



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2026

Kimberlee Waddell
NRMI LLC
17199 N. Laurel Park Dr., Suite 424
Livonia, MI 48152

RE: License #: AS810412110
Investigation #: 2026A0122024
Crane Cove

Dear Kimberlee Waddell:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (313) 456-0380.

Sincerely,

A handwritten signature in cursive script that reads "Vanita Bouldin".

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

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|---------------------------------------|--|
| License #: | AS810412110 |
| Investigation #: | 2026A0122024 |
| Complaint Receipt Date: | 06/03/2026 |
| Investigation Initiation Date: | 06/05/2026 |
| Report Due Date: | 07/03/2026 |
| Licensee Name: | NRMI LLC |
| Licensee Address: | 424 17199 N. Laurel Park Dr. Livonia, MI 48152 |
| Licensee Telephone #: | (734) 481-1200 |
| Administrator: | Kimberlee Waddell |
| Licensee Designee: | Kimberlee Waddell |
| Name of Facility: | Crane Cove |
| Facility Address: | 7171 Crane Ypsilanti, MI 48197 |
| Facility Telephone #: | (734) 528-9320 |
| Original Issuance Date: | 06/01/2022 |
| License Status: | REGULAR |
| Effective Date: | 12/01/2024 |
| Expiration Date: | 11/30/2026 |
| Capacity: | 6 |
| Program Type: | PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED |

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| | MENTALLY ILL TRAUMATICALLY BRAIN INJURED |
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II. ALLEGATION(S)

| | Violation Established? |
|---|-----------------------------------|
| Resident A has been without teeth for 2.5 months due to staff negligence. | No |

III. METHODOLOGY

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|------------|--|
| 06/03/2026 | Special Investigation Intake 2026A0122024 |
| 06/04/2026 | APS Referral |
| 06/05/2026 | Special Investigation Initiated - Face to Face Conducted interview with Resident A. Reviewed Resident A's file. |
| 06/05/2026 | Contact – Telephone calls made Conducted interviews with case manager, Amy Vadasy, and Guardian A1. |
| 06/09/2026 | Exit Conference Discussed findings with licensee designee, Kimberlee Waddell. |

ALLEGATION: Resident A has been without teeth for 2.5 months due to staff negligence.

INVESTIGATION: On 06/05/2026, I conducted an interview with Resident A who reported that he has no teeth and has a desire to obtain a set of full dentures. He felt that he should have received dentures a long time ago but is uncertain of where he is in the process of obtaining them. Resident A stated that he is on a regular diet and is able to consume most of his meals, he reported that he is not in any pain.

On 06/05/2026, I reviewed Resident A's file. He was admitted to the Crane Cove adult foster care facility on 05/25/2025 and is diagnosed with a traumatic brain injury. His Health Care Appraisal dated 05/01/2025 documents that he is on a diabetic/cardiac diet, i.e. low sugar, low salt diet. There was no statement regarding the consistency or texture of his diet. His nose, throat, mouth, neck, etc. were assessed as "normal." Resident A's Plan of Care Quality Report dated 10/17/2025 documents that Resident A, "would like dentures. (as previously agreed, upon by his new guardian)."

Resident A's Dental Notes dated 05/21/2026 and 06/08/2026, document that Guardian A1 was contacted, case manager, Amy Vadasy, and agreed to the denture obtaining process and the cost. Resident A had an appointment on 06/11/2026 to begin the process for him obtaining dentures.

On 06/05/2026, I conducted an interview with Resident A's case manager, Amy Vadasy, who reported that Resident A was admitted without a full set of dentures but made a request for them at the time of admission. Per Ms. Vadasy, she has been working on an appropriate referral and securing funds for Resident A's dentures. She stated that she made an error and Resident A was referred to obtain implants, which would have included invasive oral surgery, which he opted out of. Ms. Vadasy reported that as 05/22/2026, Resident A has been referred to a correct dentist to begin the denture process and funding to pay for them have been secured.

On 06/05/2026, I conducted an interview with Guardian A1, who confirmed what was reported by Amy Vadasy. Guardian A1 stated that the correct process for Resident A to obtain his full set of dentures was started by case manager, Amy Vadasy and Guardian A1 has secured the funds for Resident A to pay for them. Guardian A1 does not feel that the staff of Crane Cove have been negligent in obtaining dentures for Resident A but stated there had been a high turnover in staff employed to address this issue for Resident A, which caused the delay. Guardian A1 reported she had no concerns with the care being provided by the staff members of the Crane Cove adult foster care facility.

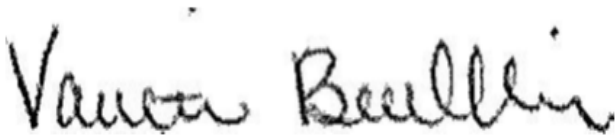
On 06/09/2026, I conducted an exit conference with licensee designee, Kim Waddell, and informed her of my findings. Ms. Waddell agreed with my findings and had nothing further to add to my investigation.

| APPLICABLE RULE | |
|------------------------|---|
| R 400.689 | Resident health care. |
| | (1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional. |

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| ANALYSIS: | Based upon my investigation, which consisted of multiple interviews with Resident A, case manager, Amy Vadasy, and Guardian A1, and a review of pertinent documentation relevant to this investigation there is no evidence to substantiate the allegations that Resident A has been without teeth for 2.5 months due to staff negligence. Therefore, the licensee has followed the instructions and recommendations of Resident A's physician. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

IV. RECOMMENDATION

I recommend no change to the status of the license.



Vanita C. Bouldin
Licensing Consultant

Date: 06/15/2026

Approved By:



Ardra Hunter
Area Manager

Date: 06/17/2026