GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2024

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

RE: License #: AS820412115
Investigation #: 2024A0575024
Greenland

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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. In the event that 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 #:	2024A0575024
Complaint Receipt Date:	08/19/2024
Investigation Initiation Date:	08/19/2024
Report Due Date:	09/18/2024
Licensee Name:	NRMI LLC
Licensee Address:	17187 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(734) 646-1603
Administrator:	Kimberlee Waddell
Licensee Designee:	Kimberlee Waddell
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:**	REGULAR
Effective Date:	12/22/2022
Expiration Date:	12/21/2024
Capacity:	6
Program Type:	PH; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A eloped three times since 6/29/2024.	Yes

III. METHODOLOGY

08/19/2024	Special Investigation Intake-2024A0575024
08/19/2024	Special Investigation Initiated – Telephone
08/19/2024	Contact - Telephone call made-(1) complainant; (2) (a) direct care staff-Cassandra Rice; (b) direct care staff-Benjamin Doyle-Burnette
08/19/2024	APS Referral
08/21/2024	Contact - Telephone call made-(a) Resident A's guardian; (b) facility program director, Susan Finney
08/22/2024	Inspection Completed On-site-interviews with Resident A
08/22/2024	Exit Conference with Kimberlee Waddell
08/22/2024	Inspection Completed-BCAL Sub. Compliance
08/28/2024	Contact - Telephone call made-direct care staff-Kaylah McCuller

ALLEGATION:

Resident A eloped three times since 6/29/2024.

INVESTIGATION:

An APS referral was made.

On 8/19/2024, I contacted the complainant who stated he was contacted on 6/29/2024 and again on 8/3/2024 by the facility staff who reported Resident A had eloped from the facility and could not be located. He stated he had no other information in his data base about any other elopements regarding Resident A at this address.

On 8/19/2024, I interviewed Benjamin Doyle Burnette and Cassandra Rice. Benjamin Doyle Burnette stated that he was not Resident A's 1:1 staff on the 8/3/2024 elopement incident. He stated he was on duty on the 6/29/2024 elopement incident when Resident A was on every 15-minute supervision schedule, and that Resident A just walks off the property and staff are supposed to give him verbal prompts to return and then call the local police if he won't comply or gets out of eyesight. Cassandra Rice stated she was Resident A's 1:1 staff on the 8/3/2024 elopement incident and that Resident A went outside for a cigarette and then he just walked off and she lost sight of him since it around dusk, he had on dark clothes, and he cut through other private properties.

On 8/21/2024, I interviewed Resident A's public guardian. She stated she was aware of the elopement incidents, that he has a history of elopement and physical aggression towards staff. Therefore, she has approved his transfer to another of the licensee's facilities.

On 8/21/2024, I interviewed Susan Finney. She stated that Resident A has eloped from the facility on 6/29/2024, 7/22/2024, and 8/3/2024. She stated that direct care staff Benjamin Doyle Burnette and Kaylah McCuller were disciplined for not conducting 15-minute checks on Resident A on the 6/29/2024 elopement incident and that Resident A's 1:1 direct care staff Cassandra Rice was disciplined for improperly supervising Resident A on the 8/3/2024 elopement incident. The staff involved in the 7/22/2024 elopement incident was not disciplined because she tried to follow Resident A but lost sight of him. Finally, she stated Resident A was returned to the facility by the Livonia police on the 6/29/2024 and 7/22/2024 incidents. Resident A returned to the facility by himself on the 8/3/2024 incident.

On 8/22/2024, I interviewed Resident A. He stated he eloped because either he was feeling anxious or he didn't like another resident.

On 8/22/2024, I conducted an exit conference with Kim Waddell. She agreed with my conclusion and stated Resident A was being transferred to another of their facilities to better provide for his safety and protection.

On 8/28/2024, I interviewed Kaylah McCullers who was on vacation when I interviewed Benjamin Doyle Burnette and Cassandra Rice. She stated the incidents have been discussed with management and answered no other questions.

APPLICABLE RULE	
R 400.14305	**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:	Even though the staff were either monitoring Resident A every 15 minutes or had him constantly within eyesight as 1:1 staff, they were still not able to prevent him from eloping form the facility and losing visual contact with him on three different occasions. Therefore, Resident A's personal needs, including protection and safety were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable plan of correction; I recommend no change in the license status.

Jeffrey J. Bozsik
Licensing Consultant
Date: 9/9/2024

Approved By:

Ardra Hunter
Area Manager
Date: 9/24/2024