GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 24, 2026

Robert Norcross
Medilodge of Grand Rapids
2000 Leonard Street
Grand Rapids, MI 49505

RE: License #: AH410413805
Investigation #: 2026A1021048
Medilodge of Grand Rapids

Dear Robert Norcross:

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

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 #:	AH410413805
Investigation #:	2026A1021048
Complaint Receipt Date:	07/09/2026
Investigation Initiation Date:	07/09/2026
Report Due Date:	09/08/2026
Licensee Name:	Grand Rapids Opco, LLC
Licensee Address:	2000 Leonard St. NE Grand Rapids, MI 49505
Licensee Telephone #:	(618) 458-1133
Administrator Authorized Representative:	Robert Norcross
Name of Facility:	Medilodge of Grand Rapids
Facility Address:	2000 Leonard Street Grand Rapids, MI 49505
Facility Telephone #:	(616) 458-1133
Original Issuance Date:	09/01/2022
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	103
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not cared for.	No
Additional Findings	Yes

III. METHODOLOGY

07/09/2026	Special Investigation Intake 2026A1021048
07/09/2026	Special Investigation Initiated - Telephone message left with complainant
07/14/2026	Inspection Completed On-site
07/24/2026	Exit Conference

ALLEGATION:

Resident A is not cared for.

INVESTIGATION:

On 07/09/2026, the licensing department received a complaint with allegations Resident A was found covered in urine and feces. The complainant alleged that Resident A's call light would go unanswered for a long time. The complainant alleged that Resident A developed a bed sore and was admitted to the hospital with a UTI.

On 07/14/2026, I interviewed staff person 1 (SP1) at the facility. SP1 reported that Resident A was admitted to the facility on 07/01/2026. SP1 reported that she completed an investigation into the call light response time. SP1 reported that 80% of the call lights were answered within 15 minutes, which is the expectation. SP1 reported that there were a few isolated incidents in which it was greater than 15 minutes due to it being during shift change. SP1 reported that she did test the call light system and the system is working properly. SP1 reported that Resident A resides with Resident B and at times Resident B would be cautious to unlock and open the door. SP1 reported that for caregivers to hear the alarm, they must go to the computer in the hallway. SP1 reported that if a caregiver is in a resident room, they can not hear the call light system. SP1 reported that she completed an internal investigation into the concerns of Resident A not changed and a new bed sore. SP1 reported that when Resident A was admitted to the facility, Resident A had a healed

bed sore. SP1 reported that care staff were administering Destin on Resident A's buttocks but there was not any open sore. SP1 reported that Resident A required staff to change her, however, she was not a check and change every two hours. SP1 reported that care staff reported they did change Resident A appropriately. SP1 reported that Relative A1 came into the facility, reported that Resident A's cognition was not at baseline, and that Resident A was to be transferred to the hospital. SP1 reported that this occurred on 07/09/2026 at 7:00am and caregivers were in Resident A's room to provide care at 5:00am. SP1 reported that Resident A was admitted to the hospital for low sodium, not UTI. SP1 reported that care staff did provide appropriate care to Resident A.

On 07/14/2026, I attempted to interview Resident A at the facility, however, Resident A was still at the hospital.

I reviewed Resident A's progress notes. The notes read,
07/08/2026: Resident refused to eat breakfast but will eat lunch. Also she refused to be checked and changed, stated that it was already done.
07/08/2026: Resident's family was upset waiting for 8 min after pressing call button. Staff offered help and residents family refused help claimed resident was female only for check and change, when suggested that MT would call for other aids to assist residents family refused. Also stated that they pressed the call button for help and no one came for a long time but when staff checked it was only ringing for 8 min.
07/09/2026: Staff went to do rounds and change resident when wiping resident, she had a small BM and her poop was black.
07/09/2026: Was notified by staff at 700am that resident was unresponsive. Sent to Blodget."

I reviewed the facility caregivers' statements that were completed during the internal investigation on call light response time and resident care. The statements read,

" (SP2) call me around 8:00pm to report that a family member was upset with the call light wait time. (SP2) reported he saw (Resident A) push her call light and it had been approximately 8 minutes. When we went down there, he said family was upset and said they had been waiting a long time. (SP2) offered assistance but family declined due to requesting a male aid. (SP2) offered to get a female aide but family again declined stating they just changed her themselves."

(SP3) reported that she and (SP5) last completed a check and change on (Resident A) at 5:00am on 07/09. No concerns noted about mental status or level of consciousness at that time.

(SP4) reported that she completed a 2-hour check and change during her shift on 7/8 but (Resident A) did refuse her morning change and breakfast reporting it was already done, a note was placed at this time. (SP4) reported no concerns with skin that she noted during her shift.

SP6 reported that during cares she has never noticed any skin concerns. She reports that daughter did provide a cream to apply after brief changes. (SP6) reports that (Resident A) uses her call light when brief changes are needed, which is typically every two hours. (SP6) reports that (Resident B) frequently locks the door and can take an extended period to open it when staff are responding to call lights."

I reviewed call light response time for 07/08/2026. There were two call requests, and the average time was 9.25 minutes.

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: **R 325.1901**	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and review of documentation revealed lack of evidence to support the allegation that Resident A was not cared for.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:
INVESTIGATION:

SP1 reported that Resident A was a total assist. SP1 reported that Resident A required medicaiton administration, check and change q2, and required 1:1 feeding.

Resident A's service plan read,

"Ambulation: 1 person assist
Bathing: 1 person assist
Bed mobility: 2 person assist
Dressing: 1 person assist
Eating: 1 person assist
Personal hygiene: 1 person assist
Toileting: 2 person assist
Transfers: 2 person assist
Transfers: Sit-to-stand lift with 2 person assist."

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:	Review of Resident A's service plan revealed the service plan omitted specific care needs that Resident A required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/15/2026

Kimberly Horst — Date
Licensing Staff

Approved By:

07/23/2026

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