GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 1, 2026

Beth Gorkisch
NRMI LLC
17199 N. Laurel Park Dr.
Livonia, MI 48152

RE: License #:	AS610411847
Investigation #:	2026A0356034
	River St. Home

Dear Ms. Gorkisch:

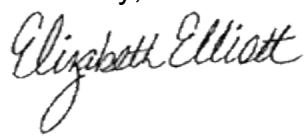
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610411847
Investigation #:	2026A0356034
Complaint Receipt Date:	04/07/2026
Investigation Initiation Date:	04/09/2026
Report Due Date:	06/06/2026
Licensee Name:	NRMI LLC
Licensee Address:	17199 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(231) 893-1462
Administrator:	Beth Gorkisch
Licensee Designee:	Beth Gorkisch
Name of Facility:	River St. Home
Facility Address:	620 E. River St. Whitehall, MI 49461
Facility Telephone #:	(231) 893-4150
Original Issuance Date:	03/13/2023
License Status:	REGULAR
Effective Date:	09/13/2025
Expiration Date:	09/12/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A suffered an injury at the facility.	Yes

III. METHODOLOGY

04/07/2026	Special Investigation Intake 2026A0356034
04/07/2026	APS Referral Joe Clark, APS, Muskegon County DHHS
04/07/2026	Contact - Document Received Kim Waddell, Quality Michigan, Neuro restorative care, BS, CBIS
04/07/2026	Contact - Document Received IR
04/09/2026	Special Investigation Initiated - Telephone Joe Clark, APS Muskegon Co. DHHS.
04/13/2026	Contact-Document Received Amanda Eely, program manager, documents and information. Ms. Eely called also.
04/16/2026	Inspection Completed On-site
04/16/2026	Contact - Face to Face Amanda Eely, program manager, Resident A, DCW Jennifer Frees.
04/16/2026	Contact - Document Received facility documents reviewed.
04/30/2026	Contact - Telephone call received Joe Clark, APS
05/07/2026	Contact-Telephone call made Trinity Wound Care, left voice mail message. Bethany Tenbrock, LPN, message left.
05/08/2026	Contact-Telephone call made Andrea Steinbach-case manager, Indequest. Ashely Berger, DCW.

05/11/2026	Contact-Document received Trinity Health Urgent Care-North Muskegon Medical records.
05/17/2026	Contact - Telephone call made Bethany Tenbrock, LPN, Neuro restorative care, Trinity Health Wound Care Clinic.
06/01/2026	Exit conference-Beth Gorkisch, Licensee Designee.

ALLEGATION: Resident A suffered an injury at the facility.

INVESTIGATION: On 04/07/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported on 04/03/2026, Resident A received a burn on her inner thigh following a staff member putting a hot bowl in Resident A's lap without the normal protective device that does not allow heat transfer. Resident A was taken to urgent care following the injury. The complainant reported Resident A has been in this facility since December 2025 and has sustained another burn injury on one of her knuckles on the right index finger. That incident occurred when a warmed-up rice heating bag that was overheated and placed on her hand.

On 04/07/2026, I received a IR (Incident Report) from Kim Waddell, Quality Manager, Neuro restorative care. The IR documented an incident that occurred on 04/02/2026 at 5:29p.m., the IR was signed by Ms. Waddell and documented the following information, *'On 04/2/2026, the program nurse reported to on call supervisor that (Resident A) had a blister on her leg where there was redness the previous day. (Resident A) reports that the redness is from a burn from a staff member who placed a hot bowl on (Resident A's) lap. The program nurse assessed (Resident A's) skin and covered the skin. The program nurse contacted the on-call supervisor, as we will have to follow up tomorrow on the next steps, as (Resident A) didn't want to go to urgent care immediately. On 04/03/2026, (Resident A) initially refused to go to the urgent care for assessment, after multiple attempts, (Resident A) was transported to urgent care for assessment. Care will be coordinated based on the recommendations from urgent care.'*

On 04/13/2026, I briefly interviewed Amanda Eely, program manager, via telephone. Ms. Eely stated from what she knows right now, Resident A reported that a staff member left a hot bowl on her lap on Monday, 04/01/2026 but that the red mark did not show up until Wednesday, 04/03/2026 and by Thursday, 04/04/2026, the spot was blistered. Ms. Eely stated initially, they thought the red mark on Resident A's thigh was from the stat lock (catheter holder) used to keep Resident A's catheter equipment in place and Resident A did not report a hot bowl was set in her lap by staff to the facility nurse. Ms. Eely stated Resident A did report that staff left a hot

bowl in her lap to the doctor when she went to urgent care on 04/03/2026. Ms. Eely is reviewing documentation and will provide the information to me upon review.

On 04/13/2026, I received an email from Ms. Eely, that contained information and a picture of the injury on Resident A's thigh. Ms. Eely reported that, *'staff found a reddened area on 04/01/2026 on (Resident A), nursing went to look at the reddened area on 04/02/2026 and noticed a blister that was not there in the original picture. (Resident A) reports that it is a burn from a staff member placing a hot bowl on her lap a couple days prior. The program nurse reported to the program director as she was not going to be in the next day and (Resident A) was requesting to go to urgent care to get it looked at. On 04/03/2026 (Resident A) was brought to urgent care to look at the burn. (Resident A) originally refused to go to the urgent care until a different program nurse and the program director went to (Resident A) and asked for her to go to urgent care. (Resident A) was transported to the urgent care via staff in a company vehicle with a Hoyer to assist (Resident A) to the table for evaluation. Once the physician reviewed the skin, he asked (Resident A) what happened and (Resident A) reported that the staff placed a hot bowl on her lap and it left the burn mark. The Physician did tell (Resident A) that he was going to contact APS per protocol. This led to the investigation of the employee referenced. The employee was suspended on 04/03/26 pending investigation. I was able to interview both the staff and the nurse. I have reviewed documentation as well. The redness did not appear until 04/01/26. The day that the staff placed a hot bowl on her lap was 3/30/26.'*

On 04/13/2026, I reviewed staff notes that documented the following information regarding marks, bruises, seen on Resident A by staff:

- 03/27/2026, 6:59a.m., 'red round spot and red circular spot on right buttock from catheter hose.'
- 03/28/2026, 6:57a.m., 'bruising on left forearm.'
- 03/29/2026 6:59a.m., 'bruises to both arms from hospital and both lower ankles and feet swollen.'
- 03/30/2026, nothing noted by staff.
- 03/31/2026, 9:23p.m., 'bruising on right hand from blood draw this morning.'
- 04/01/2026, 10:26p.m., 'red streak on thigh.'
- 04/02/2026, 6:52a.m., 'red area left upper thigh.'
- 04/02/2026, 9:59p.m., 'blister on left thigh near STAT bandage, forming pressure ulcer on coccyx-RN observed, (Resident A) refused any care.

Ms. Eely documented that Ashlie Berger worked at the facility on 03/30/2026 and 03/31/2026 and if the burn had been from her placing a bowl on Resident A's lap, it would or should have been noted in staff charting either of those nights yet there is no documentation of such. Ms. Eely documented that the burn does not show up until 04/01/2026 and that she (Ms. Eely) does not see in anywhere in charting where other staff would have placed items in Resident A's lap.

On 04/13/2026, I reviewed a picture that Ms. Eely sent of Resident A's left upper

thigh and observed a raised red mark in a crescent shape. The mark appears as though it could have been caused by a recent burn.

On 04/16/2026, I conducted an unannounced inspection at the facility and interviewed Resident A in her room. Resident A stated she has been at this facility since 12/17/2025 and had an earlier incident on 01/26/2026, when she sustained a burn to the knuckle on her right hand when a warmed rice pack was placed on her hand. Resident A stated she is quadriplegic and cannot feel anything that may be set in her lap that is hot. Resident A stated she did not get medical attention for this injury. Resident A stated the most recent incident occurred earlier in the month (April 2026) “right before Easter.” Resident A stated she sits at the dining room table but because of her wheelchair, she cannot sit close to the table, so staff place the bowls or plates in her lap, and she eats with the food sitting on her lap. Resident A stated staff Ashley Berger warmed up a bowl of food and placed it on her left thigh and “told me it was hot.” Resident A stated she had long pants on, and Ms. Berger set the bowl on her pant leg, but she is unable to feel the heat because she is quadriplegic and had no idea the hot bowl was causing a burn underneath her pant leg. Resident A stated Bethany Tenbrock, LPN for Neuro restorative care was changing her catheter two days later and Resident A showed her the burn on her thigh. Resident A stated Ms. Tenbrock told her that she could not go to urgent care because it had been two days since the burn occurred and she did not need to go. Resident A stated then, Ms. Ten Brock put the catheter tape over the burn mark. Resident A stated she told staff the following day that she was going to urgent care. Resident A stated she went to the North Muskegon urgent care, saw Dr. Chapman who said it was a burn on her thigh and “he took a picture of it.” Resident A stated she went to Trinity Wound care today, 04/16/2026 and they measured the burn and said it was ¼ inch wide and 3 inches long.

On 04/16/2026, I interviewed Amanda Eely at the facility. Ms. Eely and I reviewed the above information she sent to me, and Ms. Eely stated the original picture of the red mark on Resident A’s upper thigh was taken on 04/01/2026 and a photo was taken on 04/06/2026 of the red mark as it had turned into blisters. Ms. Eely did not have that photo available for my review.

On 04/16/2026, I interviewed DCW (direct care worker) Jennifer Frees at the facility. Ms. Frees stated she saw the red mark on Resident A’s leg on 04/02/2026, took a picture of it, and sent it to the facility nurse, Bethany Tenbrock. Ms. Frees stated Ms. Tenbrock stated she would “get eyes on it” on 04/02/2026 when she was in the facility. Resident A went to urgent care on 04/03/2026. Ms. Frees stated Resident A directed staff to set her food bowl on her left thigh or her belly area and they use a special bowl cover to protect Resident A from the heat of the bowl because she cannot feel the heat coming from the bowl due to paralysis. I observed several bowl covers in the laundry room, after being washed, and Ms. Frees stated they use those bowl covers all the time, the bowl covers fit around a hot bowl, so it is not hot to the touch. Ms. Frees stated she had seen Resident A with a rice sock on her hand in the past as stated in the allegation. Ms. Frees stated she cannot figure out how

the rice sock only burned one knuckle when it would sit on her entire hand and stated that she had also seen Resident A “gnawing on her knuckles” and wonders if that contributed to an injury to her knuckles rather than the warmed rice sock.

On 05/07/2026, I interviewed Bethany Tenbrock, Neurorestorative Care LPN (licensed practical nurse). Ms. Tenbrock stated staff thought the red mark on Resident A’s thigh was from the stat lock that holds Resident A’s catheter in place. It is sticky, and the red mark was located close to where the stat lock was. Ms. Tenbrock stated Resident A never told her that staff Ashley Berger had placed a hot bowl in her lap on 04/01/2026. The following day, 04/02/2026, staff reported to Ms. Tenbrock that Resident A had a blister on her thigh and when Ms. Tenbrock changed Resident A’s catheter, she saw the blister. At that time, Resident A refused to go to urgent care. Ms. Tenbrock stated on 04/03/2026 Resident A confirmed that staff had placed a hot bowl in her lap causing the injury and insisted on going to urgent care at that point. Ms. Tenbrock stated she never refused to allow Resident A to go to urgent care. Ms. Tenbrock stated Resident A went to urgent care on 04/03/2026 and got Bacitracin for the burn. Ms. Tenbrock stated she did not take a picture of the burn or blisters because Resident A does not like her to be involved in her care as it is.

On 05/08/2026, I interviewed Ashley Berger, DCW (former) via telephone. Ms. Berger stated she worked on Monday, 03/30/2026 and then again on Thursday 04/02/2026. Ms. Berger stated on 03/30/2026, she heated food in the microwave for 1 minute and set it on Resident A’s lap as requested by Resident A and as is common to do. Ms. Berger stated Resident A typically eats food from a plate or a bowl on her lap as the table is too hard for her to manage to sit close to and eat in her wheelchair. Ms. Berger stated the bowl did not have a protective cover on it, that staff did not have or use bowl covers that she is aware of and she had never been trained to use anything such as that for hot bowls. Ms. Berger stated she carried the bowl to Resident A with no problem as it was not too hot. She told Resident A “this is a little warm” and Resident A told her to set it on her lap. Ms. Berger stated she never saw any marks on Resident A and she does not think she is the person that burned Resident A. Ms. Berger stated on 04/01/2026, she took Resident A to the doctor for a blood draw and Resident A did not say anything about a burn on her leg while at the doctor’s office and no one said anything about seeing a red mark on Resident A. Ms. Berger stated on 04/02/2026, an IR was completed, and she reiterated that she worked with Resident A on 03/30/2026 and then again on 04/02/2026. Ms. Berger stated she did see Resident A with a blister on her fingers in the past but was not aware of what the blisters were from.

On 05/11/2026, I reviewed Trinity Health Urgent Care-North Muskegon written by Dr. M. Chapman, DO and provided by Andrea Steinbach, BSN, RN, CCM, Indequest nurse case manager for Resident A. The medical notes documented, *‘this patient sustained a burn of less that 1% body surface area on the left anterior aspect of the thigh. This was a result of one of her care workers putting a hot bowl of food on her lap so she could feed herself. Typically, a special adaptive device is used so that*

heat would not transfer to the patient. Because the patient is quadriplegic, she was unable to feel pain to notify immediately of the burn. It was only later that it was noticed. In addition, the Foley catheter leg adhesive was placed directly in the area of the burn. Because of the nature of this I do feel it is important to report this to Adult Protective Services which I informed the patient and she agreed that this should be performed. Treatment for the burn will just be triple antibiotic ointment over the area and a non-adherent dressing. Patient states that she requested the bowl be placed there for her to feed herself but typically an adaptive device is used so heat would not transfer.'

On 06/01/2026, I conducted an exit conference with Beth Gorkisch, Licensee Designee. Ms. Gorkisch stated she has ordered more protective bowl coverings and will conduct refresher training for staff on the importance of using the coverings to prevent injury. Ms. Gorkisch stated she understood the information, analysis, and conclusion of this applicable rule violation.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	The complainant reported Resident A received a burn on her inner thigh after staff placed a hot bowl in Resident A's lap. Based on my investigative findings, on or around 03/30/2026, Resident A sustained a burn to her left thigh due to staff placing a hot bowl of food on Resident A's lap without the usual bowl cover used to prevent the transfer of heat to Resident A's skin. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Elizabeth Elliott

06/01/2026

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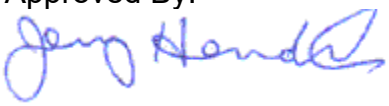
Elizabeth Elliott Date

Licensing Consultant

Approved By:



06/01/2026

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Jerry Hendrick Date
Area Manager