GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 1, 2024

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

RE: License #: AS810412127
Investigation #: 2024A0122031
Pineview 1

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.
- 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS810412127
Investigation #:	2024A0122031
Complaint Receipt Date:	07/26/2024
Investigation Initiation Date:	07/26/2024
Report Due Date:	09/24/2024
Licensee Name:	NRMI LLC
Licensee Address:	160 17187 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(734) 646-1603
Administrator:	Kimberlee Waddell
Licensee Designee:	Jamie Nicoloff
Name of Facility:	Pineview 1
Facility Address:	6180 Textile Rd Ypsilanti, MI 48197
Facility Telephone #:	(734) 481-1794
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 07/24/2024, staff, Geremiah Williams, threw the tiedown unit onto the floor of the facility van and it hit Resident A in the face.	Yes
Additional Findings	No

III. METHODOLOGY

07/26/2024	Special Investigation Intake 2024A0122031
07/26/2024	Special Investigation Initiated - Telephone Completed interview with staff, Geremiah Williams.
07/26/2024	Contact – Telephone call made. Left voice message for staff, Erin Chadwick.
07/29/2024	Inspection Completed Onsite Completed interview with Resident A. Guardian A1 and Home Manager, Jessica Reid were present.
07/29/2024	Contact – Telephone call made. Completed interview with staff, Erin Chadwick.
07/29/2024	Contact – Document received. Resident A's After View Summary
07/29/2024	Exit Conference Discussed findings with licensee designee, Kimberlee Waddell.
07/31/2024	Contact – Telephone call made. Adult Protective Service Referral made.

ALLEGATION: On 07/24/2024, staff, Geremiah Williams, threw the tiedown unit onto the floor of the facility van and it hit Resident A in the face.

INVESTIGATION: On 07/26/2024, I completed a telephone interview with staff, Geremiah Williams. Initially Mr. Williams was reluctant to participate in a telephone interview stating that he would submit a statement. However, after several attempts of asking him to tell me verbally what happened Mr. Williams gave me this statement: On 07/24/2024, he was attempting to release the tiedown unit from

Resident A, but he wasn't going at the speed or pace that staff, Erin Chadwick, wanted him to go. Therefore, he felt, Ms. Chadwick was speaking to him in an antagonistic manner. Per Mr. Williams, Ms. Chadwick stated, "Get out before you do something wrong." Mr. Williams stated he responded by grabbing his belongings and getting out of the van. Mr. Williams denied throwing the tiedown unit down and inadvertently striking Resident A in the face. Mr. Williams described a tiedown unit as a strap used to stabilize a wheelchair during transport. As of 07/31/2024, I have not received a written statement from Geremiah Williams.

On 07/29/2024, I completed an interview with Resident A. Resident A uses a speaking aid (Alphabet Letter Sheet) so Guardian A1 and home manager, Jessica Reid was present as well to assist Resident A with the interview process. Resident A did not remember, the male staff by name so Ms. Reid identified, Geremiah Williams, as the only male staff assigned to work during the alleged incident.

Resident A reported the following: As the male staff was releasing the tiedown, he was saying, "This is bullshit and I'm tired of this shit." Resident A stated that as he released the tiedown it hit me in my eye. I asked Resident A if Mr. Williams threw the tiedown as he was releasing it, Resident A was unable to answer the question.

Resident A reported that she did not want Geremiah Williams to return to her home. Guardian A1 stated she felt that the investigation of the incident was handled appropriately. Guardian A1 stated she has no issues and/or concerns with the care Resident A is receiving by the staff of Pineview 1.

I asked Jessica Reid about the normal procedure for releasing a tiedown, i.e. once a person releases the tiedown what should happen. Ms. Reid stated once a tiedown is released gravity should take over and it should fall to the vehicle floor. Ms. Reid stated when used properly a tiedown should not come into contact with anyone's face.

On 07/29/2024, I completed an interview with staff, Erin Chadwick. Ms. Chadwick confirmed that she worked with Mr. Williams and observed the incident involving him and Resident A on 07/24/2024. Ms. Chadwick reported the following: she redirected Mr. Williams to begin unloading Resident A from the vehicle as she was closest to the back, and he had started with a different resident. Per Ms. Chadwick, Mr. Williams complied with her request, however, she noticed that he was aggressive removing Resident A's tiedowns, she described that Mr. Williams was releasing the tiedowns and throwing them to the floor.

Ms. Chadwick stated as Mr. Williams began releasing the strap around Resident A's waist, it was released incorrectly, and she observed the strap hit Resident A's face. Ms. Chadwick told Mr. Williams, "You can stop before you F**k something up." Ms. Chadwick stated Mr. Williams responded by grabbing his items, getting out of the vehicle and leave the property. Ms. Chadwick reported that another staff assisted in getting the residents out of the van and into the facility. Ms. Chadwick stated the

incident was reported to Ms. Jessica Reid and Resident A received a medical assessment on the same day.

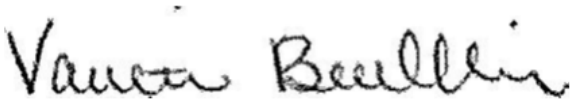
On 07/29/2024, I reviewed Resident A's After View Summary dated 07/24/2024. The Summary documents that Resident A received a medical assessment from medical personnel at the Trinity Health Urgent Care in Canton, MI. Resident A was assessed for "facial injury, initial encounter." There were no treatment recommendations given, Resident A is to see her primary care physician on 08/22/2024.

On 07/29/2024, I completed an exit conference with licensee designee, Kimberlee Waddell and discussed my findings to her. Ms. Waddell agreed with my findings and had nothing further to add.

APPLICABLE RULE	
R 400.14305	**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 upon my interviews with Resident A and staff, Geremiah Williams and Erin Chadwick, as well as a review of pertinent documentation relevant to this investigation, there is evidence to substantiate the allegations that staff, Geremiah Williams threw the tiedown unit onto the floor of the facility van and it hit Resident A in the face. Resident A was not treated with dignity and his or her personal needs, including protection and safety, was not attended to at all times in accordance with the provisions of the act
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: 07/31/2024
Licensing Consultant

Approved By:

Ardra Hunter Date: 08/01/2024
Area Manager