STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

January 13, 2025

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

RE: License #: AH410397992
Investigation #: 2026A0627006
The Cortland Wyoming

Dear Mr./Ms. Gran:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH410397992
Investigation #:	2026A0627006
Complaint Receipt Date:	09/09/2025
Investigation Initiation Date:	09/25/2025
Report Due Date:	11/09/2025
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:	Emily Gran
Authorized Representative/	Emily Gran, Authorized Repr.
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	147
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident is neglected by staff, his room is dirty, wears clothes that are soiled, and his skin is breaking down.	No
Additional Findings	No

II. METHODOLOGY

09/09/2025	Special Investigation Intake 2026A0627006
09/25/2025	Special Investigation Initiated - Face to Face
1/14/2026	Exit Conference via email

ALLEGATION: Resident is neglected by staff, his room is dirty, wears clothes that are soiled, and his skin is breaking down.

INVESTIGATION:

On 09/09/2025 the Bureau of Community and Health Systems received a complaint from Adult Protective Services (APS) alleging that Resident A is being neglected by facility staff, his room is dirty, his clothing soiled, his briefs unchanged, and staff members are unresponsive to his calls for assistance.

On 9/25/2025, I interviewed Emily Gran, Executive Director in which care of Resident A was discussed. The Executive Director described Resident A as 82 years old and a 13-year resident of the facility. Resident A has diagnoses that include Diabetes, Depression, and Dysuria with a foley catheter. The Executive Director reported Resident A can be pleasant and cooperative at times but also prone to being demanding, and often refuses personal care, refuses to change clothing, refuses to change soiled briefs and refuses to allow housekeeping to come in and clean. The Executive Director reported knowledge of Resident A recently having mild skin breakdown on his bottom and heels for which hospice implemented heel protectors but no therapeutic mattress yet as hospice documented wanting to observe his skin breakdown on his backside. The Executive Director also reported that resident A has a Hoyer lift for transfers but refuses to use that too.

On 9/25/2025, I went with the Executive Director to Resident A's room for an interview. Resident A was found in bed, alert, pleasantly conversational, using an

iPad and in no apparent distress. His clothing did not appear dirty or otherwise soiled. Resident A reported getting good care, having his call light answered timely and had no complaints to express. Resident A reports that “They haven’t let me out of bed for a couple of months to use my computer.” The call light was activated to test how long it took staff to answer and staff came to the room within 2 minutes. There was a strong smell of urine in the air and a foley catheter with dark urine noted in the bag. The resident’s room was observed to be moderately tidy but had a missing kitchenette sink door with visible dirt on the bottom shelf. The carpeting on the floor also had visible staining. The bathroom had visible dirt in the corners.

On 09/25/2025 I interviewed the Executive Director again regarding what Resident A said about facility staff not letting him out of bed to which the Executive Director responded that Resident A is offered all the care the facility offers but it is frequently and randomly refused. The Executive Director reported her impression that Resident A is depressed and wants to have control over the things in his life that he can control.

On 9/25/2025 I interviewed other Residents and toured their rooms at the facility. Resident B was interviewed and reported receiving good care. Resident B’s room was observed to be clean and tidy. Resident C was a hospice patient and reports receiving good care. Resident C’s daughter was present and had no concerns about the quality of care her mother was receiving from the facility. Resident C’s room was tidy. Resident D Reported no concerns about the care received residing in the facility. Resident D’s room was visibly clean and tidy also. There was no evidence of similar untidiness as was observed in Resident A’s room.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair. **(2) A room shall be provided in the home or on the premises for equipment and furniture maintenance and repair and storage of maintenance equipment and supplies.** **(3) Hazardous and toxic materials shall be stored in a safe manner.**

ANALYSIS:	Based on interviews with Resident A, the Executive Director, other residents, one family member and observations of their respective rooms, there was no evidence of similar patterns of untidiness, soiled clothing, or general neglect of other residents to suggest staff arbitrarily neglect Resident A versus other facility residents. The facility is making services available for Resident A but Resident A is not always accepting of those services.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

I recommend no change in the status of the license.

11/6/2025

Rick Brummette Date
Licensing Staff

Approved By:

01/13/2026

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