GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2025

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

RE: License #: AH410397992
Investigation #: 2025A1021045
The Cortland Wyoming

Dear Emily Gran:

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) 284-9730.

Sincerely,

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 #:	AH410397992
Investigation #:	2025A1021045
Complaint Receipt Date:	03/19/2025
Investigation Initiation Date:	03/20/2025
Report Due Date:	05/18/2025
Licensee Name:	AHR Wyoming MI TRS Sub, LLC
Licensee Address:	Ste 300 18191 Von Karman Ave Irvine, CA 92612
Licensee Telephone #:	(949) 270-9200
Administrator/ Authorized Representative:	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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident B has been found in urine-soaked bed, with no clothes on, and no bedding.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/19/2025	Special Investigation Intake 2025A1021045
03/20/2025	APS Referral complaint was sent from APS; APS not investigating
03/20/2025	Special Investigation Initiated - Telephone interviewed complainant
03/24/2025	Inspection Completed On-site
03/25/2025	Exit Conference

ALLEGATION:

Resident B has been found in urine-soaked bed, with no clothes on, and no bedding.

INVESTIGATION:

On 03/19/2025, the licensing department received a complaint from Adult Protective Services (APS). The APS reporting source alleged on 03/14/2025 and 03/15/2025, Resident B was observed to be sleeping in his bed with no clothes on, there was no linens on the bed, and the bed was covered in urine and fecal matter. The reporting source alleged Resident B's mattress is ruined due to facility staff not putting the mattress pad on the bed.

On 03/19/2025, the licensing department received another complaint with the same allegations.

On 03/24/2025, I observed Resident B at the facility at 9:41am. I observed Resident B to be sleeping in his bed. In Resident B's room, there was a trash bag of bedding. Resident B was covered with a comforter blanket but there were no linens on the

bed. There was a mattress cover on the mattress. Resident B did have a sweatshirt on his body.

On 03/24/2025, I interviewed staff person 1 (SP1) at the facility. I informed SP1 of the condition that Resident B was in, and she appeared to be unaware that Resident B had no bedding on his bed. SP1 reported Resident B must have soaked through the bedding on the night shift. SP1 reported Resident B is incontinent of urine and will soak through many linens. SP1 reported Resident B is reluctant to receive care and will yell at caregivers. SP1 reported it typically takes two staff members to provide care. SP1 reported Resident B is on checks but could not provide the frequency of said checks. SP1 reported she is unsure if there is to be a mattress pad on Resident B's mattress.

On 03/24/2025, I interviewed SP2 at the facility. SP2 reported she is also providing care to Resident B and appeared unaware that Resident B had no linens on his bed. SP2 reported Resident B does require laundry services at least once a day due to incontinent issues. SP2 reported Resident B does require checks but could not say how frequently Resident B is checked on. SP2 reported Resident B is often combative with staff and will refuse care.

On 03/24/2025, I interviewed SP3 at the facility. SP3 statements were consistent with regard to the behaviors of Resident B.

On 03/24/2025, I interviewed administrator Emily Gran at the facility. Administrator reported Resident B is incontinent and will often soak through his bedding. Administrator reported Resident B's family and facility has provided mattress pad protectors and Resident B used to have two. Administrator reported Resident B's mattress has been changed due to incontinent issues. Administrator reported Resident B requires laundry services multiple times a week. Administrator reported Resident B is to be checked on at shift change and throughout the shift. Administrator reported Resident B will often refuse care and is often combative with staff members.

I reviewed Resident B's service plan. The service plan read,

"Home management: Laundry: requires assistance with laundry on scheduled days."

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.

ANALYSIS:	On 03/24/2025, Resident B was observed to be laying in bed with no clean linens on the bed, only a blanket. Interviews conducted revealed Resident B must have soaked through the bedding on third shift, which was hours after Resident B was observed not to have linens on his bed. The facility did not ensure Resident B's linens were washed and the bed was appropriately changed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Interviews conducted revealed Resident B is often combative with staff members and often requires two staff members to provide care.

Review of Resident B's service plan read,

"Resident is resistant to toileting assistance. Needs regular or frequent assistance to bathroom."

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:	Interviews conducted revealed Resident B is resistant to care and will often require increase time of two staff members to provide care. In addition, Resident B is heavily incontinent of urine and requires multiple clothing and bedding changes. Review of Resident B's service plan did not provide these specific details pertaining to the care needs of Resident B nor the frequency of checks Resident B requires.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/25/2025

Kimberly Horst Date
Licensing Staff

Approved By:

03/25/2025

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