GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 21, 2026

Kimberlee Waddell
NRMI LLC
17199 N. Laurel Park Dr., Suite 424
Livonia, MI 48152

RE: License #: AS820412107
Investigation #: 2026A0122018
Bemis Ridge

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 (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 #:	AS820412107
Investigation #:	2026A0122018
Complaint Receipt Date:	04/06/2026
Investigation Initiation Date:	
Report Due Date:	05/06/2026
Licensee Name:	NRMI LLC
Licensee Address:	424 17199 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(231) 893-1462
Administrator:	Kimberlee Waddell
Licensee Designee:	Kimberlee Waddell
Name of Facility:	Bemis Ridge
Facility Address:	48722 Bemis Rd. Belleville, MI 48111
Facility Telephone #:	(734) 697-3893
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 04/05/2026, Resident A fell out of bed due to insufficient staffing.	Yes

III. METHODOLOGY

04/06/2026	Special Investigation Intake 2026A0122018 APS Referral
04/06/2026	Contact - Document Sent Sent an email to Complainant requesting a phone call. Telephone number submitted by Complainant is a non-working number.
04/08/2026	Inspection Completed On-site Observed Resident A. Reviewed Resident A's file. Conducted interview with Resident Director, Tammy Zentz.
04/08/2026	Contact – Telephone call made Conducted an interview with Guardian A1.
04/09/2026	Contact – Telephone call made Conducted an interview with staff member, Xcentric Samuels.
04/10/2026	Exit Conference Discussed findings with licensee designee, Kim Waddell.

ALLEGATION: On 04/05/2026, Resident A fell out of bed due to insufficient staffing.

INVESTIGATION: On 04/08/2026, I conducted an onsite inspection and observed Resident A sitting in his wheelchair in the facility living room. Resident A was appropriately dressed, calm, showing no signs of discomfort or distress.

On 04/08/2026, I reviewed Resident A’s file. His Assessment Plan documents that he receives staff assistance with toileting, bathing, and grooming. He requires 1:1 supervision at all times with oral intake according to his Active Treatment Program

which was revised on 03/04/2026. Resident A also requires a two person assist with transfer as documented in his Transfer CD dated 11/19/2025.

On 04/08/2026, I conducted an interview with resident director, Tammy Zentz. Ms. Zentz confirmed that on 04/05/2026 Resident A fell out of bed, there was only one staff member working in the facility at the time and there should have been two staff members working on that day. However, one of the assigned staff members called off and didn’t work their assigned shift that day.

On 04/09/2026, I conducted an interview with Guardian A1. Guardian A1 confirmed that she had been notified about Resident A’s fall and the incident had been discussed. Guardian A1 has no concerns at this time regarding the care that is being provided to Resident A.

On 04/09/2026, I conducted an interview with staff member, Xcentric Samuels. Ms. Samuels confirmed that she worked independently on 04/05/2026 and stated the following regarding Resident A’s fall incident, she put Resident A in the bed. Once she got him settled, Ms. Samuels left Resident A to assist the other residents in the facility. Per Ms. Samuels, Resident A’s bed alarm sounded, she went into his room to investigate and found him on his knees on the floor.

Ms. Samuels stated she assessed that Resident A had no visual injuries. She was unable to independently assist Resident A with getting off the floor, so she lowered him to the floor, and laid a pillow behind his head. Ms. Samuels stated she contacted her supervisor and the facility nurse to inform them of Resident A’s fall. Ms. Samuels stated that Resident A was transported to Trinity Health Emergency Room for a medical assessment and later returned to the facility.

On 04/10/2026, I reviewed the Trinity Health After Visit Summary dated 04/05/2026, which documents that Resident A was medically assessed after his fall on the same day. The summary documents that there were no injuries found on Resident A and he was returned to the facility with recommendations of seeking additional medical help if needed.

On 04/10/2026, I reviewed the staff schedule for the Bemis Ridge adult foster care facility for the date of 04/05/2026. According to the staff schedule, direct care workers, Xcentric Samuels and Keyon Davis, were scheduled to work from 3:00 p.m. until 11:00 p.m. On 04/08/2026 and 04/09/2026, both Tammy Zentz and Xcentric Samuels confirmed that staff member, Keyon Davis, did not work the scheduled shift and Ms. Samuels worked independently in the facility on 04/05/2026.

On 04/10/2026, I conducted an exit conference with licensee designee, Kim Waddell, and discussed my findings with her. Ms. Waddell acknowledged that on 04/05/2026, there was only one staff member, Xcentric Samuels, providing care to the residents of the Bemis Ridge adult foster care facility. Ms. Waddell agreed with

my findings and stated she would submit a corrective action plan to address rule violations documented in this report.

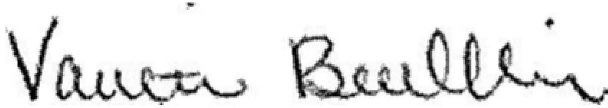
APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with Tammy Zentz, Guardian A1, and staff member, Xcentric Samuels, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 04/05/2026, Resident A fell out of be due to insufficient staffing. Resident A's Transfer CD documents that he is to have two staff members assist when transferring him for toileting, bathing, etc. Therefore, on 04/05/2026 there was insufficient staff on duty to provide personal care to Resident A on 04/05/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with Tammy Zentz, Guardian A1, and staff member, Xcentric Samuels, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 04/05/2026, Resident A fell out of bed due to insufficient staffing. Resident A's Assessment Plan documents that he is to receive assistance from staff with toileting, bathing, and grooming, his Transfer CD documents that he is to have two staff members assist when transferring him with toileting, bathing, etc. Therefore, on 04/05/2026 there was insufficient staff on duty to provide personal care as outlined in Resident A's Assessment Plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



Vanita C. Bouldin Date: 04/21/2026
Licensing Consultant

Approved By:

Ardra Hunter Date: 04/21/2026
Area Manager