



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 9, 2026

Lynda Sallee
AHR Northview Grand Rapids MI TRS Sub, LLC
Ste. 300
18191 Von Karman Ave.
Irvine, CA 92612

RE: License #: AL410418384
Investigation #: 2026A0579049
The Cortland Terrace Harbor

Dear Lynda Sallee:

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 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 (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Cassandra Duursma".

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410418384
Investigation #:	2026A0579049
Complaint Receipt Date:	08/18/2026
Investigation Initiation Date:	08/18/2026
Report Due Date:	10/17/2026
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:	Lynda Sallee
Licensee Designee:	Lynda Sallee
Name of Facility:	The Cortland Terrace Harbor
Facility Address:	3740 Vista Springs Ave NE, Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	09/27/2024
License Status:	REGULAR
Effective Date:	09/27/2025
Expiration Date:	09/26/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's DNR order was not filed appropriately and was not followed prior to Resident A's death.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/18/2026	Special Investigation Intake 2026A0579049
08/18/2026	Special Investigation Initiated - Letter Lynda Sallee, Licensee Designee Tiffany Ziemba, Direct Care Worker
08/18/2026	APS Referral
08/19/2026	Contact- Document received Lynda Sallee, Licensee Designee Tiffany Ziemba, Acting Licensee Designee
08/31/2026	Contact-Face to Face Melissa Collins, Direct Care Worker Shauna Meegs, Direct Care Worker Tiffany Ziemba, Acting Licensee Designee Gene Coulter, Licensing Consultant
09/01/2026	Contact- Telephone call made Annastasha Randle, Direct Care Worker
09/01/2026	Contact- Document Sent Lynda Sallee, Licensee Designee Tiffany Ziemba, Acting Licensee Designee
09/03/2026	Exit Conference Lynda Sallee, Licensee Designee Tiffany Ziemba, Acting Licensee Designee

ALLEGATION: Resident A's DNR order was not filed appropriately and was not followed prior to Resident A expiring.

INVESTIGATION: On 8/18/26, I entered this referral after licensee designee Lynda Sallee reported that Resident A's Do Not Resuscitate (DNR) order had not been filed

correctly by a former administrative worker. As a result, the DNR was not followed when Resident A died on 8/17/26.

On 8/18/26, I requested an incident report, contact information for the direct care workers (DCWs) present, Resident A's most recent assessment plan, and Resident A's DNR order from Ms. Sallee and Tiffany Ziemba who is preparing to be appointed as the home's new licensee designee.

On 8/19/26, Ms. Ziemba provided the requested documents. Resident A's quarterly assessment plan dated 7/14/26 contained a blank code status section, and no other resuscitation information. A DNR order dated 7/17/26 was provided. The incident report stated Resident A was found not breathing at 9:00 p.m. on 8/17/26. Because her DNR and hospice status were not listed, she appeared as "full code," leading staff to initiate CPR and call 911. First responders pronounced her deceased. DCWs Makayla Thomas and Anastasha Randle were present.

On 8/31/26, I conducted an unannounced onsite visit with licensing consultant Gene Coulter. We interviewed DCW Melissa Collins and Ms. Ziemba. Ms. Ziemba stated Ms. Thomas and Ms. Randle were not working that day.

Ms. Collins demonstrated how to check code status in the electronic file for one resident. She reported no concerns with locating DNR orders. She stated if a DNR order was listed in the resident's file, she would contact management and not proceed with life saving measures. She stated if a resident was "full code", she would call 911 and begin CPR.

On 9/1/26, I completed a telephone interview with Ms. Randle who reported Ms. Thomas was working by herself in this home and could not locate Resident A's code status when she found Resident A not breathing. She stated Ms. Thomas called for help and Ms. Randle was able to leave her assigned home due to sufficient staffing and came to assist.

Ms. Randle stated upon her arrival, she observed Resident A and believed she was deceased. She checked Resident A's electronic file but could not find the code status, so she followed the chain of command until receiving confirmation that Resident A was listed as "full code." She then instructed Ms. Thomas to perform CPR until first responders arrived, which Ms. Thomas did. She later learned a valid DNR existed but had not been filed properly.

Ms. Randle reported there has been significant turnover in management, resulting in communication challenges regarding resident care. She stated about a week before this incident, she informed management that Resident A had begun hospice services around 7/15/26, but her file had not been updated to reflect this. She stated she does not recall which managers she addressed these concerns with.

APPLICABLE RULE		
R 400.671	Resident care.	

	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Ms. Sallee, Ms. Ziemba, and Ms. Randle confirmed Resident A's DNR was not filed appropriately, leading DCWs to believe she was full code and perform CPR contrary to her wishes. Resident A's assessment plan also lacked code status information. Based on the interviews completed and documentation reviewed, there is sufficient evidence that Resident A's DNR order was not appropriately added as an addendum to or maintained with Resident A's assessment plan.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING

On 8/31/26, Mr. Coulter and I interviewed Ms. Collins at a licensed AFC home connected to this home by a shared door that was propped open. Residents were observed moving between the two licensed programs. Ms. Collins stated she was solely responsible for supervising all 11 residents, four of whom reside in this home. She reported assistance would be provided by staff from other licensed programs on this property if needed.

While completing on-site contact at another licensed AFC program on this property, I completed an interview with DCW Shauna Meegs. Ms. Meegs reported at times she has left the licensed AFC we were speaking at to help the sole DCW working at this licensed program if needed.

Ms. Ziemba confirmed the use of roaming/floating staff and that only one DCW is scheduled between this licensed program and the adjoining licensed program. Consultation was provided to Ms. Ziemba regarding staffing in licensed AFC homes.

On 9/1/26, an email was sent to Ms. Sallee and Ms. Ziemba providing consultation regarding staffing in AFC homes and ensuring both were aware that as was agreed to at the time of license issuance, per the original licensing study report, reliance on the use of roaming staff is not allowed in AFC homes at any time and must be discontinued immediately. Ms. Sallee responded with clarifying questions. A response was sent further explaining the consultation provided.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.
ANALYSIS:	Ms. Collins was interviewed at a licensed home that is adjoined to this home. She reported she was providing supervision to the residents at this licensed program while simultaneously providing supervision of residents at another adjoining licensed program. Ms. Meegs was interviewed at a separate licensed program and reported leaving that home to aid at this home when needed. Ms. Ziemba confirmed the use of roaming staff on this property and that only one DCW had been scheduled to supervise residents at this home and the adjoining licensed home. Based on the interviews completed and observations made, there is sufficient evidence that adequate staffing of not less than one direct care worker to 15 residents during waking hours at this license was not being appropriately provided.
CONCLUSION:	VIOLATION ESTABLISHED

On 9/3/26, I completed an exit conference with Ms. Sallee and Ms. Ziemba. They did not dispute my findings or recommendations.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend that the status of the license remains the same.

Cassandra Duursma

09/03/2026

Cassandra Duursma

Date

Licensing Consultant

Approved By:

A handwritten signature in blue ink, appearing to read "Jerry Hendrick".

09/04/2026

Jerry Hendrick
Area Manager

Date