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 #: 2026A1021049
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 responsible party 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 #:	2026A1021049
Complaint Receipt Date:	07/09/2026
Investigation Initiation Date:	07/13/2026
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Wound care was not provided.	Yes
Additional Findings	No

III. METHODOLOGY

07/09/2026	Special Investigation Intake 2026A1021049
07/13/2026	Special Investigation Initiated - Telephone message left with complainant
07/14/2026	Inspection Completed On-site
07/16/2026	Contact-Document Received Received documents
07/24/2026	Exit Conference

ALLEGATION:

Wound care was not provided.

INVESTIGATION:

On 07/09/2026, the licensing department received an intake with allegations that the facility delegated to unlicensed medical staff members wound care for Resident C. The complainant alleged that the wound care was inconsistent and performed wrong which resulted in amputation.

On 07/13/2026, I interviewed the complainant by telephone. The complainant alleged that the facility had a nurse, SP7, that was to provide wound care. The complainant alleged that SP7 delegated these tasks to unlicensed and untrained medical staff. The complainant alleged that the wound care was to be completed daily but at times it was not.

On 07/14/2026, I interviewed SP1 at the facility. SP1 reported that SP7 was the facility nurse but has since been removed from the position. SP1 reported that the wound care was delegated to the medical technicians, which was appropriate, however, SP7 should have been more involved. SP1 reported that medication technicians do complete the wound care daily and document that it is completed.

SP1 reported that the wound care is very simple and does not require nurse oversight. SP1 reported that Resident C is now seen at an outpatient wound care clinic.

On 07/14/2026, I interviewed SP8 at the facility. SP8 reported Resident C has very simple wound care instructions. SP8 reported that the wound has not improved. SP8 reported the wound care is provided as prescribed.

I reviewed Resident C's service plan. The service plan read,
"Float heels and reposition resident every 2 hours and in chair every 30 minutes. Float heels in bed and chair. Make sure resident is wearing non-skin footwear."

I reviewed SP2 and SP9 employee records. The records revealed both staff were trained in skin care procedures.

I reviewed Resident C's TAR for May 2026. The TAR revealed the following:
"Aquacel Foam 4. Apply to left foot wound topically two times a day for wound care."
The TAR revealed staff members did not document that this was completed on 05/01 at 1600, 05/03-05/04 at 1600, 05/11 at 1600, 05/13-05/15 at 1600, 05/15 at 0800.

Apply Bactroban ointment and cover with a Band Aid every day and evening shift for in grown toe nail.
The TAR revealed staff did not document that this was completed on 05/24 in the evening.

I revealed Resident C's TAR for June 2026. The TAR revealed the following:
Right plantar 5th toe stage III wound-Cleanse with wound cleanser, pat dry with gauze. Apply Hydrofea blue to wound base only.
The TAR revealed staff members did not document that this was completed on 06/23 and 06/25.

Left anterior leg wound. Apply dry and Tubi grip one day a day for wound care.
The TAR revealed staff members did not document that this was completed on 06/23 and 06/28.

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:	Review of Resident C's TAR revealed multiple orders for wound care and multiple instances in which caregivers did not document that wound care was provided. By doing so, the facility failed to ensure the protection and safety of Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/21/2026

Kimberly Horst Date
Licensing Staff

Approved By:

07/23/2026

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