GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 22, 2025

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

RE: License #: AS810412114
Investigation #: 2025A0122012
The Hills

Dear Ms. Waddell:

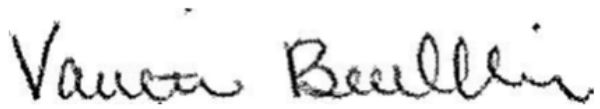
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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

I. IDENTIFYING INFORMATION

License #:	AS810412114
Investigation #:	2025A0122012
Complaint Receipt Date:	01/10/2025
Investigation Initiation Date:	01/13/2025
Report Due Date:	02/09/2025
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:	Kimberlee Waddell
Name of Facility:	The Hills
Facility Address:	3985 Hillside Ypsilanti, MI 48197
Facility Telephone #:	(748) 434-8830
Original Issuance Date:	06/01/2022
License Status:	REGULAR
Effective Date:	12/01/2024
Expiration Date:	11/30/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff did not follow physician wound care instructions for Resident A.	Yes

III. METHODOLOGY

01/10/2025	Special Investigation Intake 2025A0122012
01/13/2025	Special Investigation Initiated - Telephone Completed interview with Director of Nursing, Kendra Peker.
01/13/2025	Contact - Document Received Resident A's documents.
01/13/2025	APS Referral
01/15/2025	Onsite inspection Completed interviews with Resident A, staff members, Jessica Smith and Riad Alhakim. Reviewed Resident A's file.
01/17/2025	Contact – Telephone call made Completed interview with Guardian A.
01/21/2025	Contact – Telephone call made Completed interview with nurse, Deb Hawker.
01/21/2025	Exit Conference Discussed findings with licensee designee, Kim Waddell.

ALLEGATION: Staff did not follow physician wound care instructions for Resident A.

INVESTIGATION: On 01/10/2025, licensee designee, Kim Waddell, reported that staff did not follow Resident A's wound care instructions outlined in his after-visit hospitalizations summaries dated 12/10/2024 and 12/27/2024. Per Ms. Waddell, Resident A had a partial toe amputation on 01/05/2024.

On 01/13/2025, I completed an interview with nurse director, Kendra Peker. Ms. Peker reported the following: on 12/10/2024 and 12/27/2024, Resident A was taken to the hospital, Trinity Health, Ann Arbor, MI, and assessed for cellulitis of the toe and chronic ulcer of the great toe of right foot respectively, along with other ailments. He was treated and sent back to the facility with the directions to follow up with his physician and podiatrist, start and finish oral antibiotics and, “apply warm compresses 2-3 times per day, start oral antibiotic and continue for the full prescribed course, monitor closely for worsening of infection…”

Per Ms. Peker, staff did not apply warm compresses instead had Resident A completed feet soaks at the direction of nurse, Deb Hawker. Ms. Peker stated Resident A’s wound did not improve, he was taken to the hospital on 12/27/2024 at the request of vocational program manager and had a partial right toe amputation on 01/05/2025.

On 01/13/2025, I reviewed Resident A’s After Visit Summaries dated 12/10/2024 and 12/27/2024. I confirmed what was stated by Ms. Peker, Resident A was assessed for cellulitis of the toe and chronic ulcer of the great toe of right foot on 12/10/24 and 12/27/204. Resident A’s wound instructions were as stated by Ms. Peker.

On 01/13/2025, I reviewed Resident A’s wound care document dated 12/17/2024 through 12/25/2024. It gives the following directions, “Staff will each evening soak…feet in warm soapy water and dry completely. Then staff will apply the ammonium lac cream 12% to his great toe on both his right and left feet. Staff will apply clean socks on his feet each night and remove his shoes when in bed.” There are staff assigned numbers to document that this task was completed for each date on the document.

On 01/13/2025, I reviewed Resident A’s wound care document dated 12/26/2024 through 01/03/2025. It gives similar directions, stating, “Staff will each evening soak…feet in warm soapy water…”, apply an antibiotic cream, apply clean socks, and remove shoes when he is in bed. Again, there are staff assigned numbers on the document to verify these tasks were completed for each date on the document.

On 01/15/2025, I completed an onsite inspection. I completed an interview with Resident A. I observed Resident A in his room resting, with a bandage on his right foot. Resident A reported that he was doing well and reported no issues with staff. I asked Resident A to give me a description of how staff members provided wound care, Resident A was unable to answer that specific question but reported that he had a wound on his toe that would not heal, and he had surgery to address the issue. Resident A is diagnosed with a traumatic brain injury and thereby has cognitive limitations.

On 01/15/2024, I completed interviews with staff members, Jessica Smith and Riad Alhakim. Both reported they completed the following wound care instructions given by nurse, Deb Hawker: fill a basin with warm soapy water, submerge Resident A's feet and allow them to soak, dry, apply ointment, and place clean socks on his feet. Both stated they were directed to remove Resident A's shoes when he was in bed. Both stated that Resident A complied with their wound care tasks.

On 01/17/2025, I completed an interview with Guardian A. Guardian A reported that she had been informed about Resident A's wounds, wound care, hospital visits, and hospital admissions. Guardian A stated she had also been informed of the error made with Resident A's wound care instructions by staff and that she has confidence this issue will be addressed by the administration.

On 01/21/2025, I completed an interview with nurse, Deb Hawker. Ms. Hawker confirmed that she gave staff members the following directions for Resident A's wound care: soak Resident A's feet in warm, soapy water every night. Ms. Hawker stated she also attempted to get Resident A's podiatry appointment schedule sooner to no avail.

On 01//2025, I completed an exit conference with licensee designee, Kim Waddell and discussed my findings with her. Ms. Waddell agreed with my findings and stated she would submit a corrective action plan to address rule violation found in this investigation.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility staff members, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that staff did not follow physician wound care instructions for Resident A. All staff members, Jessica Smith, Riad Alhakim, and Deb Hawker reported they submerged Resident A's feet in warm, soapy water instead of applying a warm compress daily as stated in Resident A's After Visit Summaries dated 12/10/24 and 12/27/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Vanita C. Bouldin Date: 01/21/2025
Licensing Consultant

Approved By:

Ardra Hunter Date: 01/22/2025
Area Manager