GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 6, 2025

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

RE: License #: AH410397992
Investigation #: 2025A1021052
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) 335-5985.

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 #:	2025A1021052
Complaint Receipt Date:	04/30/2025
Investigation Initiation Date:	05/01/2025
Report Due Date:	06/30/2025
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 A's fingernails have not been cut.	No
Resident A refused medications and was combative.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/30/2025	Special Investigation Intake 2025A1021052
05/01/2025	Special Investigation Initiated - Telephone interviewed administrator by telephone
05/02/2025	Contact - Document Received received Resident A's documents
05/06/2025	Contact-Telephone call made Interviewed SP1
05/06/2025	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.

ALLEGATION:

Resident A's fingernails have not been cut.

INVESTIGATION:

On 04/30/2025, the licensing department received a complaint with allegations Resident A's fingernails have not been groomed in weeks and are so sharp that she has cut herself and others.

On 05/01/2025, I interviewed the administrator Emily Gran by telephone. The administrator reported Resident A is a picker and picks at herself. The administrator reported caregivers are to cut Resident A's fingernails but at times Resident A will refuse for caregivers to provide care.

On 05/06/2025, I interviewed staff person 1 (SP1) by telephone. SP1 reported care staff are to provide nail care while providing basic hygiene. SP1 reported at times Resident A can be very combative and resistant for caregivers to provide care. SP1 reported Resident A is very restless. SP1 reported if caregivers sit down and communicate to Resident A, then Resident A will be more receptive to receiving care.

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

"Is resistive to care. Encourage as much choice and independence as possible during care activities. If unable to provide self-care, engage in sensory bridging. If you meet resistance with ADLs: stop, ensure safety, and resume/re-approach at a later time. Requires assistance with grooming needs."

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 and review of documentation revealed Resident A can be resistive to receiving care which could contribute to un-groomed nails.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A refused medications and was combative.

INVESTIGATION:

The complainant alleged Resident A refused medications for two weeks. The complainant alleged Resident A was agitated and combative. The complainant alleged Resident A is now hospitalized.

The administrator reported Resident A has chronic health conditions. The administrator reported Resident A has a history of refusing medications. The administrator reported on 04/24/2025, Resident A was seen by the visiting physician for eye issues and eye drops were started. The Administrator reported on this day Resident A was not quite at baseline and was being observed by caregivers. The administrator reported on 04/26/2025, Resident A was not at baseline and was transferred to the local emergency department. The administrator reported Resident

A did not refuse all medications for two weeks. The administrator reported Resident A's physician was not contacted when these medications were refused.

I reviewed Resident A's medication administration record (MAR) for April 2025. The MAR revealed the following:

- Resident A was prescribed Ciprofloxacin Eye Drops and this was refused on 04/25 and 04/26.
- Resident A was prescribed Gabapentin 300mg and this was refused on 04/20-04/26.
- Resident A was prescribed Levothyroxine 50mcg tablet and this was refused on 04/25-04/26.
- Resident A was prescribed Melatonin Tab 3mg and this was refused on 04/20, 04/22, 04/24-04/25.
- Resident A was prescribed Olanzapine Tab 5mg and this was refused on 04/20-04/26.
- Resident A was prescribed Senna 8.6mg and this was refused on 04/20-04/24, and 04/26.
- Resident A was prescribed Sertraline Tab 100mg and this was refused on 04/20-04/24 and on 04/26.
- Resident A was prescribed Sertraline Tab 50mg and this was refused on 04/20-04/24 and on 04/26

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**
ANALYSIS:	Review of facility documentation and interviews conducted revealed Resident A's physician was not notified when Resident A did not receive the prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's MAR revealed Resident A was prescribed Levothyroxine Tab 50mg with instruction to administer one tablet by mouth once a day. Review of Resident A's April MAR revealed staff did not initial that this medication was administered on 04/23 and 04/27.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Review of Resident A's April MAR revealed staff did not initial that this medication was administered on 04/23 and 04/27.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 05/06/2025

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 05/06/2025

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