GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 24, 2024

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

RE: License #: AS810412125
Investigation #: 2024A0122008
Talladay Trails

Dear Kim Waddell:

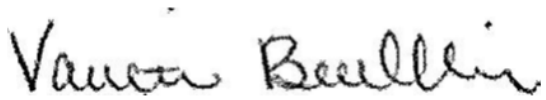
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (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 #:	AS810412125
Investigation #:	2024A0122008
Complaint Receipt Date:	01/10/2024
Investigation Initiation Date:	01/11/2024
Report Due Date:	03/10/2024
Licensee Name:	NRMI LLC
Licensee Address:	160 17187 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(734) 646-1603
Administrator:	Kim Waddell
Licensee Designee:	Kim Waddell
Name of Facility:	Talladay Trails
Facility Address:	6312 Talladay Milan, MI 48160
Facility Telephone #:	(734) 439-8398
Original Issuance Date:	06/01/2022
License **Status:**	REGULAR
Effective Date:	12/01/2022
Expiration Date:	11/30/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 01/09/2024, Resident A engaged in self-harming behavior due to improper supervision.	Yes

III. METHODOLOGY

01/10/2024	Special Investigation Intake 2024A0122008
01/11/2024	Special Investigation Initiated - Telephone Completed interview with Dr. Victor Hong, University of Michigan Hospital, Washtenaw County.
01/12/2024	Inspection Completed On-site Completed interview with Resident A. Received a copy of Resident A's Supervision Plan dated 10/05/2023.
01/12/2024	APS Referral Document received – Information from Resident A's file.
01/12/2024	Exit Conference Kim Waddell, Licensee Designee.
01/18/2024	Contact – Telephone call made. Completed interview with Maya Gist, direct care staff. Left voice messages for Cindy Treherne, Case Manager and Rose Cray, direct care staff.
01/22/2024	Contact – Telephone call received. Completed interview with Cindy Treherne, Case Manager.

ALLEGATION: On 01/09/2024, Resident A engaged in self-harming behavior due to improper supervision.

INVESTIGATION: On 01/11/2024, I completed an interview with Dr. Victor Hong, Medical Director of Psychiatric services of the University of Michigan Hospital, Ann Arbor, MI. Dr. Hong reported that on 01/09/2024 Resident A was medically assessed for a suicide attempt. He further reported that Resident A requires 1:1 supervision, the staff person should be within arm's reach of Resident A. On

01/09/2024, Resident A went into his room unsupervised and attempted to hang himself with a belt. Resident A was unsuccessful, reported the incident to the staff members present in the home, and was taken to the University of Michigan Medical Center/Psychiatric Department for treatment.

Per Dr. Hong, Resident A was not injured from the suicidal attempt, he was monitored for 24 hours, and released back to the care of the staff members of Talladay Trails adult foster care facility. Dr. Hong further reported that Resident A has a history of suicidal attempts and is diagnosed with a traumatic brain injury which leads to the requirement of 1:1 supervision. Dr. Hong reported Resident A's assigned 1:1 staff person, was using her personal cell phone causing a distraction allowing Resident A to complete a suicide attempt on 01/09/2024.

On 01/12/2024, I completed an interview with Resident A. Resident A confirmed what was reported by Dr. Hong. Resident A stated on 01/09/2024, Maya Gist was his assigned 1:1 staffing and was distracted while using her cell phone. Resident A stated he went into his room, locked the door, and attempted to hang himself by wrapping his belt around his neck and using the bar in his closet to suspend himself. Resident A stated he was able to dislodge himself from the bar and the belt; he then sat on his bed, crying for approximately 20 minutes.

Resident A then left his bedroom, entered the facility kitchen, and reported his suicide attempt to staff member, Rose Cray. Resident A stated he received no injury from the attempt and was taken to the University of Michigan Hospital for medical assessment. Resident A acknowledged that a staff member should be with him at all times, and he should not be allowed to enter his bedroom alone.

On 01/16/2023, I reviewed information from Resident A's file. Resident A's Plan of Care Summary dated 09/16/2023 documents that he receives "1:1 supervision including in the community." It also states that he is diagnosed with "TBI (Traumatic Brain Injury)/Post-Concussive syndrome, which causes negative mind-states, depression and passive suicidal ideation…"

Resident A's 1:1 Supervision Plan dated 10/05/2023 documents that Resident A requires 1:1 staffing due to his "history of suicidal ideation and suicidal gestures/attempts and impulsivity…" The plan further states that there will be one defined staff as his 1:1 staff person and that person "should position themselves within arm's reach length of" Resident A "during all shifts." It is noted that direct care staff, Maya Gist, signed this plan on 01/02/2024 documenting that she had reviewed Resident A's plan.

Resident A's After Visit Summary dated 01/09/2024 documents the reason for his visit/medical treatment was due to "suicidal ideation, suicidal behavior with attempted self-injury."

On 01/18/2024, I completed an interview with Maya Gist, direct care staff. Ms. Gist confirmed that she was assigned as Resident A's 1:1 staff person on 01/09/2024. Per Ms. Gist, she alerted her co-worker Rose Cray, that she was going to the bathroom. Upon her return she noticed that Resident A's bedroom door was closed, she knocked on the door, and Resident A responded after two minutes. Ms. Gist stated Resident A came out of his bedroom and told Ms. Cray what he had done. Ms. Gist could give no reasoning as to why Resident A was allowed to enter his bedroom unsupervised on 01/09/2024.

As of 01/23/2024, I have received no contact from direct care staff, Rose Cray. Ms. Cray has not responded to my voice message requesting a return phone call.

On 01/12/2024, I completed an exit conference with Kim Waddell, licensee designee and my findings were discussed with her. Ms. Waddell stated she agreed with my findings and would submit a corrective action plan to address the rule violation found.

On 01/22/2024, I completed an interview with Cindy Treherne, Resident A's Case manager. Ms. Treherne stated she had been informed of the incident involving Resident A on 01/09/2024. Ms. Treherne reported she believes that the administrators of Talladay Trails will address the incident appropriately. Ms. Treherne stated she has no other issues nor concerns with the adult foster care services Resident A is receiving from the staff members of Talladay Trails.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	On 01/09/2024, Resident A was not supervised and attempted to hang himself while he was alone in his bedroom. Resident A's After Visit Summary dated 01/09/2024 documents the reason for his visit/medical treatment was due to "suicidal ideation, suicidal behavior with attempted self-injury." Resident A's 1:1 Supervision Plan dated 10/05/2023 documents that Resident A requires 1:1 staffing due to his "history of suicidal ideation and suicidal gestures/attempts and impulsivity…" The plan further states that there will be one defined staff as his 1:1 staff person and that person "should position themselves within arm's reach length of" Resident A "during all shifts." On 01/09/2024, Maya Gist was assigned as Resident A's 1:1 staff. Ms. Gist confirmed that on 01/09/2024, Resident A entered into his bedroom unsupervised and attempted to hang himself. Ms. Gist signed Resident A's 1:1 Supervision Plan dated 10/05/2023 documenting that she had reviewed his plan. Based upon my investigation I find that the Licensee Designee, Kim Waddell, did not provide supervision and protection as specified in Resident A's Supervision Plan dated 10/05/2023. On 01/09/2024, direct care staff, Maya Gist, failed to provide the documented supervision stated in Resident A's Supervision Plan giving Resident A the opportunity to inflict self-harm by attempting to hang himself.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the status of the license.

Vanita C. Bouldin Date: 01/23/2024
Licensing Consultant

Approved By:

Ardra Hunter Date: 01/24/2024
Area Manager