GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 27, 2023

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

RE: License #: AS820412115
Investigation #: 2023A0575029
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 #:	2023A0575029
Complaint Receipt Date:	06/06/2023
Investigation Initiation Date:	06/06/2023
Report Due Date:	07/06/2023
Licensee Name:	NRMI LLC
Licensee Address:	17187 N. Laurel Park Dr., Ste. 160 Livonia, MI 48152
Licensee Telephone #:	(734) 646-1603
Administrator:	Greg Rostker, Designee
Licensee Designee:	Kim Waddell, Designee
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?
Residents not provided adequate staffing.	No
Resident A's medications altered without physician instructions.	Yes

III. METHODOLOGY

06/06/2023	Special Investigation Intake-2023A0575029
06/06/2023	Special Investigation Initiated - Telephone
06/06/2023	APS Referral
06/08/2023	Contact - Telephone call made-(1) direct care staff: (a) Benjamin Doyle-Burnett; (b) Tanisha Sharp; (c) Cassandra Rice; (d) Neiasha Link; (e) Jackie Davis. (2) Renisha Martin-facility manager; (3) Daria Goodman-facility nurse. (4) Hospice Nurse-Vanessa Hurley. (5) Resident A's guardian
06/14/2023 06/14/2023	Inspection Completed On-site-interviews with: (a) Kim Waddell-licensee designee; (b) Greg Rostker-administrator; (c) Daria Goodman-facility nurse Inspection Completed- Sub-Compliance
06/14/2023	Exit Conference with licensee designee
06/16/2023	Contact - Telephone call made-Resident B's guardian

ALLEGATION:

Residents not provided adequate staffing.

INVESTIGATION:

On 6/8/2023, I interviewed direct care staffs Benjamin Doyle-Burnett, Tanisha Sharp, Cassandra Rice, Neiasha Link, and Jackie Davis, the facility manager, Renisha

Martin and the facility nurse, Daria Goodman. All of them expressed satisfaction with the current staffing levels to meet the current resident's supervision, personal care and protection needs.

On 6/14/2023, I reviewed the resident's assessment plans and found none required 1:1 supervision. Administrator Greg Rostker provided the staffing schedule and stated that there are 3 staff for the 4 residents during the day, and 2 staff for the 4 residents during the overnight.

On 6/16/2023, I interviewed Resident B's guardian. Resident B was not interviewed due to his cognitive disability. She stated that she is satisfied with his current placement, and she reports he is very pleased with his music therapy class.

APPLICABLE RULE	
R 400.14206	**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:	Since the minimum staffing required is 1 staff to 12 residents (see R206(1)) and the resident's assessment plans do not identify anyone who requires 1:1 supervision, then the licensee has 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 plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medications altered without physician instructions.

INVESTIGATION:

Resident A died on 6/3/2023 so she was not interviewed.

On 6/8/2023, I interviewed direct care staffs Benjamin Doyle-Burnett, Tanisha Sharp, Cassandra Rice, Neiasha Link, and Jackie Davis. I also interviewed facility manager Renisha Martin and facility nurse Daria Goodman. All of the above staff reported

having personality conflicts and/or communication problems with hospice nurse, Vanessa Hurley regarding whether Resident A could refuse to take a prescription medication that was physician-ordered and approved by Resident A's guardian. Therefore, based on the staff concerns, I asked them if the hospice nurse, Vanessa Hurley ordered them to give Resident A morphine even if Resident A refused the medication. Four of the five direct care staff stated that hospice nurse Vanessa Hurley told them to give Resident A the medication (morphine) even if she refused it, telling the staff to say the morphine is for shortness of breath, not just for pain, which was the basis for Resident A's refusal of the morphine. The facility manager, Renisha Martin stated that Resident A told her she did not want the morphine. Finally, the facility nurse, Daria Goodman, stated that hospice nurse Vanessa Hurley did not tell her to give the medication (morphine) even if Resident A refused it.

On 6/8/2023, I interviewed hospice nurse Vanessa Hurley. She stated that she did not tell any staff to give Resident A morphine even if she refused, as she stated she understood the resident's right to refuse medication(s). She stated that she explained to the staff that the morphine was a physician's order, and you have to call in to the physician to cancel it. Finally, she stated she told staff that Resident A's prescription morphine was for pain and for shortness of breath.

On 6/8/2023, I interviewed Resident A's guardian. She stated she specifically gave hospice permission to give Resident A the physician prescribed medications. She also stated Resident A did not refuse medications and did not say she did not want the medications, as the staff alleged. Finally, she stated she was dissatisfied with this placement, though Resident A was on hospice for the last 2 years and had lived at this facility for over a decade.

On 6/14/2023, I interviewed nurse Daria Goodman. She stated that a major source of frustration for her and the staff was that there was no communication with the hospice nurses. Kim Waddell and Greg Rostker shared an email from 5/16/23 for a Resident A/hospice nurse/Resident A's guardian video meeting. Neither the hospice nurse(s) nor Resident A's guardian attended. Finally, I reviewed the medication records she provided and found that on 6/1/23/ and 6/2/23, Resident A had a physician order for morphine every 6 hours, with no hold (meaning it has to be attempted to be given). The staff administering the medication recorded she did not give the medication as prescribed and did not obtain physician approval.

On 6/14/2023, I conducted an exit conference with the licensee designee.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	On 6/1/23 and 6/2/23 the direct care staff ignored Resident A's current/last medication order, effectively changing her prescription medication without a physician's instruction/order. Therefore, the direct care staff member who supervised the taking of medication by Resident A did not comply with the provision of not adjusting or modifying a resident's prescription medication without instructions from a physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jeffrey J. Bozsik
Licensing Consultant
Date: 6/26/2023

Approved By:

Ardra Hunter
Area Manager
Date: 6/27/2023