GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 13, 2026

Tamaria White
NRMI LLC
17199 N. Laurel Park Dr., Suite 424
Livonia, MI 48152

RE: License #: AS820412107
Investigation #: 2026A0122040
Bemis Ridge

Dear Tamaria White:

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 #:	2026A0122040
Complaint Receipt Date:	09/11/2026
Investigation Initiation Date:	09/11/2026
Report Due Date:	10/11/2026
Licensee Name:	NRMI LLC
Licensee Address:	424 17199 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(734) 481-1200
Administrator:	Tamaria White
Licensee Designee:	Tamaria White
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 09/11/2026, Resident A fell, sustained injury, and staff member, Kemi Awosika, delayed assistance.	Yes

III. METHODOLOGY

09/11/2026	Special Investigation Intake 2026A0122040
09/11/2026	APS Referral
09/11/2026	Special Investigation Initiated - Telephone Conducted interview with program director, Tammy Zentz.
09/14/2026	Onsite Inspection Conducted interview with Resident A and reviewed his file.
09/14/2026	Telephone call made Conducted interview with staff members, Kemi Awosika and Zavion Ayler.
10/02/2026	Exit Conference Discussed findings with licensee designee, Tamaria White.

ALLEGATION: On 09/11/2026, Resident A fell, sustained injury, and staff member, Kemi Awosika, delayed assistance.

INVESTIGATION: On 09/11/2026, I conducted an interview with program director, Tammy Zentz, who reported the following, on O9/11/2026, Resident A fell with only one staff member, Kemi Awosika, present. Resident A sustained injury, however, Ms. Awosika did not obtain assistance with Resident A until hours later. Per Ms. Zentz, staff member, Kemi Awosika, who worked from 12:00 a.m. through 8:00 a.m., observed that Resident A had fallen and had blood on his face at approximately 6:30 a.m., however it was not until 7:58 a.m. that the incident was reported and he was sent out for a medical assessment.

Ms. Zentz acknowledged that due to the needs of the residents of Bemis Ridge adult foster care facility there should have been two staff members present from 12:00 a.m. through 8:00 a.m. Ms. Zentz stated on 09/11/2026, one of the assigned staff members failed to show up for their scheduled shift, leaving staff member, Kemi Awosika, to provide care to the residents. Ms. Kentz reported that staff members

Zavion Ayler and Sherylyn Zunga-Esquivel reported to work at 8:00 a.m. on 09/11/2026, observed Resident A with injury, and proceeded to obtain a medical assessment for him.

On 09/14/2026, I conducted an interview with Resident A who reported the following, he was laying on his bed, attempted to get up, however, he got too close to the edge of the bed and fell off. Resident A stated that he hit his head as he fell. Resident A is uncertain how long it was before he received assistance from staff.

On 09/14/2026, I reviewed Resident A's file. Resident A's Assessment Plan documents that he requires assistance with all activities of daily living, including walking/mobility.

Resident A's After Summary Visit Report dated 09/11/2026 documents that he was assessed by the medical staff of Trinity Health Emergency Center in Ann Arbor on 09/11/2026. Resident A was treated for a fall and released back to the facility on the same day.

On 09/14/2026, I conducted an interview with staff member Zavion Ayler. Mr. Ayler reported the following, he arrived for his shift at approximately 8:00 a.m. and staff member, Kemi Awosika, requested his assistance with Resident A. Mr. Ayler stated he observed Resident A on the floor next to his wheelchair with dried blood on his face. Per Mr. Ayler, Ms. Awosika stated Resident A had been on the floor for a while as he had not been able to pull himself up to sit in his wheelchair.

According to Mr. Ayler, he used a gait belt to assist Resident A in his wheelchair, assessed him for injuries, and called emergency medical personnel. Mr. Ayler stated that Kemi Awosika reported that she found Resident A on the floor at approximately 6:00 a.m. but did not receive assistance with Resident A until Mr. Ayler arrived at 8:00 a.m.

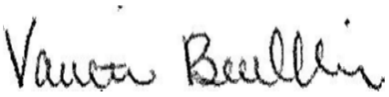
On 09/14/2026, I conducted an interview staff member, Kemi Awosika, who reported the following, on 09/11/2026, she worked alone between the hours of 12:00 a.m. through 8:00 a.m. She checked on Resident A at approximately 7:00 a.m. and found him on the floor. Per Ms. Awosika, she was unable to get him up independently, so she moved the wheelchair closer to him as an attempt to have him hoist himself up in the wheelchair. Ms. Awosika stated she then went to obtain equipment to check his vitals, however, another resident came and asked for his medication. Ms. Awosika stated she got distracted and Resident A wasn't assisted until additional staff arrived at 8:00 a.m. Ms. Awosika confirmed that Resident A didn't receive assistance from his fall until approximately one hour after she found him on the floor.

On 10/02/2026, I conducted an exit conference with licensee designee, Tamaria White, and discussed my findings with her. Ms. White agreed with findings and stated she would submit a corrective action plan to address the rule violation found in my investigation.

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 the direct care staff to residents must not be less an 1 direct care staff to either of the following: (b) 12 residents for small group and family homes.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with Resident A, staff members, Zavion Ayler and Kemi Awosika, and program director, Tammy Zentz, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 09/11/2026, Resident A fell, sustained injury, and staff member, Kemi Awosika, delayed assistance. Therefore, the licensee did not provide personal care as specified in the resident's assessment plan record.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



Vanita C. Bouldin Date: 10/02/2026
Licensing Consultant

Approved By:



Ardra Hunter Date: 10/13/2026
Area Manager