GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 30, 2023

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

RE: License #: AL630412118
Investigation #: 2023A0612030
North Ridge

Dear Ms. Waddell:

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 (248) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630412118
Investigation #:	2023A0612030
Complaint Receipt Date:	07/05/2023
Investigation Initiation Date:	07/06/2023
Report Due Date:	09/03/2023
Licensee Name:	NRMI LLC
Licensee Address:	160 17187 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(734) 646-1603
Administrator:	Tammy Zentz
Licensee Designee:	Kimberlee Waddell
Name of Facility:	North Ridge
Facility Address:	25911 Middlebelt Farmington Hills, MI 48336
Facility Telephone #:	(248) 516-1370
Original Issuance Date:	06/01/2022
License Status:	REGULAR
Effective Date:	12/01/2022
Expiration Date:	11/30/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving 1:1 staffing.	No
Resident A's call light is unplugged.	Yes

III. METHODOLOGY

07/05/2023	Special Investigation Intake 2023A0612030
07/06/2023	Special Investigation Initiated - On Site I completed an unscheduled onsite investigation. I interviewed Administrator Tammy Zentz, Residential Program Manager Erica Mabry, Life Skills Trainer Natalya Lewis, Team Leader Jacqueline Smith, Resident B, Resident C, Resident D, and Resident E.
07/12/2023	Contact - Telephone call made Telephone interviews completed with Social Worker Heather Cornett, Life Skills Trainer Deangela Gains, Life Skills Trainer Sarah Huchla, Life Skills Trainer Gabrielle Anderson, Life Skills Trainer Kay'Lynn Davis and Resident A.
07/12/2023	Contact - Document Received I received a copy of Resident A's Individual Service Plan via email.
0717/2023	Exit Conference Telephone call to licensee designee Kimberlee Waddell and administrator Tammy Zentz to conduct an exit conference.

ALLEGATION:

Resident A is not receiving 1:1 staffing.

INVESTIGATION:

On 07/06/23, I received a complaint that indicated Resident A expressed concerns regarding the care he currently receives. He states the facility does not have adequate staff to provide safe 1:1 care. He also states that a staff member intentionally unplugged his call light so that he could not call for help (he states they were irritated with how

often he was using the call light). When asked how he was able to call for help if he needed assistance (as he is quadriplegic and needs assistance with all activities of daily living) he said that he was not able to do so. Resident A states this happened two times in the past two to three weeks. Resident A reported the first incident to "the head nurse."

On 07/06/23, I completed an unscheduled onsite investigation. I interviewed Administrator Tammy Zentz, Residential Program Manager Erica Mabry, Life Skills Trainer Natalya Lewis, Team Leader Jacqueline Smith, Resident B, Resident C, Resident D, and Resident E. While onsite I obtained a copy of Resident A's AFC Assessment Plan.

On 07/06/23, I interviewed Administrator Tammy Zentz and Residential Program Manager Erica Mabry. Ms. Zentz and Ms. Mabry stated Resident A has a spinal cord injury. He uses an electric wheelchair and is dependent on staff assistance with all personal care. Resident A receives 15 hours of 1:1 staffing per week, as needed. Resident A's 1:1 staffing is used to complete his personal care/activities of daily living and eating/feeding. Resident A receives 1:1 staff in the morning, at night, during meals and during the day as needed. When Resident A is not assigned a 1:1 staff he is typically in his wheelchair which he can move around the facility independently. Resident A also has a personal cell phone and a computer that he uses to contact staff or the nurse's station if he requires assistance. Ms. Zentz and Ms. Mabry stated Resident A has recently moved to this facility from his own home where he was accustomed to receiving 2:1 staffing. This has been an adjustment for him.

On 07/06/23, I interviewed Life Skills Trainer, Natalya Lewis. Ms. Lewis stated she has worked at this facility for 21 months she works the day shift 8:00 am – 4:00 pm. Ms. Lewis stated Resident A receives 1:1 staffing in the morning, at bedtime, and during meals as he needs to be fed. Resident A needs assistance with all of his activities of daily living (ADL's) and he needs to be transferred in and out of his wheelchair. Ms. Lewis stated Resident A moved to the facility from his own home where he was used to getting 1:1 staffing, living in a facility and sharing staff has been an adjustment for him. Ms. Lewis stated Resident A uses an electric wheelchair, he can move independently around the facility. If Resident A does not have an assigned 1:1 staff, and he requires assistance with something he will usually come into the hallways and get a staff or use his cellphone or computer to call a nurse.

On 07/06/23, I interviewed Team Leader, Jacqueline Smith. Ms. Smith has worked at this facility for 11 years. She works on the day shift, 8:00 am – 4:00 pm. Ms. Smith stated Resident A does not receive 1:1 staff all day. He is assigned a 1:1 staff in the morning, at night, and during meals. Resident A requires assistance with all ADL's. Resident A will provide staff with verbal directions on how to assist him. Resident A's personal care tends to take a long time. Once his personal care is completed and Resident A is in his electric wheelchair if he does not have an assigned 1:1 staff and he needs assistance he will come and ask a staff for help.

On 07/06/23, I interviewed Resident B. Resident B stated she lives at this facility with her husband. Staff meet her needs; she has no issues or concerns.

On 07/06/23, I interviewed Resident C. Resident C stated the staff are good if she needs help, they assist her. Resident C stated, “I am happy to be here.”

On 07/06/23, I interviewed Resident D. Resident D stated she has lived in the neighborhood near this facility her whole life. She understands that she will be living at this facility long term. Resident D stated the staff are good. Resident D provided no issues or concerns.

On 07/06/23, I interviewed Resident E. Resident E stated he was recently using a wheelchair, but he has started walking again. He reports no complaints with the facility or staffing.

On 07/12/23, I completed a telephone interview with Social Worker, Heather Cornett. Ms. Cornett stated while Resident A was in the hospital, he reported that the facility does not have adequate staff to provide safe 1:1 care. Ms. Cornett stated Resident A spoke to his external case manager regarding his options for discharge and it was determined that Resident A would be discharged back to the facility. Resident A stated he felt safe returning. Ms. Cornett explained due to changes in the auto laws Resident A has recently experienced a lot of life changes as he had to move from his own home where he had his own caregivers to a facility.

On 07/12/23, I completed a telephone interview with Life Skills Trainer, Deangela Gains. Ms. Gains works midnights, 12:00 am – 8:00 am. Ms. Gains stated per Resident A’s clinical directive he does not receive 1:1 staffing all day. Resident A has 1:1 staffing for feeding and to be transferred in and out of bed in the morning and at night. Ms. Gains stated Resident A requires assistance with all personal care. As such, his care takes staff a long time to complete. More recently, they have been assigning two staff to assist Resident A with his personal care in the morning.

On 07/12/23, I completed a telephone interview with Life Skills Trainer, Sarah Huchla. Ms. Huchla stated she has worked at this facility for five years. She works on the midnight shift 12:00 am – 8 :00 am. Ms. Huchla stated Resident A receives 1:1 staffing in the morning. Resident A gets up by 6:00 am. He is assisted by one or two staff with getting dressed, completing his ADL’s, and transferring into his wheelchair. Resident A also receives 1:1 staffing during eating/feeding. Throughout the rest of the day Resident A receives general staffing, he does not get 1:1 care. Resident A uses an electronic wheelchair. Once he is in his wheelchair if he needs assistance he can come and get a staff who will assist him.

On 07/12/23, I completed a telephone interview with Life Skills Trainer, Gabrielle Anderson. Ms. Anderson stated she has worked at the facility for three months. She works on the midnight shift, 12:00 am – 8:00 am. Ms. Anderson stated, Resident A has a lot of personal care needs. He gets up at 5:00 am he is assisted by a 1:1 staff with his

ADL's and he is transferred into his wheelchair. Ms. Anderson stated recently they have begun scheduling two staff to assist Resident A in the morning with his ADL's as his care takes staff a long time to complete. Ms. Anderson stated she is unaware of Resident A's staffing levels at other times of the day.

On 07/12/23, I completed a telephone interview with Life Skills Trainer Kay'Lynn Davis. Ms. Davis has worked at the facility for six years. She works days and afternoons. Ms. Davis stated throughout the day Resident A receives general staffing, he is not assigned a 1:1 staff. In the morning and during meals Resident A gets 1:1 staffing to assist with transferring him in and out of his wheelchair and completing his ADL's. Ms. Gains stated in the morning there is typically one to two staff assisting Resident A with his personal care needs.

On 07/12/23, I completed a telephone interview with Resident A. Resident A stated previously he was living in his own home and receiving 1:1 staffing. However, there was a change in the no fault auto laws which resulted in him having to move into this facility three months ago. Resident A stated he should be receiving 1:1 staffing 24 hours a day. However, he is only receiving 1:1 each morning and at night. Resident A stated the length of time staff are with him to providing 1:1 care varies ranging up to two hours. When he has a 1: 1 staff they assist him with transferring in and out of his wheelchair, completing his personal hygiene, and eating. Resident A stated he would rather live in his own home.

I received and reviewed Resident A's Individual Service Plan and Resident A's AFC Assessment Plan.

- Per Resident A's Assessment Plan – Resident A uses an electric wheelchair. He requires assistance with all self-care (eating, bathing, grooming, dressing, and completing personal hygiene.) Resident A can move his wheelchair independently. He is alert to his surrounding and he can communicate his needs.
- Per Resident A's Individual Service Plan – Resident A's call light should be within reach at all times and answered promptly. Resident A is at risk for autonomic dysreflexia. Resident A receives general supervision. Resident A requires complete assistance with all aspects of personal hygiene, oral care, and eating/feeding.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A is not receiving direct care as it is specified in his assessment plan. Although Resident A stated he should be receiving 1:1 staffing 24 hours a day, Resident A's Individual Service Plan and AFC Assessment Plan do not indicate that Resident A requires 1:1 staffing 24 hours a day. Resident A's Individual Service Plan and AFC assessment plan indicate that Resident A requires total assistance with all self-care, transfers, and eating/ feeding. Once transferred into his wheelchair Resident A can move independently around the facility. He is alert to his surrounding and he can communicate his needs. All staff interviewed consistent stated Resident A receives general staffing throughout the day. Resident A receives 1:1 staffing in the morning, evening, and during mealtimes to assist with completing ADL's, transfers and eating. Resident A confirms that he is receiving 1:1 staffing during these times. As such, Resident A's care is being provided as it is specified in his AFC assessment plan and his Individual Service Plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A's call light is unplugged.

INVESTIGATION:

On 07/06/23, I completed an unscheduled onsite investigation. I interviewed Administrator Tammy Zentz, Residential Program Manager Erica Mabry, Life Skills Trainer Natalya Lewis, Team Leader Jacqueline Smith, Resident B, Resident C, Resident D, and Resident E.

During the onsite investigation, I observed Resident A's call light. The call light was clipped onto his bed. The cord ran against the wall from his bedroom into the hallway. It was plugged in and functioning at the time of the inspection. The call light can be unplugged in the hallway or at the end that is inside of Resident A's bedroom.

On 07/06/23, I interviewed Administrator Tammy Zentz and Residential Program Manager Erica Mabry. Ms. Zentz and Ms. Mabry stated Resident A has a call light in his bedroom. It is attached to his bed so he can press it using his head or the side of his wheelchair due to his limited mobility. When pressed the call light makes a noise in the hallways to alert staff. It is possible that the call light could become unplugged. Ms. Zentz and Ms. Mabry stated they do not suspect that any staff are intentionally unplugging the call light. Ms. Zentz and Ms. Mabry stated if Resident A's call light should become unplugged Resident A has a person cell phone and a computer that he

regularly uses to contact the nurse's station if he requires assistance. If Resident A is in his wheelchair and the call light is unplugged Resident A can independently move his wheelchair and go locate a staff to assist him.

On 07/06/23, I completed a face-to-face interview with Life Skills Trainer, Natalya Lewis and Team Leader, Jacqueline Smith. On 07/12/23, I completed a telephone interview with Life Skills Trainer, Sarah Huchla. Ms. Lewis, Ms. Smith, and Ms. Huchla consistent stated Resident A has a call light in his bedroom, it is clipped on his bed. Resident A pushes the button with his wheelchair or his head. On no occasion have they observed Resident A's call light unplugged. Ms. Lewis, Ms. Smith, and Ms. Huchla consistently stated that they have never witnessed or heard about any staff intentionally or unintentionally unplugging Resident A's call light. Ms. Lewis, Ms. Smith, and Ms. Huchla denied that they have ever unplugged Resident A's call light.

On 07/06/23, I interviewed Resident B. Resident B stated her call light is always plugged in and always works.

On 07/06/23, I interviewed Resident C. Resident C stated her call light is always plugged in. When she calls for staff, they come and help her.

On 07/06/23, I interviewed Resident D and Resident E. Due to their respective cognitive delays they were both unable/ unwilling to answer questions related to this allegation.

On 07/12/23, I completed a telephone interview with Social Worker, Heather Cornett. Ms. Cornett stated while in the hospital Resident A reported that a staff member intentionally unplugged his call light so that he could not call for help. Resident A stated that they were irritated with how often he was using the call light. Resident A is quadriplegic and needs assistance with all activities of daily living he said that he was not able to call for help when his call light is unplugged. Resident A stated this happened two times in the past two to three weeks.

On 07/12/23, I completed a telephone interview with Life Skills Trainer, Deangela Gains. Ms. Gains works on the midnight shift. Ms. Gains stated on two to three occasions she has witnessed Resident A's call light unplugged. It has been unplugged on the end in the hallway and the end that is inside of his bedroom. Ms. Gains stated she does not know if the light was unplugged on purpose or by accident. Ms. Gains denied that she unplugged Resident A's call light.

On 07/12/23, I completed a telephone interview Life Skills Trainer, Gabrielle Anderson. Ms. Anderson works on the midnight shift. Ms. Anderson stated she has never witnessed any staff unplugging Resident A's call light however, she has observed his call light unplugged. It was unplugged at the end that is in the hallway. Ms. Anderson stated she cannot confirm if this was done intentionally or accidently. However, when she found the light unplugged, she plugged it back in. Ms. Anderson denied that she unplugged Resident A's call light.

On 07/12/23, I completed a telephone interview with Life Skills Trainer Kay'Lynn Davis. Ms. Davis works on the day and afternoon shift. Ms. Davis stated that there have been times during her shift that she has observed Resident A's call light unplugged. Ms. Davis denied that she unplugged Resident A's call. Ms. Davis stated she has never witnessed any staff unplugging the light and cannot confirm if it was done accidently or intentionally.

On 07/12/23, I completed a telephone interview with Resident A. Resident A stated he has a call light in his bedroom there have been a couple of times that his call light was unplugged by an unknown staff. Resident A stated the last time this occurred was a Friday morning. He stated staff were upset that he was using the call light too much. He heard a voice from the hallway say, "I am sick of this" and then they call light was unplugged. Resident A said that he informed a nurse that his light was unplugged. Resident A stated when his call light is unplugged, he is unable to call for help. Resident A acknowledged that he has a cell phone and a computer that he can use to call the nurses station however, he states in the event of a true emergency like if he were to be choking, it would be too difficult to call for help on the phone or computer.

I received and reviewed Resident A's Individual Service Plan. In summary, the plan indicated Resident A's call light should be within reach at all times and answered promptly. Resident A is at risk for autonomic dysreflexia.

On 07/17/23, I called licensee designee Kimberlee Waddell and administrator Tammy Zentz to conduct an exit conference. There was no answer. I left Ms. Waddell and Ms. Zentz detailed voicemails regarding my findings. I indicated that a corrective action plan would be required.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude Resident A's needs including safety were not always attended to. Resident A reports there have been multiple occasions that his call light has been unplugged and therefore, he is unable to call staff for help/ assistance. Life Skills Trainer, Deangela Gains, Gabrielle Anderson, and Kay'Lynn Davis consistently stated that they have observed Resident A's call light unplugged. Per Resident A's Individual Service Plan his call light should be within reach at all times and answered promptly. Resident A is quadriplegic

	and at risk for autonomic dysreflexia. Although it cannot be confirmed that Resident A's call light has been unplugged intentionally there is concern that Resident A's safety is compromised when the call light is unplugged and he cannot alert staff of his care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

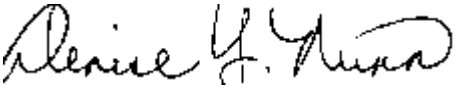
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

07/17/2023

_____

Johnna Cade Date
Licensing Consultant

Approved By:



08/30/2023

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Denise Y. Nunn Date
Area Manager