GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 1, 2025

Lynda Sallee
The Cortland Rediscovery
3736 Vista Springs Ave.
Grand Rapids, MI 49525

RE: License #: AH410400149
Investigation #: 2026A1010001
The Cortland 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 (877) 458-2757.

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 #:	2026A1010001
Complaint Receipt Date:	09/30/2025
Investigation Initiation Date:	10/03/2025
Report Due Date:	11/30/2025
Licensee Name:	AHR Northview Grand Rapids MI TRS Sub, LLC
LicenseeAddress:	Ste. 300 18191 Von Karman Ave. Irvine, CA 92612
Licensee Telephone #:	(810) 923-4742
Authorized Representative/ Administrator:	Lynda Sallee
Name of Facility:	The Cortland 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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	56
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell on 09/25/2025 and broke her hip. Staff did not get Resident A proper medical treatment after she fell.	Yes
Additional Finding	Yes

III. METHODOLOGY

09/30/2025	Special Investigation Intake 2026A1010001
10/03/2025	Special Investigation Initiated - Letter Received email from the administrator on 10/01/2025 regarding the incident. The email was reviewed
10/07/2025	Contact - Telephone call made Message left for the complainant, a telephone call back was requested
10/07/2025	Inspection Completed On-site
10/07/2025	Contact - Document Received Received resident incident report and service plan
10/07/2025	Contact – Document Received Received resident MAR via email from the administrator
10/09/2025	Contact - Telephone call received Message from the complainant received
11/04/2025	Contact – Telephone call made Interviewed the complainant by telephone
11/05/2025	Contact – Document sent Email sent to the complainant
11/07/2025	Contact – Telephone call made I left a message for SP1 and requested a telephone call back
11/10/2025	Contact – Document received I received the video footage from Resident A’s room on 09/25/2025 and 09/26/2025

12/01/2025	Exit Conference

ALLEGATION:

Resident A fell on 09/25/2025 and broke her hip. Staff did not get Resident A proper medical treatment after she fell.

INVESTIGATION:

On 09/30/2025, the Bureau received the complaint. The allegations read, “Resident fell and was left on floor by staff member who does not speak English. She didn’t help [Resident A] or get help. She was on her phone and did not attend to the resident. [Resident A] was eventually moved by staff from the floor to the bed. Resident was not provided EMS or medical care until her family came to the community and demanded she be sent to the hospital. It was determined that [Resident A] had a hip fracture. This was downplayed by the Executive Director.”

On 10/03/2025, I re-reviewed an email I received from the administrator on 10/01/2025. The administrator reported, “I'm checking in to let you know that my DON left the building abruptly on Friday afternoon after giving a three week notice to end on October 10. We had an unwitness fall take place in the building on Thursday night and I am just learning that on Friday morning while I was busy in another building the DON was communicating with this family and they demanded their loved one be sent out for observation. I reached out to the family on Monday morning requesting updates and I'm not getting a return call. Late Monday afternoon I was notified by staff in that building that [Relative A1] came and moved [Resident A’s] belongings out but wouldn't talk to staff. Yesterday, mid afternoon, my assistant received a call on the business line from the family stating the resident would not be back as they were taking her full-time to a skilled nursing facility when asked if they would like to speak to me, they said no. Please reach out if you have additional questions.”

On 10/07/2025, I left a message for the complainant. I requested a telephone call back.

On 10/07/2025, I interviewed the administrator at the facility. The administrator stated she was referring to Resident A’s fall on 09/25/2025 in the email she sent to me on 10/01/2025. The administrator’s statements were consistent with her email that was sent on to me 10/01/2025.

The administrator said she received a telephone call at approximately 9:45 pm from Staff Person 1 (SP1) who was the scheduled medication technician (med tech) on when Resident A fell on 09/25/2025. The administrator reported SP1 informed her that Resident A was observed on the floor by SP2. The administrator stated she instructed SP1 to take Resident A’s vitals and complete a range of motion (ROM)

check on Resident A. The administrator said Resident A is her own person. The administrator reported Resident A's listed responsible person was called by SP1 when Resident A fell on 09/25/2025.

The administrator reported Relative A1 arrived at the facility in the morning on 09/26/2025. The administrator stated Relative A1 "demanded" that Resident A be sent to the hospital. The administrator said Resident A was transported to the hospital at that time. The administrator stated the facility's director of nursing (DON) at the time was speaking with Resident A's family, however the DON "walked off the job" and quit that day. The administrator stated an incident report was completed.

The administrator provided me with a copy of Resident A's incident report dated 09/25/2025 for my review. The *Nursing Description* section of the report read, "At approximately 9:30, [Resident A] was found lying on the floor near the entrance to the bathroom in their room. The resident appeared to have fallen while attempting to walk from the bathroom. The resident was found in a supine position on the floor. Staff responded immediately after hearing a noise and being alerted. Resident never pushed call pendant for help." The *Resident Description* section of the report read, "Resident said she slipped coming from bathroom." The *Description of Action Taken* section of the report read, "The resident was assessed for injuries by medication tech. Minor injuries (scratch on arm) were noted at the time. Resident vitals were checked and recorded. Ther resident was assisted back to chair, with two staff members assisting. The ED and family were contacted."

On 10/07/2025, I interviewed SP3 at the facility. SP3 reported when there is a resident fall, staff are trained to take the resident's vitals, call the DON and the administrator, call the resident's responsible person(s) and their physician, and complete an incident report. SP3 said if the resident hits their head, it is the facility's policy and procedure to send the resident to the hospital for evaluation. SP3 stated she was not present on 09/25/2025 when Resident A fell.

On 10/07/2025, I was unable to interview Resident A as she was admitted to the hospital with a fractured hip due to her fall on 09/25/2025.

On 11/04/2025, I interviewed the complainant by telephone. The complainant reported Resident A's responsible person was not contacted by telephone when Resident A fell on 09/25/2025. The complainant stated Resident A's responsible persons learned of Resident A's fall after video footage of Resident A in her room on 09/25/2025 was reviewed by them. The complainant explained in the video footage, staff are observed entering Resident A's room while she is on the floor in her bathroom. The responding staff persons are then heard calling the facility's administrator. The complainant said the administrator is heard telling staff "to only call her if it is an emergency." The complainant reported staff are then observed transferring Resident A to her bed. The complainant stated Resident A is heard crying out in pain while she is being transferred.

The complainant explained that the video footage of the following morning on 09/26/2025 was observed and showed Resident A crying out in pain again when staff got her up for the day and transferred her to her recliner chair. The complainant stated after viewing the video footage, Resident A's responsible persons went to the facility to check on Resident A at approximately 11:00 am on 09/26/2025. The complainant said Resident A was in pain, therefore Resident A's responsible person demanded staff contact 911 so Resident A could be transferred to the hospital. The complainant stated Resident A was admitted to the hospital with a fractured hip due to her fall on 09/25/2025. The complainant reported staff did not seek appropriate medical attention after Resident A was found on the floor. The complainant said Resident A was in apparent pain after staff got her up off the floor, however staff proceeded to place Resident A in bed. The complainant reported staff continued to transfer and move Resident A after she fell, despite Resident A's audible indications that she was in pain.

The complainant said when emergency medical staff (EMS) staff arrived at the facility at approximately 12:40 pm on 09/26/2025, they discovered Resident A had not been administered her morning medications. On 10/07/2025, I received a copy of Resident A's September medication administration record (MAR) for my review. The MAR read Resident A was not administered her 8:00 am medications on 09/26/2025 because she "was asleep."

On 11/05/2025, I requested the video footage of Resident A from 09/25/2025 and 09/26/2025.

On 11/07/2025, I left a telephone voicemail for SP1. I requested a telephone call back.

On 11/10/2025, I received video footage via email from the complainant of Resident A's room after she fell on 09/25/2025 and the video footage of the morning on 09/26/2025 when staff were assisting Resident A to get up and dressed for the day. In the video footage after Resident A fell on 09/25/2025, SP2 is observed responding to the incident. Resident A is not observed on the floor, due to the camera angle, however Resident A can be heard moaning in pain. In the following video footage clip, SP2 enters the room and can be heard asking Resident A, "are you in pain?" SP2 then tell SP1 she is going to contact the administrator and hospice.

While SP1 is out of the room, SP2 is observed leaving Resident A's bathroom to sit in Resident A's recliner chair in the living area of Resident A's room. While SP2 is sitting in Resident A's recliner chair, she is observed on her cell phone for several minutes while Resident A can be heard moaning in pain from the floor in her bathroom. When SP1 re-enters Resident A's room, she is heard on the telephone with the administrator. The administrator can be heard telling SP1, that "if it is not emergent, text me." When SP1 gets off the telephone with the administrator, she and SP2 are heard getting Resident A up off the floor. Resident A's vitals and range

of motion were not assessed before SP1 and SP2 got her up. SP1 is heard saying Resident A is not on hospice, and she and SP2 continue to get Resident A up to get her in bed.

While SP1 and SP2 are getting Resident A up off the floor, Resident A can be heard clearly expressing pain, however SP1 and SP2 continue to get Resident A up. After Resident A is off the floor, SP1 exits the room and SP2 continues to transfer Resident A to her bed using Resident A's four wheeled walker. While Resident A continues to audibly express pain, SP2 is observed standing Resident A up and transferring her to her bed despite Resident A's clear expressions of pain. While Resident A is in bed, SP2 is observed moving Resident A's legs around to change her pants. Despite Resident A's continued clear expressions of pain, SP2 is observed continuing to move Resident A's legs in a rough manner. SP2 is observed leaving the room after Resident A is in bed and her pants are changed.

The video footage of the following morning on 09/26/2025 shows staff continuing to stand Resident A up and transfer her to her recliner despite her clear and audible expressions of pain.

As of 11/12/2025, I have not received a telephone call back from SP1.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	The interview with the complainant, along with my review of the video footage of Resident A's room on 09/25/2025 and 09/26/2025 revealed staff did not contact emergency medical professionals after she had an unwitnessed fall on 09/25/2025. SP1 and SP2 did not take Resident A's vitals or assess her in any manner before getting her up off the floor. Resident A can be heard audibly expressing pain, however SP1 and SP2 continued to transfer Resident A without seeking medical guidance. Resident A's expressions of pain were ignored by responding staff persons. When resident A was transported to the hospital on 09/26/2025, she was diagnosed with a fractured hip.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
MCL 20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(o) A patient or resident is entitled to adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.**
ANALYSIS:	Review of the video footage of Resident A's room revealed she did not receive adequate and appropriate pain and symptom management as her continued expressions of pain were ignored by responding staff. Staff were observed making Resident A transfer and change her clothing, despite her clear and audible indications that she was in pain. Resident A was not transported to the hospital until her responsible persons responded to the facility and ensured EMS staff were contacted to transport Resident A to the hospital. Resident A was diagnosed with a fractured hip.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 11/04/2025, the complainant reported Resident A's responsible persons were not notified of her fall on 09/25/2025. The complainant explained Resident A's responsible persons learned Resident A fell after reviewing the video footage of her room. Resident A's responsible persons then responded to the facility on 09/26/2025. SP1 is heard calling the administrator after Resident A fell on 09/25/2025. SP1 did not call Resident A's physician or responsible persons.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or

	designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	The interview with the complainant revealed Resident A's responsible persons were not notified when Resident A fell on 09/25/2025. The video footage of the incident revealed SP1 contacted the facility's administrator, but not Resident A's physician or responsible persons. Review of Resident A's incident report revealed Resident A's responsible person(s) or her physician were not named as being notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility's authorized representative on 12/01/2025.

IV. RECOMMENDATION

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

11/12/2025

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Lauren Wohlfert Date
Licensing Staff

Approved By:

11/25/2025

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