GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 13, 2026

Tamaria White
NRMI LLC
17199 N. Laurel Park Dr., Suite 424
Livonia, MI 48152

RE: License #: AS810412109
Investigation #: 2026A0122037
Carpenter Creek

Dear Tamaria White:

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 (517) 284-9720.

Sincerely,



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

License #:	AS810412109
Investigation #:	2026A0122037
Complaint Receipt Date:	09/03/2026
Investigation Initiation Date:	09/04/2026
Report Due Date:	10/03/2026
Licensee Name:	NRMI LLC
Licensee Address:	424 17199 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(734) 481-1200
Administrator:	Tamaria White
Licensee Designee:	Tamaria White
Name of Facility:	Carpenter Creek
Facility Address:	6180 Carpenter Rd Ypsilanti, MI 48197
Facility Telephone #:	(734) 528-1798
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

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged.	Yes

III. METHODOLOGY

09/03/2026	Special Investigation Intake 2026A0122037
09/03/2026	APS Referral
09/04/2026	Contact - Document Received Email received by Complainant 1.
09/08/2026	Contact – Telephone call made Guardian A1 – not available.
09/14/2026	Contact – Document Received Discharge letter with certified mail receipts.
09/17/2026	Contact – Telephone call made Conducted interview with Guardian A1.
09/17/2026	Contact – Telephone call made Conducted interview with case manager, Sade Wilson.
10/02/2026	Exit Conference Discussed findings with licensee designee, Tamaria White.

ALLEGATION: Resident A was improperly discharged.

INVESTIGATION: On 09/04/2026, Trinity Health social worker, Karley Dochterman, sent an email informing me of the following, that Resident A was admitted to the hospital, Trinity Health, on 08/08/2026 for suicidal and homicidal ideations. Per Ms. Dochterman, she received a notice that from the corporation, NRMI LLC, social worker, Debbie Bearman, that Resident A would not be able to return to her facility and that Resident A's last day would be 08/28/2026.

Ms. Dochterman stated that neither Resident A nor Guardian A1 received a discharge notification from the licensee, NRMI LLC.

On 09/09/2026, I conducted an onsite inspection. I conducted an interview with program director, Tammy Zentz. Ms. Zentz stated she would be speaking on behalf of Debbie Bearman who was out sick. Ms. Zentz reported the following, Resident A had been sent out to the hospital approximately three days in a row due to being physically aggressive towards staff, residents, displaying self-harm behaviors, and attempting to open the door of car of a moving vehicle. Per Ms. Zentz, each time Resident A was taken to the hospital she requested that Resident A be admitted and have a psychiatric and medication assessment completed by medical personnel.

Ms. Zentz reported due to Resident A's behavior, she felt that staff were unable to care for her safety and the safety of the other residents, so Resident A was issued a 30-day discharge notice. Resident A's behaviors continued to escalate, so the last time she was taken to the hospital Ms. Zentz made the decision that she was unable to return to the facility. Ms. Zentz stated that Guardian A1 was issued a 30-day discharge notice on Resident A's behalf and once Resident A's behavior escalated Guardian A1 was informed that Resident A could not return to the facility. I requested documentation of Resident A's discharge notice, dates that Guardian A1 had been issued the discharge notice and notification to Guardian A1 that Resident A could not return to facility based on the escalation of her behavior.

On 09/14/2026, I reviewed Resident A's Notice of Intent to Discharge letter addressed to Guardian A1 dated 07/29/2026. The letter states the following, "serves as a thirty (30) day notice of NeuroRestorative's intent to discharge," Resident A, "Alternative placement for this participant should begin on or before 08/28/26. Please be aware that all other NeuroRestorative programs have already been considered serving this participant through an internal review process and are not able to offer placement at this time…"

On 09/17/2026, I conducted an interview with Guardian A1, who confirmed that she had heard of the discharge letter dated 07/29/2026 sent certified mail, however, she did not receive it. Guardian A1 stated that not less than 10 days after she heard of the discharge letter, she received a report from an unknown representative of NeuroRestorative stating that Resident A was in the hospital and cannot return to her assigned facility. Guardian A1 stated as of 09/17/2026, Resident A is still

hospitalized awaiting an appropriate placement to be found. Guardian A1 has opened a case with Washtenaw County Community Mental Health to obtain resources for placement assistance.

On 09/17/2026, I conducted an interview with Washtenaw County Community Mental Health case manager, Sade Wilson. Ms. Wilson confirmed that Resident A is ready for discharge at Trinity Hospital, Ypsilanti, MI but she needs to locate an appropriate placement for her.

On 09/28/2026, I conducted an exit conference with licensee designee, Tamaria White, and discussed my findings with her. Ms. White stated she understood my findings and would submit a corrective action plan to address the rule violation found, including allowing Resident A to return to the facility until an appropriate placement can be found.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(7) A licensee shall not discharge a resident to a setting without an address or to a hospital emergency department.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with hospital social worker, Karley Dochterman, program director, Tammy Zentz, and case manager, Sade Wilson, Guardian A1 and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that Resident A was improperly discharged. Therefore, the licensee attempted to discharge Resident A to a hospital emergency department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



Vanita C. Bouldin — Date: 10/02/2026
Licensing Consultant

Approved By:



Ardra Hunter — Date: 10/13/2026
Area Manager