GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 26, 2025

Beatrice Rutaboba
5090 Amanda Drive SW
Wyoming, MI 49418

RE: License #:	AS410418208
Investigation #:	2026A0356002
	Ruta's Home Care

Dear Ms. Rutaboba:

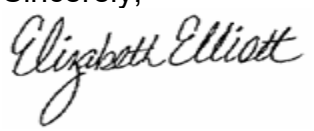
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410418208
Investigation #:	2026A0356002
Complaint Receipt Date:	10/01/2025
Investigation Initiation Date:	10/02/2025
Report Due Date:	11/30/2025
Licensee Name:	Beatrice Rutaboba
LicenseeAddress:	5090 Amanda Drive SW Wyoming, MI 49418
Licensee Telephone #:	(616) 589-7682
Administrator:	Beatrice Rutaboba
Licensee Designee:	Beatrice Rutaboba
Name of Facility:	Ruta's Home Care
Facility Address:	5090 Amanda Dr SW Wyoming, MI 49418
Facility Telephone #:	(616) 589-7682
Original Issuance Date:	11/12/2024
License Status:	REGULAR
Effective Date:	05/12/2025
Expiration Date:	05/11/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A's personal care at this facility is not adequate.	No
Staff at the facility did not administer Resident A's medications/special medical procedures as prescribed by the healthcare provider.	Yes

III. METHODOLOGY

10/01/2025	Special Investigation Intake 2026A0356002
10/01/2025	APS Referral
10/02/2025	Special Investigation Initiated - Telephone Leondra Fair, APS/DHHS.
10/06/2025	Telephone call made Leondra Fair, APS.
10/21/2025	Inspection Completed On-site
10/21/2025	Contact - Face to Face Beatrice Rutaboba, Licensee.
10/21/2025	Contact - Telephone call made Resident A.
10/21/2025	Contact - Document Received Facility documents.
10/28/2025	Contact - Document Received Facility docs-MAR
11/14/2025	Contact-Telephone call made Trinity Health-Chaunee Gilbert, RN
11/17/2025	Contact-Telephone call made Trinity Health wound care clinic- Nicole Lonyo.
11/26/2025	Exit conference-Beatrice Rutaboba, Licensee.

ALLEGATION: Resident A's personal care at this facility is not adequate.

INVESTIGATION: On 10/01/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported there are concerns about Resident A not receiving proper care at the AFC home. The complainant reported Resident A's hygiene is poor. Resident A is not adequately groomed, his clothing is dirty, and his fingernails are long.

On 10/06/2025, I interviewed APS (adult protective services) worker, Leondra Fair via telephone. Ms. Fair reported she saw Resident A when he was discharged from the hospital. Ms. Fair stated it sounds as though Resident A does not like to shower but staff encourage him to keep up his personal care. Ms. Fair stated there were no concerns regarding his hygiene or nails when she conducted the home visit.

On 10/21/2025, I conducted an unannounced inspection at the facility and interviewed Licensee Beatrice Rutaboba. Ms. Rutaboba stated Resident A was homeless prior to admission to this facility and he does not like to or is not used to showering and cleaning up daily. Ms. Rutaboba stated she tried to get him to shower regularly and to keep up on his ADLs (activities of daily living). Ms. Rutaboba stated the agency that placed Resident A in this facility also reported that Resident A does not like to take showers, but he can take showers on his own. Ms. Rutaboba stated even after Resident A got a shower chair that he said he needed, he still would not shower regularly. Ms. Rutaboba stated Resident A does not have a guardian.

On 10/21/2025, I interviewed Resident A via telephone. Resident A stated he changed his clothes daily but did not shower daily because he did not have his shower chair but once he got a shower chair, he showered and completed all ADL's including cutting his nails on a regular basis. Resident A stated he is capable of completing his ADL's without staff assistance.

On 10/21/2025, I reviewed Resident A's assessment plan for AFC residents dated 03/28/2025. The assessment plan documented Resident A is independent with bathing other than requiring assistance in and out of the shower. Resident A is independent with grooming but needs some assistance with personal hygiene. The assessment plan does not explain the type of assistance Resident A requires with personal hygiene.

On 11/14/2025, I interviewed Chaunee Gilbert, RN at Trinity Health. Ms. Gilbert stated Resident A saw Michelle Aue, PA-C (physician assistant) and records show when Resident A was seen by Ms. Aue on 09/29/2025, Ms. Aue documented that Resident A was disheveled. Ms. Gilbert reported that Resident A's history is homelessness and adult failure to thrive.

On 11/17/2025, I interviewed Nicole Lonyo, care manager, Trinity Health wound care clinic. Ms. Lonyo stated there is nothing in their clinical notes that expressed concern

regarding Resident A's well-being, his personal hygiene or that he is not being cared for in this facility.

On 11/26/2025, I conducted an exit conference with Ms. Rutaboba via telephone. Ms. Rutaboba stated she understands and agrees with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported Resident A's hygiene is poor. Resident A is not adequately groomed, his clothing is dirty, and his fingernails are long. Ms. Fair stated there were no concerns regarding his hygiene or nails when she conducted the home visit. Ms. Aue's notes described Resident A's appearance as disheveled during a doctor's visit. Ms. Lonyo stated there is nothing in their clinical notes that expressed concern about Resident A having poor personal hygiene. Ms. Rutaboba stated she tried to get Resident A to shower and to keep up on his ADLs on a consistent basis, but Resident A was resistant to showering daily. Resident A stated he changed his clothes daily but did not shower daily. Resident A's assessment plan documented Resident A is independent with bathing and grooming but needs some assistance with personal hygiene. Based on investigative findings, there is not a preponderance of evidence to show that staff at the facility failed to aid Resident A with personal hygiene. A violation of this applicable rule is not established.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff at the facility did not administer Resident A's medications/special medical procedures as prescribed by the healthcare provider.

INVESTIGATION: On 10/01/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported there are concerns about Resident A not receiving proper care at the AFC home. The complainant reported Resident A has a concerning wound, a referral to the wound clinic for further treatment is being made but Resident A has a wound on his arm that has not been changed or dressed in over a week. The complainant reported staff are not checking Resident A's blood sugars because they do not have a glucometer and staff are not making sure Resident A is attending scheduled medical appointments.

On 10/06/2025, I interviewed APS (adult protective services) worker, Leondra Fair via telephone. Ms. Fair reported she saw Resident A when he was discharged from the hospital so at that time, Resident A's wound was wrapped. Medical staff had wrapped the wound the day before and the wound was wrapped well. Ms. Fair reported the wrap was supposed to be changed every 5 days, but they are being changed, according to the referral source every 7 days. Ms. Fair stated staff at the facility reported they are wrapping the wound with bandages provided by the hospital, but the bandages stuck to the wound which may have made the wound look worse. Ms. Fair reported staff at the facility now have nonstick bandages. Ms. Fair reported Resident A did not have an insurance card while in the hospital and recently lost his blood sugar monitor, so Resident A was waiting on insurance before he was able to get another one. In the meantime, Resident A is using a friend's glucometer to check his blood sugar until he can get a new one from the pharmacy.

On 10/21/2025, I conducted an unannounced inspection at the facility and interviewed Licensee Beatrice Rutaboba. Ms. Rutaboba stated Resident A no longer resides in the facility as he could no longer get up and down the stairs. Ms. Rutaboba stated Resident A was admitted to the facility in March 2025 and went into the hospital in July 2025, he returned to the facility on July 15,2025 and then went back into the hospital in August 2025 for surgery and that's when the IV wound occurred. Ms. Rutaboba stated Resident A was discharged from the hospital and returned to the facility in September with the wound on his arm and discharged from the AFC home on October 12, 2025, due to his inability to get up and down the steps in the facility.

Ms. Rutaboba stated Resident A got the wound on his arm while in the hospital from an IV and they sent him home with a sticky band aid type cover for the wound that when she removed it from Resident A's arm, it stuck to the wound and made it look worse. Ms. Rutaboba stated Resident A was supposed to get wound care from an

agency at the facility upon discharge from the hospital, but wound care was never set up. Ms. Rutaboba took Resident A to the doctor on 09/29/2025 and after that, wound care was initiated, and wound care specialists treated the wound in office. Ms. Rutaboba stated she was instructed how to care for the wound on Resident A's arm when she took Resident A to the wound care hospital on 09/15/2025.

Ms. Rutaboba stated Resident A was admitted to the facility in March 2025, in July 2025, Resident A's doctor told Resident A he needed to monitor his blood sugar levels with a glucometer. Ms. Rutaboba stated Resident A had lost his insurance card and did not have the funds to pay for one, so he was waiting for a new insurance card so they could get the glucometer. Ms. Rutaboba stated the pharmacy would not fill the order because Resident A's insurance would not cover it. Ms. Rutaboba stated the other option was for Resident A to use his UCard balance, but he had lost that card and his wallet. Ms. Rutaboba stated she had attempted to order new cards for Resident A, but no one would talk to her, they would only talk to Resident A and by then he was in the hospital. Ms. Rutaboba stated Resident A was in and out of the hospital from July-September 2025 and upon his return to the facility, again, the doctor told Resident A that he needed a glucometer to monitor his blood sugar levels but the pharmacy said Resident A's insurance needed to be updated so a glucometer could be ordered. Ms. Rutaboba stated once he was back in the facility in September 2025, they began the process of ordering a new UCard and insurance cards which finally resulted in Resident A getting a glucose monitor and then Resident A moved from the facility on 10/12/2025.

Ms. Rutaboba stated Resident A missed some doctor appointments because he was in and out of the hospital for 3 months. Ms. Rutaboba stated Resident A's doctors were upset that Resident A was not being seen but after being discharged from the hospital, the surgery doctors were scheduling Resident A's appointments, and at times they conflicted with other appointments, so the appointments had to be cancelled and rescheduled.

On 10/21/2025, I interviewed Resident A via telephone. Resident A stated he received good care while at this facility and did not want to leave but he could no longer get up and down the steps. Resident A stated he had "3 square meals a day" and that Ms. Rutaboba took care of the wound on his arm. Resident A stated he got a glucometer once he got his insurance and moved out of this facility on the following day.

Resident A stated Ms. Rutaboba got him to his doctor's appointments and if she could not get him to them, she re-scheduled them. Resident A stated he did not miss doctor's appointments while living in this facility.

On 10/21/2025, I reviewed Resident A's MARs (medication administration records) for the months of April, May, June, July, August and September 2025. The MAR document Resident A's medications administered as prescribed in April and May 2025.

- The June MAR documented Lantus Solostar Inj. 3 ML, inject 10 units under the skin every night at bedtime, 8:30p.m. was not administered at all during the month of June 2025. The June MAR documented Resident A was in the hospital from June 24, 2025 throughout the remainder of the month.
- The July MAR documented Resident A returned to the facility from the hospital on July 16, 2025. The MAR documented Lantus Solostar Inj. 3 ML, inject 10 units under the skin every night at bedtime, 8:30p.m. was not administered at all the remainder of the month of July 2025.
- The July MAR documented a contour glucose monitor for blood sugar readings to be used every day. The glucose monitor was not signed as administered from July 16-31, 2025, as prescribed.
- The August MAR documented Resident A was in the hospital and rehab the entire month of August 2025.
- The September MAR documented Resident A returned to the facility on September 12, 2025, and the MAR documented a contour glucose monitor for blood sugar readings to be used every day. The glucose monitor was not signed as administered as prescribed from September 12, 2025, for the remainder of the month.

On 11/14/2025, I interviewed Chaunee Gilbert, RN at Trinity Health. Ms. Gilbert stated Resident A saw Michelle Aue, PA-C (physician assistant) and records for Resident A's appointments show two "no shows", one on 06/24/2025 and one on 09/15/2025, a cancelled appointment on 07/11/2025 and that appointment was cancelled by Resident A. There were several appointments where he was seen, 04/11/2025, 08/13/2025, 09/09/2025, 09/29/2025, and on 11/19/2025, there is a scheduled appointment, but Resident A is in the hospital again. Ms. Gilbert stated the record does not reflect a large amount of no show or missed appointments and there could be an explanation for that given the amount of time Resident A spent in the hospital.

Ms. Gilbert stated a glucometer was ordered for Resident A on 04/11/2025. Ms. Gilbert stated there was nothing Ms. Rutaboba could have done about getting the glucometer if Resident A's insurance would not cover it or if his card was missing/lost.

Ms. Gilbert stated an IV certainly could cause a wound on the arm especially on a diabetic. Ms. Gilbert stated the wound Resident A had on his arm was a bad, very involved wound. Ms. Gilbert stated the wound clinic dresses the wound and educates caregivers on how to change the dressings. Resident A would have gone into the wound clinic to have the wound dressings changed and new ones put on, a referral to the wound clinic was made on 09/29/2025 after Ms. Aue saw Resident A on that date.

Ms. Gilbert stated Ms. Aue documented notes on 09/29/2025 after a visit with Resident A and they said she questions the care given to Resident A at this facility,

they have not been changing the wound on Resident A's arm, they should be putting a fresh covering on the wound every 4-5 days, and it was last changed a week ago.

On 11/17/2025, I interviewed Nicole Lonyo, care manager, Trinity Health wound care clinic. Ms. Lonyo stated they are an outpatient clinic. Patients must come into the clinic, there is no home care. Ms. Lonyo stated the referral was made to them on 09/29/2025 by Trinity Health, River Town office, it was received on 09/30/2025 and Resident A's first appointment was on 10/07/2025. Ms. Lonyo stated Ms. Rutaboba must have taken Resident A to see Ms. Aue on 09/29/2025 and a referral to the wound clinic was made at that time. Ms. Lonyo stated Resident A was seen in the wound care clinic on 10/7/2025 for his first appointment and it is not mentioned in the notes that anyone was with Resident A at the appointment, but a caregiver could have been sitting in the waiting room for him. Ms. Lonyo stated Resident A's wound was a standard necrotic wound that required debriding and cauterizing. Ms. Lonyo stated there is nothing in the wound care clinic notes about wound care not being done for Resident A in the facility. Ms. Lonyo stated the wound on Resident A's arm was a significant wound, but the notes do not indicate lack of care.

On 11/26/2025, I conducted an exit conference with Ms. Rutaboba via telephone. Ms. Rutaboba stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	The complainant reported there are concerns about Resident A not receiving proper care at the AFC home. The complainant reported Resident A has a concerning wound, staff are not checking Resident A's blood sugars because they do not have a glucometer, and staff are not making sure Resident A is attending scheduled medical appointments. Based on investigative findings, there is evidence to show that the licensee was getting Resident A to scheduled medical appointments including wound care. There is evidence by a review of Resident A's MARs that Resident A's blood sugar levels and some medication prescribed by Resident A's health care professional were not administered as prescribed and therefore a violation of this applicable rule is established.

CONCLUSION:	**VIOLATION ESTABLISHED**

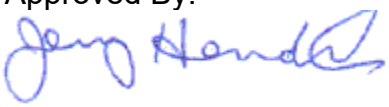
IV. RECOMMENDATION

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

11/26/2025

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



11/26/2025

Jerry Hendrick — Date
Area Manager