GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 29, 2023

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

RE: License #: AL630412119
Investigation #: 2024A0612003
South 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
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 #:	AL630412119
Investigation #:	2024A0612003
Complaint Receipt Date:	10/26/2023
Investigation Initiation Date:	10/27/2023
Report Due Date:	12/25/2023
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:	South 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?
• Staff are sleeping during the midnight shift. • Residents are getting neglected and becoming sick due to the lack of care they are getting.	Yes
• Resident's briefs are not being changed. • Resident's teeth are not being brushed.	Yes

II. METHODOLOGY

10/26/2023	Special Investigation Intake 2024A0612003
10/27/2023	Special Investigation Initiated - Telephone Referral made to Adult Protective Services (APS) via centralized intake.
10/27/2023	APS Referral I made a referral to Adult Protective Services (APS) via centralized intake.
11/01/2023	Inspection Completed On-site I completed an unannounced onsite investigation. I interviewed administrator Tammy Zentz, residential program manager Erica Mabry, life skills trainer Jalen Bean, Resident A, Resident B, Resident C, and Resident D.
11/06/2023	Contact - Document Received I received copies of recent hospitalizations, census records, proof of wounds, oral care and brief checks.
11/15/2023	Contact - Telephone call made Telephone interview conducted with administrator, Tammy Zentz.
11/20/2023	Contact - Telephone call made Telephone interview conducted with team lead Alicia Byrd. Telephone call placed to life skills trainer Shantel Bickerstaff and Victoria Pounds. There was no answer. I left a voicemail requesting a return call.

11/20/2023	Exit Conference I emailed licensee designee, Kimberlee Waddell and administrator, Tammy Zentz to conduct an exit conference.

ALLEGATION:

- **Staff are sleeping during the midnight shift.**
- **Residents are getting neglected and becoming sick due to the lack of care they are getting.**

INVESTIGATION:

On 10/26/23, I received an anonymous complaint from an employee that stated residents are getting neglected. Their briefs are not being changed and their teeth are not being brushed. Staff are sleeping during the midnight shift. Residents are getting sick because of the lack of care they are getting. Management has been made aware of these issues and nothing has been done. On 10/27/23, I initiated this investigation by making a complaint to Adult Protective Services (APS) via centralized intake.

On 11/01/23, I completed an unannounced onsite investigation. I interviewed administrator Tammy Zentz, residential program manager Erica Mabry, life skills trainer, Jalen Bean, Resident A, Resident B, Resident C, and Resident D. During the onsite inspection, I observed that the facility was clean, orderly, and odor free. All the residents were appropriately dressed and well groomed.

On 11/01/23, I interviewed administrator Tammy Zentz and residential program manager Erica Mabry. Ms. Zentz and Ms. Mabry consistently stated that sleeping on shift is unacceptable. In July 2023, an administrative note was sent out to all staff regarding sleeping on shift and the expectation of staff to notify management if they observe any staff sleeping. The administrative note was issued to staff and they had to sign off acknowledging their understanding. To further ensure compliance, management is completing unannounced onsite inspections during all shifts. During these checks, they have found staff sleeping. Any staff found sleeping was sent home. Staff who were found sleeping received a final written warning with one occurrence. Staff with multiple occurrences, or if a resident was neglected because of the staff sleeping were terminated. Additionally, on the midnight shift they have appointed team leaders to provide additional supervision and support. Ms. Zentz and Ms. Mabry stated the following staff have been terminated, suspended, and/or sent home for sleeping on shift and/or neglecting residents during the midnight shift:

- Jana Abdurrahman - terminated for neglect/sleeping on 08/01/23.
- Shawntanique Avery - terminated for sleeping on 09/18/23.
- Sheldon Leflore - suspended for sleeping on 07/27/23.
- Jersey Cheeks - sent home for sleeping in September 2023.

Ms. Zentz and Ms. Mabry denied that residents are becoming sick due to a lack of care. They stated that there has not been an increase in unplanned hospitalization. Unplanned hospitalizations are documented by the nurse. Ms. Zentz provided copies of the facility's recent unplanned hospitalization records.

On 11/15/23, I completed a second interview with administrator, Tammy Zentz via telephone. Ms. Zentz stated there are 13 staff on the midnight shift. The staffing ratio is one staff to four residents. If a staff is found sleeping on shift and they are sent home management, or a nurse will assist with resident care. Ms. Zentz explained that if a staff is found sleeping and there are no concerns regarding resident care the staff is terminated for sleeping. However, if a staff is found sleeping and the resident is soiled or has not been repositioned the staff is terminated for sleeping and neglect. If a staff was neglectful to a resident a health and safety assessment is completed with the resident. The health and safety assessment consists of asking the resident if they feel safe, if they know their client rights, and if they have any concerns. If a resident cannot answer questions verbally, their health and safety is assessed by a nurse.

I reviewed the administrative note sent out to staff on 07/24/23. The note indicates, "sleeping is unacceptable in this work environment for all disciplines. If a staff is sleeping disciplinary action will occur and could result in the staff being suspended or terminated. Failing to report a staff member that is sleeping could result in disciplinary action up to and including termination. Please notify the RPM on call immediately of any reports of sleeping. Any retaliation for staff reporting a sleeping employee will result in disciplinary action."

On 11/01/23, I interviewed life skills trainer, Jalen Bean. Mr. Bean has worked at this facility for two years. He works on the day shift from 8:00 am – 4:00 pm. Mr. Bean stated the facility has a no sleeping policy. He has heard about staff sleeping on shift however, he has not witnessed this himself. Mr. Bean suspects this happens more on the midnight shift. Mr. Bean stated that the residents at this facility are well taken care of. He has no concern about the quality of care they receive. Mr. Bean has no concerns about residents becoming ill due to a lack of care. Mr. Bean stated the staff are team players and they work well together to ensure that the residents are properly cared for.

On 11/01/23, I interviewed Resident A. Resident A stated he has not observed any staff sleeping while on shift. Resident A denied that he has received a lack of care and as a result became sick. Resident A remarked, the staff treat him well, he has no concerns.

On 11/01/23, I interviewed Resident B. Resident B stated she is not neglected. She feels happy and safe at this facility and everyone here is well cared for. Resident B stated she cannot recall the date, but she has observed a staff sleeping on the midnight shift.

On 11/01/23, I interviewed Resident C. Resident C made contradicting statements. Resident C stated staff are not attending to her because they do not put her braces on

her feet. Resident C then stated, that she does not want to wear her braces and that is why staff do not put them on her. Resident C ended the interview abruptly to tend to personal care needs. She did not return for further questioning.

On 11/01/23, I interviewed Resident D. Resident D stated she has been at this facility for one week. They have assisted her with all her needs. Resident D denied the allegation and stated she is not being neglected. Resident D has not observed staff sleeping during shift. Resident D stated staff respond quickly when she pushes her call button, she has no issues or concerns with the care that she is receiving.

On 11/20/23, I completed a telephone interview with team lead Alicia Byrd. Ms. Byrd worked at the facility for 10 years. She worked on the midnight shift from 12:00 am – 8:00 am. On 10/25/23, Ms. Byrd chose to terminate her employment due to the facility having several ongoing issues. Ms. Byrd stated management was notified of the problems, but they did not address them. Ms. Byrd stated staff sleeping on shift happens frequently and she remarked, it is ridiculous. When Ms. Byrd observed a staff sleeping on shift, she would take a nurse with her as a witness while waking up the staff. However, nurses were afraid of retaliation from the staff because the staff would lash out against them. Ms. Byrd stated she verbally informed managers Salena Brown, Tammy Zentz, and Erica Mabry about the ongoing issues however, nothing was done. Ms. Byrd stated residents are becoming sick due to the lack of care they receive. The facility does not react quickly enough when a resident experiences a change in health status. Ms. Byrd stated when a resident is ill, the facility waits approximately two weeks before sending the resident to the hospital. In 2020, during the COVID-19 pandemic when residents would begin coughing, Ms. Byrd stated they were not transferred to the hospital immediately. There were two deaths at the facility that Ms. Byrd believes could possibly have been prevented if the residents were transferred to a hospital sooner. Ms. Byrd explained when a resident has a change in health status such as a change in their color, or a change in their urine, staff complete documentation to monitor the change. In October 2023, Resident H had a change to her urine, it became dark and developed a strong odor. Resident H was eventually sent to the hospital and was prescribed an antibiotic. Ms. Byrd believes Resident H should have been sent to the hospital sooner than she was. Also, in October 2023, Resident I began staying awake all night. He would get a bloody nose and pass out. This went on for two days. Resident I was eventually sent out to the hospital. Ms. Bryd stated he should have been sent out sooner as this behavior was unusual for Resident I.

I reviewed the facility's unplanned hospital admissions. The following was noted.

- Resident E was hospitalized on the following dates:

10/04/23 due to aspiration pneumonia. Symptoms started -10/03/23.
10/13/23 for cellulitis r/o abscess. Symptoms started - 10/13/23.
10/29/23 for a left hip abscess. Symptoms started - 10/29/23.

- Resident F was hospitalized on the following dates:

10/16/23, Resident F was hospitalized due to a right distal ureter/UVJ calcium, 3 cm stone burden, UTI. Symptoms started - 10/16/23.

The unplanned hospital admission form documents efforts made to attempt to manage the issue in the program and what ultimately lead to the decision to transfer to the hospital. All hospitalizations have been reviewed by a nurse and the form indicates that each hospitalization was appropriate and could not have been prevented.

I reviewed the facility's wound records. The stage, status, wound type, wound location, and onsite date of each wound is consistently documented. In October 2023, the following was noted. Resident G has a continued watched on four pressure ulcers located on his left calf, coccyx/sacrum, left toes 2 – 5, and right heel. Resident E has a new pressure ulcer on the gluteal clef and a surgical incision on the left hip.

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 that staff are sleeping on the midnight shift. Administrator Tammy Zentz, residential program manager Erica Mabry, team lead Alicia Byrd and Resident B consistently stated staff have been observed sleeping during the midnight shift. Although sleeping on shift is prohibited from July 2023 - September 2023, four staff have been terminated, suspended, and/or sent home for sleeping. Ms. Zentz and Ms. Mabry consistently stated to reduce the risk of recurrence an administrative note was issued to all staff regarding the no sleeping policy. There is however insufficient information to conclude that the residents are becoming sick due to the lack of care they are receiving. On 11/01/23, I completed an unannounced onsite investigation. I observed that the facility was clean, orderly, and odor free. All the residents were appropriately dressed and well groomed. There is no information that indicates residents are becoming ill due to receiving a lack of care. There has not been an increase in unplanned hospitalizations or in resident wounds. Resident E and Resident F both had unplanned hospitalizations in October 2023. The onsite of their symptoms occurred no more than 24 hours before they were transferred to a hospital. Resident A, Resident B, Resident C, and Resident D were interviewed, they consistently denied the allegation and voiced no concerns regarding the care they receive.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident's briefs are not being changed.**
- **Resident's teeth are not being brushed.**

INVESTIGATION:

On 11/01/23, I completed an unannounced onsite investigation. I interviewed administrator Tammy Zentz, residential program manager Erica Mabry, life skills trainer, Jalen Bean, Resident A, Resident B, Resident C, and Resident D. During the onsite inspection, I observed that the facility was clean, orderly, and odor free. All the residents were appropriately dressed and well groomed.

On 11/01/23, I interviewed administrator Tammy Zentz and residential program manager Erica Mabry. Ms. Zentz and Ms. Mabry stated residents who wear adult briefs are checked every two hours. Staff complete documentation at the time of each check that indicates if the resident required a brief change at that time of the check. Ms. Zentz and Ms. Mabry explained that resident's wounds are consistently monitored. In their experience, if a resident's brief is not being changed frequently enough, they will experience an increase in wounds. There has not been an increase in wounds at the facility. Ms. Zentz and Ms. Mabry stated residents receive oral care at least two times a day however, it is scheduled three times a day to account for residents who may be out of the building or otherwise engaged. Staff complete documentation when oral care is offered.

On 11/01/23, I interviewed life skills trainer, Jalen Bean. Mr. Bean stated residents who wear briefs are changed every two hours. Documentation is completed at the time of each change. If a resident refuse it is indicated in the documented. Mr. Bean stated he does not find residents soiled or left sitting in wet briefs. Staff check residents every 15 minutes and team leads check behind staff to ensure that resident's briefs are clean and dry. Mr. Bean stated staff assist residents with oral hygiene on each shift. The midnight shift completes oral care in the morning. When oral hygiene is provided staff complete documentation. If a resident's treatment plan indicates that they require oral care more than three times a day, then it is provided to them. Mr. Bean has no concerns that residents are not receiving proper oral care.

On 11/01/23, I interviewed Resident A. Resident A stated staff provide him reminders to brush his teeth at least twice daily. Resident A does not wear briefs and stated he can toilet himself independently, he does not require assistance. Resident A stated he showers every other day. Staff treat him well and he has no concerns with the care that he is receiving.

On 11/01/23, I interviewed Resident B. Resident B stated she wears a pull up at night and she gets changed regularly. Resident B remarked that she is always very clean.

She makes sure of it. Resident B stated that she brushes her teeth every day. Resident B remarked that she is well cared for.

On 11/01/23, I interviewed Resident C. Resident C stated staff assist with changing her brief twice a day, which is not frequent enough. Resident C ended the interview to tend to personal care needs which staff assisted her with immediately upon request. She did not return for further questioning.

On 11/01/23, I interviewed Resident D. Resident D stated he does not wear briefs and he brush his teeth daily, he does not require assistance from staff. Resident D reported no issues or concerns with the care that he is receiving.

On 11/20/23, I completed a telephone interview with team lead, Alicia Byrd. Ms. Byrd stated resident's briefs are not being changed regularly. On an unknown date staff Victoria Pounds left Resident F in a soiled brief for the duration of the midnight shift. Resident F was not changed until 6:00 am. Ms. Byrd stated management were aware that this occurred, and Ms. Pounds did not receive disciplinary action. Ms. Byrd stated residents are not receiving proper oral care. Staff who work on the midnight shift should assist residents with oral care in the morning. Ms. Byrd stated midnight staff would wake residents up for the day, get them dressed without assisting the resident with a bed bath or a shower, change them into clean clothes, and not complete their oral care. Ms. Byrd stated she verbally informed management about this issue, and nothing was done.

I reviewed the incontinence brief change log. Residents who wear briefs are checked every 2 hours, 24 hours a day. The log reflects the time that the resident was checked and if the resident was continent, incontinent, or if they did not void. If the resident was not available at the time of the check this is also indicated on the log. The log is thoroughly completed for each resident.

I reviewed the oral hygiene log. Oral hygiene is offered three times a day. The time oral hygiene is offered to the resident is documented on the log. The log indicates if the resident completed or did not complete oral hygiene. If the resident is unavailable or refused that is also reflected on the log. The logs are thoroughly completed each day. All residents received oral care at minimum once daily.

On 11/20/23, I emailed licensee designee, Kimberlee Waddell and administrator, Tammy Zentz to conduct an exit conference and review my findings. Ms. Waddell and Ms. Zentz were advised of the rule violations and informed that a corrective action plan is required.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and

	personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to conclude that staff Jana Abdurrahman failed to provide adequate personal hygiene as Ms. Abdurrahman was terminated for neglect/failure to provide resident care while sleeping on the midnight shift. Additionally, team lead, Alicia Byrd has observed a resident left in a soiled brief during the midnight shift and Resident C stated that her brief is not changed frequently enough. There is however insufficient information to conclude that residents are not being offered the opportunity to complete oral hygiene daily. Residents are provided with the opportunity to complete oral hygiene three times daily. Staff regularly complete thorough documentation regarding oral hygiene care. Resident A, Resident B, Resident C, and Resident D were interviewed, and they voiced no concerns regarding their opportunity to complete oral hygiene.
CONCLUSION:	**VIOLATION ESTABLISHED**

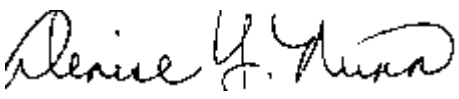
III. RECOMMENDATION

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

11/20/2023

Johnna Cade — Date
Licensing Consultant

Approved By:



11/29/2023

Denise Y. Nunn — Date
Area Manager