GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 25, 2025

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

RE: License #: AH410400149
Investigation #: 2025A1010034
The Cortland Memory Care & Rediscovery

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 #:	AH410400149
Investigation #:	2025A1010034
Complaint Receipt Date:	02/20/2025
Investigation Initiation Date:	02/21/2025
Report Due Date:	04/22/2025
Licensee Name:	AHR Northview Grand Rapids MI TRS Sub, LLC
Licensee Address:	Ste. 300 18191 Von Karman Ave. Irvine, CA 92612
Licensee Telephone #:	(810) 923-4742
Authorized Representative/Administrator:	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's care needs were not met by staff.	Yes

III. METHODOLOGY

02/20/2025	Special Investigation Intake 2025A1010034
02/21/2025	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
02/21/2025	APS Referral APS referral emailed to Centralized Intake
02/24/2025	Contact - Telephone call made Message left for the complainant, a telephone call back was requested
02/24/2025	Inspection Completed On-site
02/24/2025	Contact - Document Received Received resident service plan and staff progress notes
03/10/2025	Contact - Document Received Email received from assigned Kent Co. APS worker Leondra Fair
03/25/2025	Contact - Telephone call received Interviewed the complainant by telephone
03/25/2025	Contact - Document Received Email received from Ms. Fair
04/02/2025	Contact – Telephone call made Interviewed Witness 1 (W1) by telephone
04/25/2025	Exit Conference

ALLEGATION:

Resident A's care needs were not met by staff.

INVESTIGATION:

On 2/20/25, the Bureau received the allegations from the online complaint system. The complaint read, “On 10/8/25 we walked into [Resident A’s] room and the overwhelming smell of urine hit us in the face. [Resident A] was laying on an unmade bed (completely bare mattress). The bed was soiled with urine and the pillows looked like they had been taken out of a dumpster. [Relative A1] had been there a couple of days prior and they reported there was feces all over the lid, seat and bowl of the toilet. That was still the case when we arrived as well. So, this had been the case for a solid 2 days. They had told us previously that they needed to lock up her clothing in the closet because she was layering and it was making it harder for them to get her changed.”

On 2/21/25, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 2/24/25, I left a telephone message for the complainant and requested a telephone call back.

On 2/24/25, I interviewed the director of nursing (DON) at the facility. The DON denied knowledge regarding staff leaving Resident A intentionally soiled for long periods of time. The DON reported Resident A has a history of being physically combative during the provision of her care, therefore staff must re-approach her. The DON denied knowledge regarding any complaints received from Resident A’s family or visitors regarding her care.

The DON denied knowledge regarding Resident A’s bedding being intentionally left soiled. The DON reported staff are trained to change a soiled resident and their bedding immediately upon discovery. The DON stated this policy and procedure also applies to cleaning urine or feces off of the floor in a resident room, bathroom, or common area. The DON said there are instances when Resident A does attempt to toilet herself and removes her brief. The DON said all residents in the facility are to be checked on and changed if soiled by staff every two hours. The DON reported residents’ individual toileting needs are also outlined in their service plan.

The DON explained resident bed linens are changed on their scheduled days to bathe. The DON reported resident linens are changed more often as needed. The DON denied knowledge regarding Resident A not having bed linens, or staff intentionally leaving soiled lines on her bed. The DON denied ever seeing soiled linens, or no linens present on Resident A’s bed.

The DON stated Resident A has a history of “layering her clothing,” making it difficult to change her clothing and soiled briefs. The DON reported per Resident A’s family request; Resident A’s clothing is now secured so she cannot “layer” articles of clothing. The DON said Resident A’s family brought in child proof locks for her dresser drawers.

The DON provided me with a copy of Resident A's service plan for my review. The plan read, "Has a behavior problem r/t disease process. Has a history of carrying objects without relative activity ie. Silverware, writing utensils, or other smaller items. Has history of following other female residents throughout community and wandering with intrusive nature. Has history of wearing excessive layers of clothing at one time. Access to clothing items is restricted when unsupervised. Administer medications as ordered after attempting non-medical approaches. Observe for and report to the nurse side effects and effectiveness. If medication is not effective, notify the nurse. Redirect as needed. Provide opportunity for positive interaction, empathetic listening and attention."

The *DRESSING/UNDRESSING* section of the plan read, "Attempts to dress self but may need assistance with appropriateness. Try to only have one shirt or top on. Report any changes in ability to dress/undress to Nurse. Will not dress/undress self if not assisted."

The *TOILETING* section of the plan read, "Needs assistance of one caregiver to change incontinence product. Needs assistance with toileting activities every 2 hrs check and change – she is continent only 50% of the time. Needs regular or frequent cueing assistance to toilet. Uses incontinence products brief) [sic]. Supply and disposal managed by ([sic] resident/family. Dispose of used incontinent products every shift." The *HOME MANAGEMENT* section of the plan read, "LINENS: Bed linen changed on scheduled shower day."

The DON provided me with a copy of Resident A's staff *Progress Notes* for my review. Notes dated 1/1/25, 1/2/25, 1/12/25, 1/25/25, 1/28/25, 2/2/25, 2/7/25, 2/8/25, 2/9/25, 2/10/25, 2/15/25, and 2/18/25 read Resident A refused her prescribed medications. Notes dated 1/7/25, 1/25/25, 1/26/25, 2/1/25, 2/8/25, and 2/18/25 read Resident A was physically and verbally combative during the provision of her care, which included changing her brief and clothing. A note dated 1/10/25 read, met with [Relative A2] and two of her sons this afternoon regarding concern about their mothers [sic] care. They are concerned that the resident is not being changed throughout the day and is soaking her clothes and bedding in urine. Assured the family that we are looking into ways to make it easier to make sure the resident is clean and dry when she does not wish to get washed up or changed and can become combative. We will continue to monitor caregivers and the cares provided to the resident and how often. Will follow up with family to see that care needs are being met."

A note dated 2/16/25 read, "CM had an incident earlier with [Resident B] granddaughter, [Resident B] Family was hanging out in the common area by the dinning [sic] room, and [Resident A] walked up to her family and they greeted her and [Resident A] threw a cotton candy lid at [Resident B] granddaughter."

On 2/24/25, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with the DON. SP1 reported Resident A has gotten physically and verbally combative towards her several times during the provision of Resident A's care. SP1 said as a result, it takes several attempts, and sometimes several staff persons to complete Resident A's care. SP1 reported as a result, it can take a lot of time to change Resident A's soiled brief due to having to re-approach her. SP1 stated there have also been instances when Resident A got urine and feces on her bathroom floor from attempting to toilet herself. SP1 said staff clean the area immediately upon discovery.

On 2/24/25, I interviewed SP2 at the facility. SP2's statements were consistent with the DON and SP1.

On 2/24/25, I interviewed SP3 at the facility. SP3's statements were consistent with the DON, SP1, and SP2.

On 2/24/25, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation. I observed Resident A was well groomed and wore clean clothing. I observed Resident A had clean linens on her bed. I observed the bathroom in Resident A's room was clean. There were no foul odors present.

On 2/24/25, I observed several residents in the common areas in the facility. The residents were well groomed and wore clean clothing. I also observed several resident rooms and bathrooms. The rooms were clean, and the facility was free from any foul odors.

On 3/10/25, I received an email from assigned Kent County APS worker Leondra Fair. Ms. Fair included photographs she received from the complainant in her email. I observed the photographs were from several different dates and documented Resident A with feces on her pants, soiled bedding (including Resident A's bed made with soiled bed linens), soiled laundry left in Resident A's room, and soiled briefs left on the floor in her room and on the countertop in her bathroom. This occurred on several different occasions. Ms. Fair stated she is substantiating her APS case.

On 3/25/25, I interviewed the complainant by telephone. The complainant reported there were several incidents in which the family arrived to visit Resident A and she was observed to be soiled. The complainant stated it is evident staff do not check on and change Resident A every two hours. The complainant also reported finding soiled briefs and laundry left in Resident A's room. The complainant's statements were consistent with the photographs I received from Ms. Fair.

The complainant reported there are cameras in Resident A's room that are monitored. The complainant stated during third shift overnight, no staff checked on Resident A for over six hours. Resident A was not checked on or changed. Resident

A was on the floor at one point during the night, however no staff entered her room to check on her. The complainant said this is not consistent with Resident A's need to be checked on and changed if needed every two hours. The complainant reported this was not the only occasion on which staff did not check on Resident A during third shift. The complainant said there is a hospice order that requires staff to check on Resident A and change her as needed every two hours.

The complainant reported that when Resident A exhibits aggressive behavior, staff often do not attempt to re-approach her, leaving her soiled. The complainant stated on several occasions she changed Resident A's soiled brief when she arrived at the facility.

On 4/2/25, I interviewed Witness 1 (W1) by telephone. W1's statements were consistent with the complainant. W1 reported she also had to change Resident A's soiled brief on several occasions when she arrived at the facility. W1 stated staff did not re-approach Resident A when they knew she was soiled. W1 also said it was evident staff did not follow Resident A's hospice order to be checked on and changed every two hours. W1 because Resident A is still ambulatory, she did not experience skin breakdown. W1 explained if Resident A was sedentary, she would have experienced skin breakdown from not being changed. W1 said Resident A was compliant with her when she changed her brief, she did not become physically or verbally combative.

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 complainant, W1, along with my review of photographs of Resident A wearing soiled clothing on numerous dates, revealed staff did not check on and change Resident A as outlined in her service plan. The witness statements and photographs provided evidence that the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the licensee authorized representative on 4/25/2025.

IV. RECOMMENDATION

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

04/02/2025

Lauren Wohlfert Date
Licensing Staff

Approved By:

04/24/2025

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