GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2022

Kim Waddell
NRMI LLC
17187 N. Laurel Park Dr., Ste. 160
Livonia, MI 48152

RE: License #: AS820412115
Investigation #: 2022A0575022
Greenland

Dear Ms. Waddell:

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS820412115
Investigation #:	2022A0575022
Complaint Receipt Date:	06/08/2022
Investigation Initiation Date:	06/08/2022
Report Due Date:	07/08/2022
Licensee Name:	NRMI LLC
Licensee Address:	313 Congress St Boston, MA 02210
Licensee Telephone #:	(617) 790-4800
Administrator:	James Para-Cremer, Designee
Licensee Designee:	Kim Waddell, Designee
Name of Facility:	Greenland
Facility Address:	32579 Greenland CT Livonia, MI 48152
Facility Telephone #:	(734) 421-1584
Original Issuance Date:	06/01/2022
License **Status:**	TEMPORARY
Effective Date:	06/01/2022
Expiration Date:	11/30/2022
Capacity:	6
Program Type:	PH; TBID

II. ALLEGATION(S)

	Violation Established?
Resident A mistreated by three direct care staff.	Yes

III. METHODOLOGY

06/08/2022	Special Investigation Intake 2022A0575022
06/08/2022	APS Referral-licensee self-reported
06/08/2022	Special Investigation Initiated - On Site-interviews with (a) Resident A, and (b) Kim Waddell, licensee designee and viewed video of incident.
06/08/2022	Inspection Completed-BCAL Sub. Non-Compliance
06/08/2022	Corrective Action Plan Requested and Due on 06/23/2022
06/08/2022	Exit Conference with Kim Waddell
06/08/2022	Contact - Document Received- shift schedules for the three staff involved in the incident.
06/08/2022	Contact - Telephone calls made-(a) Resident A's guardian; (b) direct care staff-1) Sharonda Christian Davis; 2) Maxine Dowell; and 3) Jazmine Oliver.
06/08/2022	Recommend Modify to Provisional license

ALLEGATION:

Resident A mistreated by three direct care staff.

INVESTIGATION:

An APS referral was self-reported by the licensee before 6/8/2022.

On 6/8/2022, I interviewed Resident A who stated staff Sharonda Christian-Davis beat him with his leg prosthesis on 5/29/2022. He showed me his leg abrasions and puncture wounds.

On 6/8/2022, I called Resident A's guardian and staff Sharonda Christian-Davis and got no response and no call back from either one.

On 6/8/2022, I called and interviewed staffs Maxine Dowell and Jazmine Oliver. They both acknowledged they worked on 5/29/2022 with Sharonda Christian-Davis and knew what incident I was referring to regarding Resident A.

Ms. Dowell initially stated Ms. Christian-Davis did not hit Resident A, but later in the conversation she stated, "She might have hit him." She also stated she was trying to separate Resident A and Ms. Christian-Davis to "protect her co-worker" and acknowledged that the incident was being videotaped.

Ms. Oliver explicitly corroborated Resident A's allegation that Ms. Christian-Davis hit Resident A with his leg prosthesis.

On 6/8/2022, Kim Waddell and I watched the video (the facility has cameras in the common areas) of the incident with Resident A and the three staff listed above. The video, dated 5/29/2022 at 1:54 p.m., has no audio. I watched the altercation between Resident A and Ms. Christian-Davis, as Ms. Christian-Davis beat Resident A with his leg prothesis. Ms. Dowell and Ms. Oliver were present in the same room and watched, at one point shut the kitchen door on Resident A's other leg, used a chair to push Resident A across the floor, mopped up the blood on the floor which was from the beating Resident A incurred from Ms. Christian-Davis, and did nothing to intervene or to stop the physical assault of Resident A.

On 6/8/2022, I conducted an exit conference with Kim Waddell. She stated the three staff's employment has been terminated, all the remaining staff will be retrained, the Livonia police were contacted and have reviewed the video and have made a copy for the prosecutor's office to review. She agreed to accepting a provisional license, given the circumstances of the incident.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

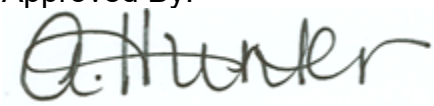
ANALYSIS:	The preponderance of evidence is that staff Sharonda Christian-Davis intentionally and egregiously mistreated Resident A and staffs Maxine Dowell and Jazmine Oliver participated in the mistreatment, did not intervene on Resident A's behalf, and found nothing wrong with their response to the incident. Furthermore, though the licensee/corporation had changed a couple of days after the incident, the staff were the same, and the prevention of resident mistreatment/abuse and their general protection and safety necessitates the new licensee/corporation be held responsible for the staff's mistreatment of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend modification of the status of the license to provisional.

Jeffrey J. Bozsik
Licensing Consultant
Date: 6/9/2022

Approved By:



Ardra Hunter
Area Manager
Date: 6/13/2022