



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 28, 2026

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

RE: License #: AH410400149
Investigation #: 2026A1010014
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,

A handwritten signature in blue ink that reads "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 #:	2026A1010014
Complaint Receipt Date:	12/17/2025
Investigation Initiation Date:	12/17/2025
Report Due Date:	02/16/2026
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
Administrator:	Lesa Vandermeer
Authorized Representative:	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?
Staff were not adequately trained to meet Resident A's care needs.	Yes
Resident A's medication was not administered as prescribed.	Yes

III. METHODOLOGY

12/17/2025	Special Investigation Intake 2026A1010014
12/17/2025	Special Investigation Initiated - Letter Emailed assigned Kent Co APS worker Sheena McBride
12/19/2025	Contact - Document Received Email from Ms. McBride received
01/05/2026	Contact - Document Received Email received from Ms. McBride
01/06/2026	Contact - Telephone call made Interviewed Witness 1 (W1) by telephone
01/06/2026	Inspection Completed On-site
01/06/2026	Contact - Document Received Received resident service plan, incident report, and December 2025 medication administration record (MAR)
01/28/2026	Exit Conference

ALLEGATION:

Staff were not adequately trained to meet Resident A's care needs.

INVESTIGATION:

On 12/17/2025, the Bureau received the complaint from Adult Protective Services (APS). The allegations read, "Adequate assistance with ADL's is not provided. Staff are also not maintaining sterile technique for [Resident A's] foley catheter, resulting in multiple recurrent UTI."

On 12/17/2025, I emailed assigned Kent County APS worker Sheena McBride.

On 12/19/2025, Ms. McBride emailed me back and stated she spoke with the facility's administrator. Ms. McBride said the administrator reported staff are being required to complete catheter care training on today's date.

On 01/05/2026, I received an email from Ms. McBride. Ms. McBride said Resident A received hospice care services while she resided in the facility. Ms. McBride reported Witness 1 (W1) informed her Resident A was actively dying on 12/31/2025, however it was decided Resident A would be "emergently moved" out of the facility due to care related concerns. Ms. McBride reported that W1 informed her Resident A's responsible persons decided to move Resident A out of the facility at approximately 5:00 pm on 12/31/2025. Ms. McBride stated Resident A passed away at the facility she was moved to at approximately 5:53 pm on 01/01/2026.

On 01/06/2026, I interviewed W1 by telephone. W1's statements were consistent with Ms. McBride. W1 said staff at the facility were not adequately trained to maintain Resident A's foley catheter. W1 stated that as a result, Resident A experienced frequent urinary tract infections (UTIs). W1 reported unless she had taken initiative, catheter maintenance training would not have been initiated for staff. W1 said there was no formal training for staff regarding catheter maintenance.

On 01/06/2026, I interviewed the administrator at the facility. The administrator stated that Resident A received hospice services with the Care Team. The administrator reported Resident A did experience frequent UTIs and her hospice nurse did associate her UTIs with improper catheter maintenance. The administrator said catheter maintenance training was being initiated with Resident A's hospice nurse, however the training was not conducted because Resident A was moved out of the facility while she was actively dying.

The administrator reported there were communication issues with Resident A's hospice nurse. The administrator stated staff were not informed that Resident A was being moved out of the facility until shortly before she was physically moved out. The administrator said Resident A's hospice nurse was present with Resident A overnight until it was decided she would be moved out of the facility that same day.

On 01/06/2026, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with the administrator.

On 01/06/2026, I interviewed SP2 at the facility. SP2's statements were consistent with the administrator and SP1.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(6) The home shall establish and implement a staff training program based on the home’s program statement, the residents service plans, and the needs of employees, such as any of the following: (c) Personal care.
ANALYSIS:	The interviews with W1, the administrator, SP1, and SP2 revealed Resident A received hospice services and had a foley catheter in place while she resided in the facility. W1, the administrator, SP1, and SP2 reported staff did not receive catheter maintenance training while Resident A resided in the facility. W1 said Resident A experienced several UTIs because her catheter was not properly cleaned or maintained. The facility was out of compliance with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A’s medication was not administered as prescribed.

INVESTIGATION:

On 12/17/2025, the complaint read, “The facility is not providing [Resident A] medications when they are ordered by hospice. The facility staff are also not taking her blood pressure despite it being ordered by hospice.”

On 12/19/2025, Ms. McBride reported a medication error regarding Resident A’s prescribed Ativan did occur. Ms. McBride stated she was in communication with the facility’s administrator and was gathering information regarding the incident.

On 01/06/2026, W1 stated staff did not administer Resident A’s medications as prescribed by Resident A’s hospice provider. W1 explained Resident A’s prescribed Ativan was discontinued, however staff did not remove the medication from the cart and therefore continued to administer it. W1 said the Ativan was administered for two weeks after it had been discontinued.

W1 reported Resident A also had prescribed as needed pain medications to be administered while she was actively dying. W1 said staff were instructed to administer the medications to Resident A every hour as she was transitioning for comfort measures. W1 stated staff were unable to “understand how to observe

[Resident A's] signs and symptoms of discomfort and when to administer [Resident A's] as needed pain medications for comfort.”

On 01/06/2026, SP1 stated there was a medication error regarding Resident A's discontinued Ativan that occurred in December 2025. SP1 reported an incident report was completed. SP1 said SP3 observed Resident A's discontinued Ativan was still in the medication cart. SP1 reported SP3 did not verify the medication in Resident A's medication administration record (MAR) before administering it. SP1 said SP3 was re-educated on medication administration because of this error.

SP1 provided me with a copy of Resident A's incident report dated 12/12/2025 for my review. The *Incident Description* section of the report read, “Resident was administered Lorazepam 0/5mg without active medication order. Order for lorazepam was discontinued on 12/4/25.” The *Immediate Action* section of the report read, “Resident observation with no adverse effects noted. Corrective counseling for staff member along with additional education for all med techs. Hospice RN onsite 12/12/25 at approx. 9:30am. All medications verified by Hospice RN and writer, discontinued medications removed and destroyed.”

SP1 emailed me a copy of SP3's *Performance Improvement Plan* that was dated 12/12/2025 for my review. The *Facts and events leading to this counseling session* section of the document read, “On 12/12/25 at approx. 12:00am, [SP3] administered Lorazepam to a resident without an active order. Medication was previously DC'd on 12/4/15. The *Expectations for performance improvement* section of the document read, “[SP3] will adhere to the 6 rights of medication administration pertaining to right medication, dose, resident, route, time, and documentation. [SP3] will only administer medications with active orders as they populate on the Medication Administration Record.” The *Active plan for performance improvement* section of the document read, “Re-Educated on Medication rights and administration.”

SP1 reported Resident A's prescribed as needed medications for comfort measures while she was actively transitioning were properly administered. SP1 stated there were four medication changes within 48 hours of Resident A's transition. SP1 provided me with a copy of Resident A's December MAR for my review. The MAR read Resident A had multiple changes to her prescribed Morphine and Haldol on 12/30/2025 and 12/31/2025. Resident A's MAR read these medications were administered as prescribed.

APPLICABLE RULE	
R 325.1932	Resident medications.
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions,

	<p>orders and by the prescribing licensed health care professional.</p> <p>(5) Prescribed medication that is no longer required by a resident must be properly disposed of consistent with the policy established by the home and manufacturer guidelines.</p>
ANALYSIS:	<p>The interview with W1, SP1, along with review of Resident A's incident report dated 12/12/2025 revealed Resident A was administered Ativan after it had been discontinued by Resident A's physician. SP3 did not verify the medication with Resident A's MAR and administered the medication because it was still present in the medication cart. When Resident A's prescribed Ativan was discontinued, it was not removed and properly disposed of, therefore the facility was not in compliance with these rules.</p> <p>Review of Resident A's December 2025 MAR revealed several order changes for Resident A's prescribed Morphine and Haldol were received on 12/30/2025 and 12/31/2025. Resident A's MARs read these medications were administered as prescribed.</p>
CONCLUSION:	<p>REPEAT VIOLATION ESTABLISHED Special Investigation Report (SIR) 2026A1021008 dated 12/04/2025</p>

I shared the findings of this report with the facility's licensee authorized representative on 01/28/2026.

IV. RECOMMENDATION

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

01/22/2026

Lauren Wohlfert
Licensing Staff

Date

Approved By:



01/28/2026

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

Date