GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2024

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

RE: License #: AS820412111
Investigation #: 2024A0122021
Elwell Point

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 #:	AS820412111
Investigation #:	2024A0122021
Complaint Receipt Date:	05/16/2024
Investigation Initiation Date:	05/16/2024
Report Due Date:	07/15/2024
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:	Elwell Point
Facility Address:	17100 Elwell Rd Belleville, MI 48111
Facility Telephone #:	(734) 697-7131
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 05/10/24, staff members Dillon Byram and Caleb Gianola performed an improper crisis intervention restraint on Resident A.	Yes

III. METHODOLOGY

05/16/2024	Special Investigation Intake 2024A0122021
05/16/2024	Special Investigation Initiated - Telephone Completed interview with Licensee Designee, Kim Waddell.
05/16/2024	Contact - Document Received Received requested documents.
05/17/2024	Inspection Completed On-site Completed interview with Resident A.
05/17/2024	APS Referral
05/17/2024	Contact – Telephone calls made. Completed interviews with staff members, Caleb Gianola and Dillon Byram.
05/20/2024	Exit Conference Discussed findings with Kim Waddell
05/21/2024	Contact – Telephone call made. Completed interview with Case Manager, Linda Leone.

ALLEGATION: On 05/10/24, staff members Dillon Byram and Caleb Gianola performed an improper crisis intervention restraint on Resident A.

INVESTIGATION: On 05/16/24, during an interview with licensee designee, Kim Waddell, she stated she received a report that on 05/10/2024, staff members Dillon Byram and Caleb Gianola completed an improper crisis intervention restraint on Resident A. Per Ms. Wadell, Resident A reported that Mr. Byram and Mr. Gianola put him in a “half neck hold (like with arm wrapped around neck, but not both arms).” Resident A stated he fell to the ground and a second staff member joined in.

Ms. Waddell stated she has completed interviews with both Mr. Byram and Mr. Gianola, and they denied using an inappropriate crisis intervention restraint with Resident A. Ms. Waddell has suspended both Mr. Byram and Mr. Gianola pending a complete internal investigation.

On 05/17/2024, I completed an interview with Resident A. Resident A confirmed that he was restrained by both Mr. Byram and Mr. Gianola on 05/10/2024. Resident A stated that prior to the incident involving the restraint he was upset as he thought that someone had entered his room while he was out of the facility, and he wasn't being told the truth. Resident A described himself as "hyped and agitated," and wanting to cause a confrontation between himself and Caleb Gianola.

Resident A reported on 05/10/2024, he observed that Mr. Gianola was in the living room, sitting at a table working on paperwork. He approached Mr. Gianola, making sure his face was in alignment with Mr. Gianola's face, and began screaming at him. Resident A stated he did not become physically aggressive but was verbally aggressive. Per Resident A, Mr. Gianola stated that Resident A spit on him and Mr. Gianola wrapped his arm around his head and tightened it. Resident A stated both he and Mr. Gianola fell to the floor, his nose hit Mr. Gianola's face, and he started bleeding. While Resident A was on the floor, he stated that Mr. Byram joined in and put his knee on his back and grabbed Resident A's arm.

Resident A stated at no time did he attempt to hit either Mr. Gianola or Mr. Byram. Resident A reported eventually they all got up from the floor and Mr. Gianola stated that Resident A attacked him but was also concerned about Resident A's bloody nose. Resident A stated the incident was reported to other individuals and he was taken to the hospital for medical treatment. Resident A confirmed that he and Mr. Gianola and Mr. Byram were the only individuals present during the incident.

On 05/17/2024, I completed interviews with staff members, Caleb Gianola and Dillon Byram. Both Mr. Gianola and Mr. Byram confirmed that they physically restrained Resident A on 05/10/2024. Mr. Gianola reported the following: on 05/10/2024, Resident A was observed as being paranoid that someone had entered his room without permission, agitated, and upset. Mr. Gianola stated prior to the incident, Resident A's behavior had been reported to his case manager and he was awaiting direction from that person.

Resident A left the facility with his therapist, returned, and confronted Mr. Gianola about someone being in his room. Mr. Gianola stated Resident A got in his face yelling, to which he requested that Resident A back up out of his personal space. Mr. Gianola stated Resident A did not comply but got even closer and he stated that Resident A spat in his mouth. Mr. Gianola stated he felt Resident A was going to become physically aggressive with him, so he responded by grabbing Resident A wherever he could, he grabbed Resident A around the head with his arm. In doing

so, Mr. Gianola stated he and Resident A fell to the floor and Mr. Byram “restrained him appropriately,” and eventually everyone got up from the floor.

Mr. Gianola stated after the restraint, he cleaned himself up as he had scraped his eye and was bleeding. He then went into the facility office, reported the incident, and went to check on the other residents. Mr. Gianola stated that Mr. Byram assisted Resident A after the incident.

On 05/17/2024, I interviewed Dillon Byram. Mr. Byram reported the same as Mr. Gianola regarding the incident with Resident A on 05/10/2024. Mr. Byram confirmed that he observed Mr. Gianola grab Resident A around the head during the initial contact of the restraint. Mr. Byram stated when Mr. Gianola and Resident A fell to the floor, he grabbed Resident A’s free arm and held it around his back so that Resident A could not hit Mr. Gianola while they were on the floor. Mr. Byram stated he got Resident A and Mr. Gianola to let go of each other and everyone got up from the floor. Per Mr. Byram, the incident was reported, and Resident A was transported to the hospital to complete an assessment by medical staff.

Both Caleb Gianola and Dillon Byram denied that either placed their knees on Resident A’s back during the restraining incident. Both Mr. Gianola and Mr. Byram reported they had been trained to complete Crisis Prevention Institute (CPI) interventions on residents. Both Mr. Gianola and Mr. Byram confirmed that Resident A was the only individual present during the incident.

On 05/17/2024, I reviewed Resident A’s paperwork. He has been diagnosed with a Traumatic Brain Injury since 07/20/1999. His Assessment Plan dated 05/16/2024 documents that he does not control his aggressive behavior, it further states that “if he is denied something he can become verbose and intimating.”

On 05/17/2024, I reviewed Mr. Gianola and Mr. Byram’s training documents, both have been trained to complete/perform CPI crisis interventions on residents. Mr. Gianola completed the training on 12/07/2023 and Mr. Byram completed the training on 10/12/2022. I reviewed pictures of the CPI crisis interventions that staff members are trained on, showing examples of techniques used. Staff members are trained to implement Holding in a seated or standing position. Neither of the pictures display the use of grabbing a person by the head or holding a free arm to the back.

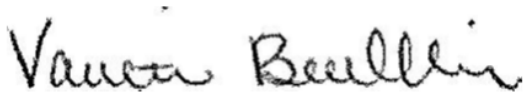
Resident A’s After Visit Summary dated 05/11/2024 documents that he was diagnosed and treated for “strain of neck muscle.”

On 05/21/2024, I completed an interview with Case Manager, Linda Leone. Ms. Leone confirmed that she had been made aware of the incident involving Resident A and Mr. Gianola and Byram on 05/10/2024. Ms. Leone stated she had no issues with the care being provided to Resident A but at the same time would like this issue to be addressed so that it doesn’t happen again. I explained to Ms. Leone the requirement of a corrective action plan and she agreed.

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(4) Crisis intervention shall be employed to allow the resident the greatest possible comfort and to avoid physical injury and mental distress.
ANALYSIS:	On 05/10/2024, staff members, Caleb Gianola and Dillon Byram, performed an improper crisis restriction on Resident A. On 05/17/2024, Resident A, Caleb Gianola, and Dillon Byram confirmed that Mr. Gianola grabbed Resident A by the head and Mr. Byram held Resident A's arm around his back. CPI crisis interventions techniques, Holding in a seated or standing position, that staff members are trained on, do not show the use of grabbing a person by the head or holding a free arm to the back. Caleb Gianola completed training on CPI techniques on 12/07/2023 and Dillon Byram completed the training on 10/12/2022. Resident A's After Visit Summary dated 05/11/2024 documents that he was diagnosed and treated for "strain of neck muscle." Based upon my investigation I find that on 05/10/2024, Caleb Gianola and Dillon Byram, did not employ the proper CPI crisis intervention technique to allow for Resident A's comfort, nor did it avoid physical injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



Vanita C. Bouldin
Licensing Consultant

Date: 05/21/2024

Approved By:

Ardra Hunter
Area Manager

Date: 05/22/2024