GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 16, 2023

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

RE: License #: AL630412118
Investigation #: 2024A0612002
North Ridge

Dear Kimberlee 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 #:	AL630412118
Investigation #:	2024A0612002
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:	North 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 2024A0612002
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.
11/06/2023	Contact - Document Received I received copies of recent unplanned hospitalizations, census records, proof of wounds, oral care, and brief checks.
11/01/2023	Inspection Completed On-Site I completed an unannounced onsite investigation. I interviewed administrator Tammy Zentz, residential program manager Erica Mabry, team leader Brandy Warren, Resident A, Resident B, and Resident C.
11/13/2023	Contact - Telephone call made Telephone interview conducted with team skills trainers Arianna Hamilton and Deangela Gains. Telephone call placed to Jacqueline Bay- Murry. There was no answer. Left voicemail requesting return call.
11/15/2023	Contact – Telephone call made Telephone interview conducted with administrator, Tammy Zentz.

11/15/2023	Exit Conference Telephone call to 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, team leader Brandy Warren, Resident A, Resident B, and Resident C. 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 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 for sleeping on shift and neglecting residents. Both staff were working on the midnight shift:

- JaQuan Jolly - terminated for neglect on 10/11/23.
- Shavonte Hutterson - terminated for neglect on 09/22/23.

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 documentation 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 consist 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 team leader, Brandy Warren. Ms. Warren stated she has worked at this facility for six or seven years. Ms. Warren works on the day shift from 8:00 am – 4:00 pm. Ms. Warren stated there is a no sleeping policy in place and staff are made aware of this policy. However, she has caught staff sleeping on shift and reported it to management. Disciplinary action was taken against these staff for sleeping. Ms. Warren remarked, staff sleeping on shift occurs more often on the midnight shift.

On 11/01/23, I interviewed Resident A. Resident A stated all the staff are very nice and treat her well. Resident A stated she has never observed any staff sleeping on shift. Resident A stated that she has never been sick due to lack of care.

On 11/01/23, I interviewed Resident B. Resident B denied the allegations and stated, "everything is cool. I am not neglected." Resident B stated he has not observed any staff sleeping on shift.

On 11/01/23, I interviewed Resident C. Resident C stated she is very well treated at this facility. She recommends it to others who need care. Resident C has never witnessed any staff asleep on shift. Resident C remarked that staff are very happy, and they provide good care.

On 11/13/23, I completed a telephone interview with team skills trainer, Arianna Hamilton. Ms. Hamilton works on the midnight shift from 12:00 am – 8:00 am. She has

worked at this facility since April 2023. Ms. Hamilton stated the facility has a no sleeping policy. The policy is posted and enforced. In the past, she has witnessed staff being walked out and terminated if they were found asleep on shift. Ms. Hamilton stated she has not observed any issues with staff sleeping on shift recently. Supervisors' complete random checks during all shifts to ensure compliance with the sleeping policy. Ms. Hamilton stated she has not observed any residents becoming ill due to lack of care. There are residents who have ongoing health issues such as seizures and may have hospitalizations or individuals who get sick during cold and flu season, but these illnesses are not the result of lack of care.

On 11/13/23, I completed a telephone interview with team skills trainer, Deangela Gains. Ms. Gains has worked at this facility for one year. She works on the midnight shift from 12:00 am – 8:00 am. Ms. Gains stated that staff complained about ongoing issues regarding staff sleeping on shift and in doing so, these staff were not properly caring for the residents. As a response to staff complaints there were several policies and procedures put into place and several staff were terminated. Within the last few months Ms. Gains estimates seven to eight staff were terminated. Since the changes, Ms. Gains remarked, things have been a lot better. During the midnight shift team leaders and supervisors have been put into place to ensure ongoing compliance with the no sleeping policy which has been helpful. Ms. Gains stated she has not recently observed any staff sleeping on shift. Ms. Gains denied that residents are becoming ill due to lack of care. She stated that a resident may be admitted into the facility with an illness, and they do as much as they can to treat them. Ms. Gains stated if there are any reoccurring issues at the facility, management has meetings to address the problem. There has not been any need for meetings recently as things have been going well.

I reviewed the facility's unplanned hospital admissions. Resident E was hospitalized on 09/20/23 – 09/26/23 due to breakthrough seizures and on 10/25/23 – 10/27/23 due to sepsis. 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 record. On 09/03/23, Resident D had the onsite of a pressure ulcer on his bilateral fifth toe. On 11/02/23, Resident F was admitted with a surgical wound on the gluteal cleft, a pressure ulcer on right heel, and a pressure ulcer on his right ear. The stage, status, wound type, wound location, and onsite date of each wound is consistently documented.

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 and residential program manager, Erica Mabry consistently stated that although sleeping on shift is prohibited in September 2023 and October 2023 two staff were terminated for sleeping on shift. To reduce the risk of recurrence an administrative note was issued to all staff regarding the no sleeping policy. Management is completing unannounced onsite inspections during all shifts. Any staff found sleeping is sent home. Staff found sleeping receive a final written warning with one occurrence. Staff with multiple occurrences, or if a resident is neglected because of the staff sleeping will be terminated. Additionally, the facility has hired team leaders on the midnight shift to increase supervision. 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 hospitalization or in resident wounds. Resident A, Resident B, and Resident C 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, team leader Brandy Warren, Resident A, Resident B, and Resident C. 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 in October 2023, Resident D was left in a wet brief. An investigation occurred and the staff member who was responsible, JaQuan Jolly was terminated for neglect on 10/11/23. Shavonte Hutterson was also terminated for neglect on 09/22/23. 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 team leader, Brandy Warren. Ms. Warren stated residents who wear briefs do soil themselves, however they are changed as needed and at minimum every two hours. Ms. Warren stated as the team leader she frequently changes residents and assures that the staff are regularly changing residents. All brief changes are documented. Regarding oral care, Ms. Warren stated residents are regularly prompted and assisted as needed with oral care. Oral care is provided at least once daily. However, Ms. Warren stated that this is an area staff could improve on. Staff document when oral care is offered/ provided.

On 11/01/23, I interviewed Resident A. Resident A denied being neglected by staff. Resident A stated she receives a shower every other day. She is never left soiled or in a wet brief. Resident A remarked, "if anything they change me too much."

On 11/01/23, I interviewed Resident B. Resident B denied the allegations and stated, "everything is cool. I am not neglected." Resident B stated he brushes his teeth twice a day. Staff provide reminders, but he can brush them independently. Resident B does not wear briefs. However, he stated that staff regularly change the residents who do.

On 11/01/23, I interviewed Resident C. Resident C stated she can brush her teeth independently, but staff provide reminders. Resident C wears briefs and staff change her regularly. Resident C denies ever being left in a wet or soiled brief. Resident C said

that she has never witnessed any of the other residents left in a soiled brief. Resident C remarked that staff are very happy, and they provide good care.

On 11/13/23, I completed a telephone interview with team skills trainer, Arianna Hamilton. Ms. Hamilton stated briefs are changed every two hours and as needed. Brief changes are documented. Residents do soil themselves however, they are never left sitting in a soiled brief. All caregivers assist as needed to ensure that the residents are changed timely. Ms. Hamilton stated oral care is to be completed on each shift. Oral care is consistently documented. Ms. Hamilton stated the midnight shift assist residents with oral care before they eat breakfast. There are some residents who have dental issues, but these issues are not a result of poor oral care.

On 11/13/23, I completed a telephone interview with team skills trainer, Deangela Gains. Ms. Gains stated residents receive oral care on every shift. Oral care is documented. Residents have the right to refuse. Ms. Gains stated residents are changed every two hours or as needed. Ms. Gains denied that residents are left in soiled briefs. Brief changes are documented.

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 11/15/23, I placed a telephone call to licensee designee, Kimberlee Waddell to conduct an exit conference. There was no answer. The voicemailbox was full and I was unable to leave a message. On 11/15/23, I also placed a telephone call to administrator, Tammy Zentz to conduct an exit conference and review my findings. Ms. Zentz acknowledged her understanding that a corrective action plan would be 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 Shavonte Hutterson and JaQuan Jolly failed to provide residents with adequate personal hygiene. Mr. Jolly and Ms. Hutterson were both terminated for neglect after it was determined that they left residents in wet briefs while they were asleep on the midnight shift. 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, and Resident C 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.

11/16/2023

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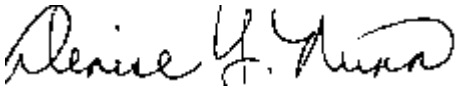
Johnna Cade — Date
Licensing Consultant

Approved By:



11/16/2023

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Denise Y. Nunn — Date
Area Manager