GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 13, 2026

Kimberlee Waddell
NRMI LLC
17199 N. Laurel Park Dr.
Livonia, MI 48152

RE: License #: AS630418299
Investigation #: 2026A0605010
Gill Crest

Dear Kimberlee Waddell:

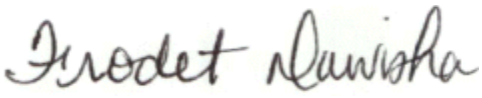
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 972-9136.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd, Ste 9-100
Cadilac Place
Detroit, MI 48202
(248) 303-6348

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS630418299
Investigation #:	2026A0605010
Complaint Receipt Date:	02/03/2026
Investigation Initiation Date:	02/03/2026
Report Due Date:	04/04/2026
Licensee Name:	NRMI LLC
Licensee Address:	424 17199 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(231) 893-1462
Administrator/Licensee Designee:	Kimberlee Waddell
Name of Facility:	Gill Crest
Facility Address:	23825 Gill Farmington, MI 48335
Facility Telephone #:	(734) 646-1603
Original Issuance Date:	08/23/2024
License Status:	REGULAR
Effective Date:	02/23/2025
Expiration Date:	02/22/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED/MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has fallen several times in the past, but recently Resident A fell on 01/25/2026 and suffered a traumatic brain injury. Resident A had surgery on 1/25/2026 and passed away on 1/29/2026. Facility is refusing to provide incident reports.	Yes

III. METHODOLOGY

02/03/2026	Special Investigation Intake 2026A0605010
02/03/2026	Special Investigation Initiated - Telephone Discussed allegations with licensee designee Kimberlee Waddell
02/03/2026	APS Referral Adult Protective Services (APS) referral not made because the resident was deceased when complaint was received.
02/04/2026	Contact - Document Received Kimberlee Waddell sent documents regarding Resident A
02/04/2026	Contact - Telephone call made Interviewed direct care staff (DCS) regarding allegations
02/05/2026	Inspection Completed On-site Conducted scheduled on-site investigation
02/05/2026	Contact – Face to Face Discussed allegations with Farmington Police Department
02/05/2026	Contact - Telephone call made Discussed allegations with case manager Suzanne Morrison, Resident A's sister, and left message for DCS Thelma Green
02/06/2026	Contact - Document Received Email with documents from Kimberlee Wadell
02/12/2026	Contact - Document Received Email received from Kimberlee Waddell
02/12/2026	Contact - Telephone call made Interviewed DCS regarding allegations

02/12/2026	Contact - Telephone call made Left message for DCS Aria Nowden
02/17/2026	Contact - Document Received Email from clinical manager Valerie Wedge
02/23/2026	Contact - Telephone call made Left another message for Aria Nowden
02/23/2026	Contact - Telephone call received Discussed allegations with DCS Aria Nowden
02/24/2026	Contact - Document Received Email from Resident A's sister
02/25/2026	Contact - Document Received Email from Valerie Wedge
03/02/2026	Contact – Telephone call made Followed up with Resident a's sister
03/02/2026	Exit Conference Conducted with licensee designee Kimberlee Waddell with my findings

ALLEGATION:

Resident A has fallen several times in the past, but recently Resident A fell on 01/25/2026 and suffered a traumatic brain injury. Resident A had surgery on 1/25/2026 and passed away on 1/29/2026. Facility is refusing to provide incident reports.

INVESTIGATION:

On 02/03/2026, intake #209231 was assigned for investigation with minimal information regarding a resident that fell on 01/25/2026, had surgery and passed away. There was no information regarding the resident's name.

On 02/03/2026, I contacted via telephone licensee designee Kimberlee Waddell who stated that Resident A who has been with NRMI LLC for 22 years, was residing at Gill Crest, slipped in the shower on 01/25/2026, fell and went to Corewell Health. He had surgery to release the pressure in his head, because when he fell, he hit his head. Resident A was then put in a coma but then died on 01/29/2026. Ms. Waddell is

currently investigating this incident to ensure staff followed NRMI LLC's policy and protocol during the incident. Resident A's sister has requested all the incident reports (IR) which Ms. Waddell is currently preparing and will be sending them to her. The direct care staff (DCS) working the midnight shift were Lucia Cohen and Reisha Wilson. Both have been suspended pending this investigation. Resident A is a standby assist with a gait belt. About two weeks ago, he was "assigned," a wheelchair because he was falling. He had a bed alarm and a door alarm to alert staff whenever he was up on his feet. Ms. Waddell will email me Resident A's identification record, the incident report, and Resident A's plan-of-care (POC).

On 02/04/2026, I received an email from Kimberlee Waddell with the documents requested. I reviewed the IR dated 01/25/2026 at 6:30AM stated "Resident A fell in restroom unwitnessed resulting in hospitalization." Staff on shift were Reisha Wilson and Lucia Cohen. 911 contacted approximately 7AM. I reviewed his admission record that stated he moved into Gill Crest on 06/11/2025. He had a diagnosis of traumatic brain injury (TBI) and seizures/convulsions. I also reviewed Resident A's POC dated 06/10/2025. Resident A's POC did not provide specifics regarding his self-care skill assessment other than "assistance will be provided by DCS." Resident A uses a cane for ambulation, which was prescribed by an authorized physician as reviewed on Resident A's health care appraisal.

On 02/04/2026, I interviewed NRMI LLC's residential supervisor Lauren Reagan regarding the allegations. Ms. Reagan overseas staffing, including staff at Gill Crest. Resident A had unsteadied gait, memory deficits, and was unaware of his surroundings. He had been an elopement risk too. He had a gait belt that was on him during waking hours and if he was ambulating, staff had to be right there with him using the gait belt to assist with his ambulation. On 01/25/2026, she was not the on-call residential supervisor as Renisha Martin was. Resident A's ambulation was declining and due to frequent falls, physical therapy (PT) recommended a wheelchair to be used for "community," only. Ms. Reagan was contacted on 01/26/2026 and advised that Resident A fell during the midnight shift on 01/25/2026, hit his head and went to the hospital. He was admitted to the hospital with "serious injury," that resulted in him passing away. The DCS working that shift were Reisha Wilson and Lucia Cohen. Ms. Reagan contacted both staff asking them what happened. Both staff reported to her that the fall was unwitnessed, and both heard a "loud sound," from the bathroom. The staff called 911 then Resident A was transported to the hospital. The internal investigation regarding the incident is still ongoing as the stories both staff are providing are not consistent. I inquired about Resident A's POC as the one provided to me has minimal information. She stated that each resident at Gill Crest has a program binder with a detailed description of the POC for each resident completed by NRMI LLC's case manager Suzanne Morrison. The case manager is the individual that ensures that staff are trained on each of the residents' POC, including Resident A.

On 02/04/2026, I interviewed NRMI LLC program director Tammy Zentz regarding the allegations. The registered nurse (RN) LaJoy Watson was on-call on 01/25/2026, and who was contacted by staff regarding Resident A's fall. The RN sent out a text message

to all managers advising that 911 was called, and Resident A went to the hospital because he had fallen, hit his head. A couple of days later, Ms. Zentz was informed how serious the injury was when Resident A required brain surgery to release pressure and then he was put in a coma and passed away. Ms. Zentz interviewed DCS Reisha Wilson and Lucia Cohen and there were discrepancies with their stories of what happened. Both staff were interviewed twice via telephone and then in-person due to the stories changing. Ms. Zentz put a timeline of when Resident A may have fallen to when management and/or the RN was contacted. Lucia stated she was passing medications when she heard a loud sound from the bathroom. According to the medication system, Lucia logged her medication at 6:12AM and 6:13AM. The RN reported she was contacted at 7AM but Reisha said, “she’s lying.” The RN checked her phone, and it was 6:52AM. It took 40minutes for staff to call anyone from the time he fell to when the first call was made to the RN. The protocol for an unwitnessed fall is to follow up with the RN; however, if there is a change in the residents’ status which in this case was, then 911 should have been contacted first and then the RN. Ms. Zentz stated that NRMI LLC will be modifying their protocol by contacting 911 immediately for any unwitnessed fall. Ms. Zentz is concerned about the lack of follow-up by staff, staff waiting 40 minutes to get help, so she will be recommending termination of both Reisha Wilson and Lucia Cohen. Ms. Zentz has provided Resident A’s sister will all the IRs. Ms. Zentz agreed to an on-site investigation tomorrow at Gill Crest.

On 02/04/2026, I interviewed Resident A’s sister via telephone regarding the allegations. Resident A’s sister was next of kin and in the process of filing for guardianship. Resident A had been residing at Gill Crest since 06/11/2025. He was in a car accident in 2003 that resulted in TBI. On 01/25/2026, she received a call from Corewell Health stating that Resident A was brought to the hospital from the group home after a fall. The hospital staff reported that Resident A was “seizing,” due to a brain injury and required “brain surgery,” due to a subdural hematoma. The sister called Gill Crest and spoke with staff Aria about what happened but did not get a clear answer. The sister did not understand how he had fallen since he wore a gait belt and when he was on his feet, staff must be on their feet as he was a standby assist. The sister is concerned that this fall could have been avoided if staff were standing by Resident A assisting him while he was in the bathroom. Resident A had fallen several times before, which is why the gait belt was prescribed. She stated, “there have been several times when staff are supposed to be in the bathroom with Resident A, but instead they are standing outside the bathroom with the door closed.” She was told by management that he had taken off all his clothes, asked by staff if he wanted to take a shower and he said no. Staff asked him to put his clothes back on and told him to stay in his wheelchair. He asked to go to the bathroom, but the sister is not sure if staff assisted him in the bathroom or not. He then went back to his bedroom and went to sleep. Resident A has a bed alarm, so she is unsure if he had been sleeping in the bed or the recliner, but the recliner also had feces on it. Resident A’s sister is unclear about what really happened and believes that the midnight staff did not follow Resident A’s POC. The sister was unsure about when the wheelchair was prescribed and when it should have been used. She saw the wheelchair in the bedroom after she went to Gill Crest to clean out his bedroom. The sister stated there was feces in the wheelchair. Resident A’s sister

received the death certificate, but it was incorrect as it stated that “Resident A died of a car accident,” which is incorrect. She will send me the death certificate once it has been corrected. Resident A’s sister received the IR’s but stated that the staff’s names have been redacted. She will forward them to me. Resident A’s sister wanted me to know that up until 01/25/2026, NRMI LLC was providing good care to Resident A. She reiterated that staff did not follow Resident A’s plan regarding standby assistance.

On 02/04/2026, I interviewed DCS Lucia Cohen via telephone regarding the allegations. Lucia was working for Rainbow for about 15 years before NRMI LLC took over. She was a fill-in staff at Gill Crest and only worked here a handful of times. Lucia is “not too familiar with Resident A.” She stated whenever she worked, “Resident A was sleeping.” She has never interacted or communicated with him. The only time she had seen Resident A was when staff would bring him to the dining room for breakfast. On 01/25/2026, she worked the midnight shift from 12AM-8AM with Reisha Wilson. There were four residents, including Resident A present and another resident on leave of absence. When she arrived, she was informed by the afternoon shift that “Resident A was difficult to deal with and he was having behaviors; more of a handful.” She does not know the names of the afternoon shift staff. Resident A had been sleeping, but she stated that “he was tossing and turning because the bed alarm was going off. He seemed restless.” Around 6AM, she went to the bathroom and when she came out, she saw Reisha in Resident A’s bedroom. Resident A was standing in front of his bed taking off his clothes. His 4-wheeled walker was next to him, but he was not using it. He appeared confused and was not responding to either of them. They asked him if he needed anything and there was no response. They asked him if he wanted them to help him put his clothes back on and no response. They placed him on the recliner, put a blanket on him and he fell asleep. They left his bedroom door cracked open. She began passing medications soon after and as she was popping out the pills, she heard a loud sound, like something fell. She stated that Reisha was sitting on the couch in the room with the fireplace speaking to another resident. They both ran into the bathroom and found Resident A on the floor. She and Reisha tried picking him up off the floor, but he was not helping them, so they laid him back down. Lucia stated, “Reisha thought he probably wanted to get into the shower, so she took the shower handle and began wetting him.” Lucia then saw blood in the water. Resident A turned his head to one side, and she felt around and saw a “scratch.” Lucia was asking Resident A, “are you hurt,” but “he was not responding.” She placed her hand on the scratch and then Reisha tried calling the on-call manager (name unknown). The manager did not pick up so Reisha called the on-call RN. The RN (name unknown) answered and told Reisha to take Resident A’s vitals. Lucia took vitals and reported the readings to the RN. The RN informed them to call 911. Lucia stated that Resident A was alert, eyes open but not responding to them. When the ambulance arrived, he was still alert, but then the EMT asked if Resident A had a history of seizures and Lucia replied, “I’m not sure.” EMT told her it seemed like he was having a seizure as his right leg was shaking. She told Reisha to go to the hospital with Resident A. Lucia has never reviewed Resident A’s POC. She only receives reports regarding each resident including Resident A by the afternoon shift during shift change. She is unsure of his medical condition or mental state because she stated, “I was never told.” She was never informed of him having seizures and does

not know if there is a seizure protocol for Resident A. Reisha mentioned that Resident A was admitted to the hospital because he had a fall with a seizure. She does not know when that happened. This was the first time she witnessed Resident A falling and the protocol for falls is to pick the resident up, place them on the chair or bed, and then call the manager or on-call RN and then take their vitals. Sometimes the RN will come to the group home and determine if 911 should be called. Lucia stated she did not know the serious state Resident A was in because prior to the fall, he was not responding to her questions, so she believed this was his baseline.

On 02/04/2026, I interviewed DCS Reisha Wilson via telephone regarding the allegations. Reisha had been working at Gill Crest for one year. She works the midnight shift from 12AM-8AM. On 01/25/2026, she was working with Lucia Cohen and when she arrived, the afternoon shift briefed them on the residents. The afternoon shift staff (names unknown) told them that Resident A “was not keeping his clothes on and kept getting up out of bed.” Around 1AM Reisha was making her rounds and noticed Resident A’s bedroom door open. She saw Resident A sitting in his recliner naked. She also noticed the sheets were off his bed. Reisha asked Resident A, “do you want to get into bed?” He did not respond. She asked him, “do you want to stay in the recliner?” He said, “yes.” She put a blanket on him, pillow behind his head, closed the door and left. She stated she did not check on him until she heard his door open and close around 4AM. She was sitting on the couch in the room with the fireplace when she heard his door alarm. She saw Resident A standing at his bedroom door naked. She stated, “I called his name, he turned to her ignored her and then she said, hey watchya doin? She got up off the couch but did not go to him and that is when Lucia came out of the bathroom. She then went to his bedroom door and saw him moving his hands as if he was “washing himself like in the shower.” She asked him if he wanted to go and take a shower, but he did not respond. She stated, “I got closer and saw poop between his butt.” Lucia got the wheelchair and Reisha went into the bathroom to turn the shower on, then Reisha wheeled him into the bathroom. As he was sitting in the wheelchair, he was trying to grab a tissue on the floor to throw it away. He did not want to get into the shower, but Reisha stated, “I was adamant to get him into the shower because he had poop on his hands.” He refused so she wheeled him back into his bedroom, told him “stay in here and don’t come out.” He stayed in his bedroom for a bit but then opened and closed the door again as she heard the door alarm when she was sitting back on the couch. She did not go to Resident A because she stated, “he didn’t close the door, but went back into the bedroom.” Around 5:30AM, she heard sweeping feet and thought it was another resident getting up to use the bathroom, but she never checked. Lucia was in the staffing area which is located between Resident A’s bedroom and where Reisha was sitting on the couch. Then Resident A came out of his bedroom in his wheelchair and attempted to grab the curtain near the sliding door in the room she was sitting in. She told him to stop but he ignored her. She got up off the couch, turned his wheelchair around and he flipped her the finger, got angry and said, “come on,” like he wanted to fight. She told him, “you wheeled yourself out here, you can wheel yourself back to your bedroom and close the door.” He did and she “reminded him to close the door.” She got up off the couch and walked towards the kitchen and saw his bedroom door closed. She then returned to the couch, sat down and began playing games on her

cellphone. She noticed it was 6AM and stated, “I said to myself, I better get up to make breakfast before Resident B wakes up and doesn’t let me.” She got up and walked towards the kitchen and heard Resident A fall and said, “Fuck.” She went to his bedroom and saw that he was not in his wheelchair then went into the bathroom and found him on the floor. Lucia was in the staffing area and came into the bathroom. She saw feces on his feet. Her and Lucia tried lifting him up off the floor but could not because he was too heavy, so they laid him back onto the floor. He was responsive and said “yeah,” when Reisha asked him if he wanted to go into the shower to clean him. She stated, “he was trying to assist me by grabbing the shower chair but then he gave out.” They tried again to lift him, but it was unsuccessful. She grabbed the removable shower head and because rinsed his body to clean the feces off his hands, feet, and body. When she put the shower head towards his head, she noticed drops of blood. Lucia told her it was blood. They looked for the cut and found it on the side of his head. Reisha stated she tried calling the on-call manager, but no response when she used the house phone. She tried calling from her personal cellphone, but again no response. She then called the RN who advised her to take vitals. They took vitals and after giving the readings to the RN, the RN told her to call 911. The RN asked Reisha, “is he seizing? Reisha replied, “No he’s fine.” The ambulance arrived and transported him to the hospital and then he passed away. Reisha confirmed and acknowledged that Resident A is a “standby assist,” whenever he is on his feet. She does not know the protocol for unwitnessed calls other than assessing the resident, calling the manager, and then the RN for instructions. She does not know how long it was since she made the first call from the time he fell around 6AM.

Note: There are discrepancies in both Lucia and Reisha’s stories of what happened to Resident A on 01/25/2026.

On 02/05/2026, I conducted an on-site investigation regarding these allegations. Present were Tammy Zentz, Lauren Reagan, DCS Pamela Alston and Residents C and D. Residents B and E were on leave of absence.

I viewed Resident A’s bedroom which is down the hallway to the end, and I viewed the staffing area where Lucia was at and the sitting room where Reisha stated she was on the couch on her cell phone. Resident A’s bedroom door has a loud door alarm that chimes whenever the door is open. The couch in the common area with the fireplace is against the wall near the sliding door. If staff is sitting on that couch, their back is towards the wall, and they are facing the fireplace; there is no direct sightline to Resident A’s bedroom from that couch. I reviewed Resident A’s POC dated 12/12/2025, which is extremely detailed regarding Resident A’s mobility needs; however, the POC did not have staff signatures on it. It only had Tammy Zentz and the CM Suzanne Morrison. When asked who is responsible for training staff, it was stated that CM trains Ms. Reagan and then Ms. Reagan places the POC in Resident A’s program binder, but there is no follow-up with staff to ensure that all staff have reviewed and are competent in the plan. Ms. Zentz and Ms. Reagan stated that they will implement a staff in-service training sheet for the POC for all their residents to ensure that staff are reviewing the POC and by signing it, acknowledging that they reviewed it.

I also reviewed Resident A's Clinical Directive regarding "to ensure safety during ambulation," was completed on 08/22/2025 by his PT. The directive clearly stated, "staff will assist Mr. Negus to ambulate with his small based quad cane and gait belt on with stand by assist. Reisha Wilson's signature is on the training verification regarding the directive.

I interviewed DCS Pamela Alston regarding the allegations. Pamela has been working for this corporation since they took over and with the previous corporation for a total of 10 years. She works afternoon shifts from 4PM-12AM. Resident A had been agitated, confused and taking his clothes off a couple of weeks prior to the incident. On 01/24/2026, she observed his confusion and appeared more agitated. He was restless, getting up from his bed or recliner several times wanting to go to the bathroom, but when she took him to the bathroom, he did not pee. Pamela observed him take his clothes off and she stated, "I had to assist him in the bathroom, hold his penis, because he seemed agitated and did not want to hold his penis and was trying not to aim in the toilet." On 01/25/2026, she was working the afternoon shift with Thelma Green. Again, Resident A seemed restless and when he was going to the bathroom, he was thrusting his hips to aim in the toilet. This was a new behavior. She got him cleaned up and Thelma put him to bed around 9PM. Resident A kept getting up out of bed while she was in the staffing area working on schedules. Thelma heard the bed alarm and immediately went into his bedroom. She asked him, "what's going on?" He said, "I have to go to the bathroom," but then did not want to go but Thelma took him anyway and he did not pee, so Thelma got him back to bed. About 10 minutes later around 11PM, he got up again and the bed alarm went off. Thelma took him to the bathroom, but he did not go. She put him back to bed, so Pamela went to help. He had his underwear on, but his clothes were off. They left the bedroom and again 10 minutes later, the bed alarm went off. Pamela told Resident A, "I'm going to sit here and watch you sleep." He said, "Ok," and fell asleep. At 12AM, he was sleeping in bed. The midnight shift staff, Reisha arrived, and Pamela left after so Thelma filled Reisha in on all the residents including Resident A. Pamela stated that according to Resident A's POC, Resident A is a "standby assist." She said, "during the afternoon shift and I can only speak to my shift, when Resident A is on his feet, we're on our feet holding his gait belt and walking with him." Sometimes he is upset because he wants independence, but I tell him that it's for his safety and then he's ok. She is unsure on why he has been experiencing agitation for the last couple of weeks, but stated he is very friendly and usually a "jokester." Resident A is a well-known fall risk, and all staff including Reisha and Lucia were aware of his needs. Pamela recalls one time when she arrived at her shift after Reisha had worked, Resident A did not have his gait belt on. Pamela stated that the gait belt must be worn always and all staff are aware of this. There were concerns she had heard other staff members say about Reisha. Some of the concerns were about Reisha "making her own rules," and "the way she spoke to the residents." One time, Reisha got into it with Resident C. Resident C told Pamela, "I don't like that girl," referring to Reisha. Pamela stated these concerns were reported to the residential supervisor Lauren Reagan. She is unsure what happened afterwards. Pamela stated that Lucia, asks "1000 questions," when "Lucia has been working this field for 10 years." Reisha told Pamela that when Resident A's bed alarm went off, Lucia never got up to help.

Pamela was emotional when speaking about Resident A and appeared to have a close bond with him.

Tammy stated that in 08/2025, Reisha was having a “power struggle,” with another resident who no longer resides at Gill Crest. Reisha did not want the resident to drink coffee during midnight shift, and she complained that the resident hit her, but he did not. There is a “record of discussion" and she was retrained on how to handle these situations through Crisis Prevention Institute (CPI) that also covers gentle teaching strategies. Tammy stated they will be revisiting the company’s fall protocols and modifying to ensure incidents such as Resident A’s do not reoccur. Concerns were discussed with Ms. Zentz and Ms. Reagan regarding Reisha reporting she was sitting on the couch playing games on her cell phone. Ms. Zentz stated that NRMI LLC has a cell phone policy that all personal devices must be kept off or on silent and stored away during their shifts. Reisha did not follow their policies. Ms. Zentz will email me a copy of their cell phone policy. She will also email me the shift change staff notes and 01/2026 staff schedule.

I attempted to interview Resident C, but he was sleeping in his bedroom. I had observed him walking around the home when I first arrived, but then he went to sleep. He appeared to have good hygiene and dressed appropriately. There were no concerns noted.

I interviewed Resident D, who uses a walker to ambulate. Resident D is verbal; however, her communication is limited due to her disability. She loves it here and loves staff. She does not know any of the staff names, just knows staff by their faces. She reported no concerns. She was dressed appropriately and had good hygiene. No concerns noted.

On 02/05/2026, I went to Farmington Police Department to discuss these allegations to find out if I was required to file a complaint regarding these allegations to be investigated by law enforcement. I spoke with Commander Hawkins who stated that if Resident A had died at the group home, then yes law enforcement would have conducted an investigation; however, since Resident A was transported to the hospital and passed away several days later, then no, law enforcement would not investigate. He stated that jurisdiction is no longer with Farmington Police Department once an individual is transported and dropped off at the hospital.

On 02/05/2026, I interviewed the CM Suzanne Morrison via telephone regarding the allegations. Ms. Morrison is employed by NRMI LLC to provide case management to all the residents, including Resident A. She also coordinates with residents’ doctors and the treatment team on residents’ needs. Resident A was prescribed with a gait belt by the PT who goes to the home and trains all staff on how to use the gait belt on Resident A. Ms. Morrison stated that the residential supervisor, Lauren Reagan, and staff were educated on what they needed to do for Resident A. All staff are oriented to these directives and have an understanding to review the POC. Ms. Morrison was contacted on 01/25/2026 by Resident A’s sister advising her that Resident A was in the hospital.

She was not contacted by staff when Resident A fell as the protocol is to call the on-call manager and not the CM. She had no other information regarding these allegations.
On 02/05/2026, I interviewed DCS Kiebra Melik via telephone regarding the allegations. She has been doing this job for about 11 years; first with the previous owners and now with NRMI LLC. Kiebra worked the afternoon shift on 01/24/2026 with Pamela from 4PM-12AM. Resident A was confused during her shift. He appeared restless. He kept getting up out of bed as his bed alarm would go off. Kiebra stated, “whenever he is on his feet, we’re right there with him on our feet using his gait belt to help him walk.” Kiebra reviewed Resident A’s POC and directives so that is how she knows that Resident A is a standby assist. She stated, “he has never fallen on my shift because I’m always right there with him.” Kiebra stated when Reisha arrived on her shift at 12AM, Kiebra told Reisha that Resident A was “very confused today,” and told her, “whenever the alarm goes off, to immediately go and check on him.” She stated, “I told Reisha this numerous times, but Reisha told her, “he’s just moving in bed.” Kiebra has worked with Reisha in the past and has observed Reisha turn the bed alarm off and say, “he’s just turning in bed.” Kiebra stated for an unwitnessed fall, she would never try to move the residents if they were injured., Kiebra said, “I would call 911 first, then the on-call manager and the on-call nurse.”

On 02/05/2026, I interviewed the on-call RN LaJoy Watson regarding the allegations via telephone. On 01/25/2026, staff (she did not know the names) called the RN around 7AM saying that Resident A fell in the bathroom and hit his head and his head was bleeding. The RN advised Reisha to immediately call 911 and then to take his vitals. The RN denied advising staff to take vitals first then after the reading was provided to her to call 911. The RN was not aware that Resident A had fallen around 6:12AM because she assumed he fell when they contacted her around 7AM. This was the first time this RN was on call for Gill Crest home. She stated, “as soon as I heard he was bleeding, I told them to call 911.” She had no other information to provide.

On 02/06/2026, I received an email from Kimberlee Waddell with the documents requested. I reviewed the cell phone policy where it stated, “personal devices must be kept off or on silent and stored away while on duty.” I also reviewed the 01/2026 showing that Lucia Cohen and Reisha Wilson worked the midnight shift from 12AM-8AM on 01/25/2026. I reviewed the POC response history (staff shift notes) for Resident A noting that on 01/24/2026 at 9:10PM, staff reported “Resident A very confused with directives given, continue to take off socks. Walking into another area, saying he’s going up stairs, leaning back.” At 10:41PM, “Resident A continues to get out of the bed three times and stripping (removing all clothing).” There was no staff shift notes documented by Reisha or Lucia on 01/25/2026.

On 02/09/2026, I received a telephone call from Resident A’s sister seeking an update. I advised Resident A that I was still investigating these allegations. She wanted me to know that NRMI LLC was “overall good to Resident A.” She expressed her concerns about why staff were not on their feet when Resident A was on his feet given, he was a fall risk. Resident A’s sister said, “When I was with him, whenever he was on his feet, I was on my feet.” If staff would have followed his POC, staff would have prevented his

fall and injuries that resulted in his death. Resident A's sister wants NRMI LLC to change their policies regarding how staff is trained to prevent this incident from happening to another resident. She expressed concerns about the wheelchair and that she did not learn about the wheelchair until 01/25/2026. She is still waiting for the death certificate and once received, she will forward it to me.

On 02/12/2026, I interviewed DCS Thelma Green via telephone regarding the allegations. Thelma worked the afternoon shift on 01/24/2026 from 4PM-12AM with Pamela. Resident A was disoriented, confused and off balance the last couple of weeks. He required a wheelchair to assist him with ambulating from room to room. During her shift, she took him to the bathroom about five-six times, but when he went to the bathroom, he did not pee. He was also having trouble forming his words. When he was up on his feet, Thelma or Pamela would be right by his side, using his gait belt to help him walk. She stated, "we treated him like he was a one-on-one during our shift. Wherever Resident A was, we were there too." Thelma stated she and Pamela are seasoned staff and know that when a resident is a fall risk, then staff must always be by their side to assist. Resident A never went anywhere without staff. He also had a bed alarm and a door alarm. Whenever either of the alarms went off, she or Pamela immediately went to his bedroom to check on him. On 01/25/2026 at 12AM, Reisha and Lucia arrived and Thelma told them both that Resident A was "more confused and had loss of balance and needed extra eyes on him." Thelma reiterated these many times to both Reisha and Lucia. When Thelma was briefing Reisha, Reisha left and went into the TV room and sat on the couch. Thelma had known Reisha for about one year but has never worked a shift with her. She's observed Reisha as being "laid back," and "slow to respond." Resident A did not have a bowel movement during her shift because if he had, then she would have documented it in his chart. Thelma reviewed Resident A's POC and directives, so she is aware of Resident A being a standby assist. She stated that all staff, including Reisha and Lucia, were aware that Resident A was a standby assist whenever he was up and walking.

On 02/12/2026, I received an email from Kimberlee Waddell with Resident A's gait belt script that was prescribed due to high risk for falls and for safety along with bed alarms. However, Ms. Waddell stated that the wheelchair Resident A was using was one owned by NRMI LLC and loaned to Resident A; therefore, there was no script received yet from PT.

On 02/17/2026, I received an email from NRMI LLC Clinical Manager, Valerie Wedge stating that "NRMI LLC was in the process of attaining a script for the wheelchair; however, had not received the signed script back yet. In order to provide for Resident A's safety, we provided a spare wheelchair from our treatment cent to use while in the process of receiving his script and ordering him a wheelchair of his own."

On 02/23/2026, I interviewed DCS Aria Nowden regarding the allegations via telephone. Ms. Nowden had been working for about three years prior to this corporation taking over. She works day shifts from 8AM-4PM and sometimes works the midnight shift. On 01/25/2026, she and Falon were on their way to Gill Crest when Reisha called Falon on

the phone. Aria was with Falon because Aria had car trouble. Reisha told Falon that Resident A fell, hit his head and was in the hospital. Falon dropped Aria off at Gill Crest and went to the hospital to relieve Reisha who was there. Lucia was at Gill Crest and when Aria asked her what happened, Lucia said, “I don’t really know.” Reisha was saying that Resident A was active, coming in and out of his bedroom. Aria is not sure if Reisha told Aria she was sitting on the couch or if she was in the kitchen when Resident A fell. Reisha then told Aria that Resident A was told to stay in his bedroom, but that his door was not closed, so he came out of his bedroom without Reisha or Lucia’s knowledge, went into the bathroom and fell. Reisha heard a loud noise and put Resident A in the shower to clean him up then Reisha saw blood. Reisha told Aria it looked like Resident A was having a seizure. Aria stated the next day, Reisha’s story changed about what happened. She stated there were several different stories given by Reisha.

On 02/24/2026, I received Resident A’s death certificate from Resident A’s sister. The manner of death was “Accident,” at the “group home.” “Cranio-Cerebral Trauma and Complications Thereof,” were also noted.

On 02/25/2026, I received an email from Valerie Wedge stating that Resident A did not have a 4-wheeled walker. He was unable to use one due to his right upper extremity impairment.

On 03/02/2026, I followed up with Resident A’s sister. She stated that Gill Crest contacted her within 48 hours of Resident A’s hospitalizations including 01/25/2026. She stated that she went out to the home to pass out Resident A’s prayer cards and was approached by a staff member (name unknown) advising her that the staff was upset about what happened to Resident A. Resident A’s sister stated she is still in the dark about exactly what happened to Resident A and how he fell. I advised her that she can request a copy of my report once it has been completed. I emailed her the information to submit the request.

On 03/02/2026, I conducted the exit conference with licensee designee Kimberlee Waddell with my findings. She acknowledged and had no questions. She agreed to submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Based on my investigation and information gathered, DCS Reisha Wilson could not meet the physical, emotional, and intellectual, and social needs nor was she capable of appropriately handling emergency situations of Resident A on 01/25/2026. Resident A has a TBI and requires standby assist from DCS when ambulating. On 01/25/2026, during the midnight shift, Reisha was working and during her interview, she informed me that when Resident A was standing at his bedroom door, she was sitting on the couch playing on her cell phone. Reisha stated she never went to assist Resident A. Resident A walked into the bathroom, fell and hit his head. After Resident A fell, Reisha and DCS Lucia Cohen did not appropriately handle the situation as it took both staff members over 40 minutes before contacting 911.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on my investigation and information gathered, DCS Reisha Wilson and Lucia Cohen did not provide supervision and protection as specified in Resident A's plan of care and clinical directives updated on 01/16/2026 regarding Resident A "needs to have close supervision with him as well as a gait belt during ambulation. On 01/25/2026, Resident A ambulated numerous times as reported by both Reisha and Lucia, but neither DCS followed his plan as he was ambulating without staff assistance. Resident A went into the bathroom without DCS, fell and hit his head. He was transported to the hospital where he passed away due to subdural hematoma on 01/29/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.673	**Use of assistive devices, therapeutic support.**
	(1) An assistive device or therapeutic support intended to achieve or maintain a resident's proper position to enhance mobility, physical comfort, safety, and well-being must be specified in the resident's assessment plan and agreed on by the resident or resident's designated representative. **(2) An assistive device or therapeutic support must be authorized in writing by an appropriately licensed health care professional, and the authorization must state the reason for and the term of the authorization.**
ANALYSIS:	Based on my review of Resident A's scripts, Resident A did not have a script for the wheelchair nor was it authorized by a licensed health care professional when DCS Reisha Wilson was using it on 01/25/2026. According to licensee designee, Kimberlee Waddell and NRMI LLC Clinical Manager Valerie Wedge, PT had yet to submit a script, but due to Resident A's safety, a spare wheelchair from NRMI LLC's treatment center was used while in the process of receiving his script. The script was never received due to Resident A being hospitalized and then passed away.
CONCLUSION:	**VIOLATION ESTABLISHED**

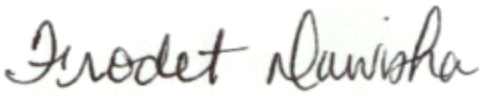
APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based on my investigation and information gathered, DCS Reisha Wilson and Lucia Cohen did not seek health care immediately for Resident A after an unwitnessed fall, hitting his head and bled on 01/25/2026. Lucia stated she was passing medications when she heard a loud sound while Reisha was sitting on the couch. Lucia and Reisha found Resident A on the floor in the bathroom. According to the medication administration log, she administered medications at 6:12AM/6:13AM but neither Lucia nor Reisha made a call to anyone until 6:52AM which was to the on-call RN LaJoy Watson and then contacted 911 at 7:01AM as stated on the Farmington Police Records showing the time dispatch received the call.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.693	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.**
ANALYSIS:	Based on my investigation and information gathered, Resident A's sister was contacted and provided with incident reports within 48 hours of Resident A being hospitalized.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



03/02/2026

Frodet Dawisha — Date
Licensing Consultant

Approved By:

For 3/13/2026

Denise Y. Nunn — Date
Area Manager