GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 5, 2025

Kimberlee Waddell
NRMI LLC
PO Box 281
Whitehall, MI 49461

RE: License #: AS810412108
Investigation #: 2025A0122021
Birchwood Grove

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 #:	AS810412108
Investigation #:	2025A0122021
Complaint Receipt Date:	04/02/2025
Investigation Initiation Date:	04/02/2025
Report Due Date:	05/02/2025
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:	Birchwood Grove
Facility Address:	7160 Textile Rd. Ypsilanti, MI 48197
Facility Telephone #:	(734) 547-9545
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?
On 03/28/2025, staff member, Natasha Walker, restrained Resident A using an inappropriate action not in line with CPI (crisis prevention institute) Nonviolent Crisis Intervention Training.	Yes

III. METHODOLOGY

04/02/2025	Special Investigation Intake 2025A0122021
04/02/2025	Special Investigation Initiated - On Site Completed interview with Resident A.
04/02/2025	APS Referral
04/09/2025	Contact – Document received Licensee Designee, Kim Waddell, submitted requested information Resident A and staff member, Natasha Walker, files.
04/10/2025	Contact – Telephone call made Completed interviews with staff members, Natasha Walker and Erica Newsome. Left voice message for Victoria Matthew.
04/18/2025	Contact – Telephone call made Left voice message for Victoria Matthew.
04/18/2025	Exit Conference Discussed findings with licensee designee, Kim Waddell.
04/21/2025	Contact – Telephone call made Completed interview with Guardian A.

ALLEGATION: On 03/28/2025, staff member, Natasha Walker, restrained Resident A using an inappropriate action not in line with CPI (crisis prevention institute) Nonviolent Crisis Intervention Training.

INVESTIGATION: On 04/02/2025, licensee designee, Kimberly Waddell submitted an email stating the following, on 03/28/2025 Resident A was restrained in a manner that is not in line with CPI training by staff member, Natasha Walker. Per Ms.

Waddell, Ms. Walker put one hand on Resident A's chin when Resident A tried to spit on her. Ms. Walker then moved his head to the side. Staff members, Victoria Matthew and Erica Newsome witnessed this incident. They intervened and took over since Resident A continued to yell. Resident A was not injured during the incident.

Ms. Waddel stated, "We do not support hands on the face." Ms. Waddell reported that Ms. Walker was suspended pending an internal investigation.

On 04/02/2025, I completed an interview with Resident A. Resident A reported on 03/28/2025, he was upset and yelling for approximately 30 minutes. He stated that it was a misunderstanding between him and staff members, but he doesn't remember about what specifically. Resident A does not remember if staff member, Natasha Walker put her hand on his chin and moved his face to the side as part of an intervention. He stated the issue was resolved and he encountered no injury during the incident. Resident A stated he had no problems and/or concerns regarding the care he has been receiving from staff members.

On 04/10/2025, I reviewed staff member, Natasha Walker's, employee file. Ms. Walker successfully completed CPI (crisis prevention institute) Nonviolent Crisis Intervention Training on 07/11/2024. CPI Nonviolent Crisis Intervention Training, "equips staff with skills to safely recognize, prevent, and respond to challenging behaviors…"

On 04/10/2025, I reviewed an incident report dated 03/28/2025, which documents staff member, Natasha Walker, "grabbed" Resident A's face and moved it to the side to prevent him from spitting on her. This incident was witnessed by staff, Victoria Matthew and Erica Newsome.

On 04/10/2025, I completed an interview with Natasha Walker. Ms. Walker confirmed that on 03/28/2025 she was involved in the following incident that involved Resident A. Per Ms. Walker, she and Resident A had a verbal disagreement that turned into Resident A attempting to become physically aggressive towards her. Ms. Walker stated that Resident A attempted to hit, bite, and spit on her. When Resident A attempted to spit on her, Ms. Walker stated she used her forearm and hands to turn his face to the opposite side of her. Ms. Walker admitted that this technique is not part of the CPI Nonviolent Intervention Training but stated she was not trained on how to intervene when a resident attempts to spit on you.

On 04/10/2025, I completed an interview with staff member, Erica Newsome. Ms. Newsome confirmed that she witnessed the incident between Resident A and staff member, Natasha Walker. Ms. Newsome stated she observed Ms. Walker take her open hand and shove Resident A's face as Resident A was trying to spit on Ms. Walker. Ms. Newsome stated she intervened by verbally redirecting Ms. Walker to stop her actions and removed Resident A from the area and taking him back to his room. Ms. Newsome stated Resident A was not injured and once he had calmed down, she reported the incident.

On 04/10/2025 and 04/18/2025, I contacted staff member Victoria Matthew by phone, leaving a message asking her to return my phone calls to complete an interview. As of 04/21/2025, I have received no contact from Ms. Matthew.

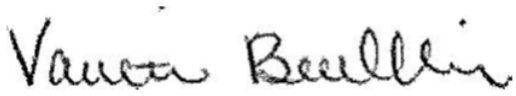
On 04/18/2025, I completed an exit conference with licensee designee, Kim Waddell and discussed my findings with her. Ms. Waddell agreed with my findings and stated she would submit a corrective action plan to address rule violation found.

On 04/21/2025, I completed an interview with Guardian A. Guardian A stated the incident had been report to her and she had no concerns at this time.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with Resident A, staff members, Natasha Walker and Erica Newsome, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 03/28/2025, staff member, Natasha Walker, restrained Resident A using an inappropriate action not in line with CPI (crisis prevention institute) Nonviolent Crisis Intervention Training. Therefore, Ms. Walker used a form of physical force with Resident A other than an approved physical restraint.
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: 04/21/2025
Licensing Consultant

Approved By:

Ardra Hunter Date: 05/05/2025
Area Manager