SP1, SP2, along with review of the staff training documents that I reviewed, revealed staff complete resident care training when they are hired at the facility. Staff must complete their training *Competency Checklist* to ensure they are adequately trained to provide care to residents in the facility. The facility was in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with licensee authorized representative Emily Gran on 12/10/2024.

IV. RECOMMENDATION

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

12/05/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

12/09/2024

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