



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 24, 2025

Karin Nalunkuuma
FAITH&GRACE ENTERPRISE LLC
15422 Arrowhead Ridge Dr
HUMBLE, TX 77396

RE: License #: AS410418647
Investigation #: 2026A0583010
FAITH HAVEN ADULT FOSTER CARE HOME

Dear Ms. Nalunkuuma:

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Toya Zylstra".

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410418647
Investigation #:	2026A0583010
Complaint Receipt Date:	11/19/2025
Investigation Initiation Date:	11/19/2025
Report Due Date:	12/19/2025
Licensee Name:	FAITH & GRACE ENTERPRISE LLC
LicenseeAddress:	1247 33rd Wyoming, MI. 49504
Licensee Telephone #:	(313) 310-2632
Administrator:	Karin Nalunkuuma
Licensee Designee:	Karin Nalunkuuma
Name of Facility:	FAITH HAVEN ADULT FOSTER CARE HOME
Facility Address:	72 Richards Ave. NW Grand Rapids, MI 49504
Facility Telephone #:	(313) 310-2632
Original Issuance Date:	10/18/2024
License Status:	REGULAR
Effective Date:	04/18/2025
Expiration Date:	04/17/2027
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED, AGED DEVELOPMENTALLY, DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was not adequately supervised.	No
Additional Findings	Yes

III. METHODOLOGY

11/19/2025	Special Investigation Intake 2026A0583010
11/19/2025	APS Referral
11/19/2025	Special Investigation Initiated - Telephone
11/20/2025	Inspection Completed On-site
11/24/2025	Exit Conference Licensee Designee Karin Nalunkuuma

ALLEGATION: Resident A was not adequately supervised.

INVESTIGATION: On 11/19/2025 complaint allegations were received from Adult Protective Services via the LARA-BCHS-Complaints system. The complaint stated the following: *“On 11/13/2025, (Resident A) left the group home with little to no intervention from staff. (Resident A) requires 1 on 1 staffing during waking hours (10a-10p). Karen allowed (Resident A) outside to get some air while watching her on the Ring camera. (Resident A) then eloped from the home, traveling in between the homes versus using the main road. (Resident A) wandered about for about three hours and was eventually sexually assaulted by a homeless man. (Resident A) was only wearing a thin gown and sandals. Police have indicated there have been other sexual assaults involving residents; however, it is unclear if this has happened within the home or outside the home due to a lack of supervision”.*

On 11/19/2025 I interviewed licensee designee Karin Nalunkuuma via telephone. She stated that Resident A is diagnosed with mental illness and developmental delays. She was admitted to the facility in September 2025 at which time an Assessment Plan and Behavior Plan were completed. She stated that Resident A was admitted to the facility directly following a psychiatric hospitalization and history of elopements from other facilities. At admission, a Formal Behavior Program Plan was implemented which consists of 1:1 staffing during the hours of 7 AM until 10 PM. She stated that per Resident A’s Behavior Plan, staff must have Resident A within a 5 to 6 foot visual radius and Resident A is not permitted to move independently within the community. She stated that the incident occurred on 11/12/2025, rather than 11/13/2025 as reported in the complaint. She stated that staff Godrey Kimera, staff Umutesi Ngabonziza, and herself were working. Ms. Nalunkuuma stated she was providing Resident A with 1:1 supervision and was not

distracted by her telephone or any other items. At approximately 6:40 PM, she stated that Resident A went outside onto the porch to get fresh air and informed Ms. Nalunkuuma that she needed space. Ms. Nalunkuuma stated that she observed Resident A from the doorway and via the ring door camera app which displayed the porch outdoor cameras. She stated she was never more than a few feet away from Resident A. After a few minutes, Ms. Nalunkuuma noticed Resident A appeared increasingly distressed and began walking toward the back of the house, an area that is dark and not well-lit. Ms. Nalunkuuma stated that Resident A began running and because Ms. Nalunkuuma didn't have shoes on, she went inside of the home to get her shoes and requested assistance from the other two staff. She stated that all three staff looked around the home for Resident A without success. Ms. Nalunkuuma stated that she briefly returned inside to grab car keys to follow her by vehicle and Mr. Kimera used the facility vehicle to look for Resident A. Ms. Nalunkuuma stated that she immediately contacted 911 to report Resident A's elopement and continued searching the nearby area for over an hour before returning to the facility. Ms. Nalunkuuma stated that at approximately 11:30 PM, Resident A returned to the home and reported that after leaving the home, she initially hid from staff. She stated she later walked to various nearby locations, including McDonald's and Burger King. During this time, she was approached by a man who offered her a coat and subsequently sexually assaulted her. Resident A attempted to fight back, ran, and was located by a security guard who called law enforcement. Law enforcement located and arrested the alleged assailant. Resident A received medical treatment at Trinity Health. She was later picked up by her guardian at approximately 5:00 AM and transported to the YWCA for further support services.

On 11/19/2025 I received an email from Adult Protective Services staff Heather Autsema who verified that she is investigating the complaint allegation.

On 11/19/2025 I received and reviewed an email from licensee designee Karin Nalunkuuma which contained Resident A's Assessment Plan and Behavior Plan. The Assessment Plan (signed 09/25/2025) states that Resident A moves independently in the community. The Community Mental Health Formal Behavior Program Plan (signed 10/20/2025) states that Resident A has a history of "self-harm, elopement and suicidal ideation" and that staff should provide a "5-6 foot radius when 1:1 staffing is needed". The plan indicates that, "Resident will receive fifteen hours of 1:1 support during her normal waking hours of 7 AM-10 PM in her home and community" and that "staff should follow behind Resident A with a 5-6 ft radius to ensure safety".

On 11/20/2025 I completed an onsite investigation at the facility and interviewed staff Umutesi Ngabonziza, staff Godfrey Kimera and Resident A.

Ms. Ngabonziza stated that on the evening of 11/12/2025 Resident A was agitated and being monitored by Ms. Nalunkuuma. Ms. Ngabonziza stated that Resident A went outside on the porch for fresh air and Ms. Nalunkuuma watched Resident A

from the open front doorway. She stated that she was in the kitchen and heard a request from Ms. Nalunkuuma to help find Resident A who had run from the porch. She stated that she attempted to run out of the house after Resident A but Resident A ran behind the house and into the dark alley way. She stated that Ms. Nalunkuuma and Ms. Kimera continued looking for Resident A behind the home. She stated that Mr. Kimera then proceeded to look around the neighborhood via the facility vehicle but could not locate Resident A. She stated staff provided adequate supervision which includes 1:1 staffing from 7 AM until 10 PM.

Mr. Kimer stated that on the evening of 11/12/2025, he was in the facility's basement when he heard Ms. Nalunkuuma call for his assistance. He stated that when he reached upstairs, he was informed that Resident A had eloped, and he immediately went outside looking for her. He stated that he could not locate her around the facility therefore he proceeded to look for her via the facility's vehicle without success. He stated that staff provided adequate supervision which includes 1:1 staffing from 7 AM until 10 PM.

Resident A stated that she has a history of elopements and psychiatric inpatient hospitalizations. She stated that she hears voices that tell her to run away. She stated that she enjoys residing at the facility and characterized it as the "best" facility she has resided in. She stated that on the evening of 11/12/2025 she was agitated because "voices" were talking to her and went out to the porch for fresh air. She confirmed that she went onto the porch alone and does not recall if Ms. Nalunkuuma was watching her from the doorway. She stated that she ran from the porch and never heard staff calling for her to stop. She stated that she exited around the front of the house to the back alley and ran from staff. She stated that she walked around the neighborhood and was sexually assaulted outside by the LaGrand Church. She stated that after the assault she walked to Trinity Health Hospital where a security guard brought her into the hospital for treatment. She stated that she was away from the home for approximately three hours. She stated that facility staff provided adequate supervision, and the facility is always staffed with a minimum of two staff. She stated that she receives 1:1 staffing from 7 AM until 10 PM.

On 11/20/2025 I interviewed Health Autsema of APS. She stated that Resident A was sexually assaulted "by a homeless man" on 11/12/2025 during the elopement and the perpetrator was arrested and charged with sexual assault. She stated that she will not be substantiating neglect on the part of staff at the facility.

On 11/20/2025 I interviewed Heather Bullock via telephone. She stated that she is Resident of A's West Michigan Community Mental Health case manager. She stated that Resident A has a history of elopement from multiple previous placements. She stated that she formulated Resident A's Assessment Plan and acknowledged that the Assessment Plan was not adequately formulated to reflect the level of supervision required to adequately supervise Resident A. She stated that Resident A is not free to move independently within the community and currently requires 1:1 staffing from 7 AM until 10 PM. She stated that facility staff

must follow Resident A's Formal Behavior Program Plan and the facility receives additional funding to provide the required 1:1 staff supervision. She stated that on 11/12/2025 Resident A did elope, and staff did provide adequate supervision during the incident. She stated that she is satisfied with the level of supervision provided at the facility and characterized the care as "the best". She stated that facility staff communicate adequately, and she has no concerns regarding the level of care provided. She agreed that a new Resident Assessment Plan is needed.

On 11/24/2025 I completed an exit conference via telephone with licensee designee Karin Nalunkuuma. She stated that she agreed with the findings and has updated Resident A's Assessment Plan to reflect her need for a higher level of supervision. She stated that she is waiting for Resident A's guardian and case manager to sign the updated document.

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:	<p>Resident A's Assessment Plan was signed on 09/25/2025 by all parties and states that Resident A moves independently in the community.</p> <p>Resident A's Behavior Program Plan was signed 10/20/2025 and states Resident A has a history of "self-harm, elopement and suicidal ideation" and that staff should provide a "5-6 foot radius when 1:1 staffing is needed". The plan indicates that "Resident will receive fifteen hours of 1:1 support during her normal waking hours of 7 AM-10 PM in her home and community" and that "staff should follow behind Resident A with a 5-6 ft radius to ensure safety".</p> <p>Licensee designee Karin Nalunkuuma stated that on 11/12/2025 Resident A eloped from the facility despite being provided 1:1 staff supervision.</p> <p>Case manager Heather Bullock stated that she is satisfied with the level of supervision Resident A received at the facility and characterizes the care in the home as "the best".</p> <p>A preponderance of evidence was not discovered during the</p>

	special investigation to support a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Resident A’s Assessment Plan lacks required behavior interventions.

INVESTIGATION: On 11/19/2025 Ms. Nalunkuuma stated via telephone that at Resident A’s admission, a Formal Behavior Program Plan was implemented which consists of 1:1 staffing during the hours of 7 AM until 10 PM and staff must have Resident A within a 5 to 6 foot visual radius. She confirmed that Resident A is not permitted to move independently within the community.

On 11/19/2025 I observed Resident A’s Assessment Plan states that Resident A moves independently in the community. I also observed the Community Mental Health Formal Behavior Program Plan states that Resident A has a history of “self-harm, elopement and suicidal ideation” and that staff should provide a “5-6 foot radius when 1:1 staffing is needed”. The plan indicates that “Resident will receive fifteen hours of 1:1 support during her normal waking hours of 7 AM-10 PM in her home and community” and that “staff should follow behind Resident A with a 5-6 ft radius to ensure safety”.

While onsite on 11/20/2025, Ms. Nalunkuuma stated that Resident A’s Assessment Plan does not adequately address Resident A’s required behavioral interventions which include 1:1 staff supervision from 7 AM until 10 PM, 5-6 foot staff visual radius, and limiting Resident A’s movement within the community. Ms. Nalunkuuma confirmed that that Assessment Plan requires revision to implement interventions to ensure the safety of Resident A given her complex history of suicidal ideation and elopement.

On 11/20/2025 Heather Bullock stated via telephone that Resident A has a history of elopement at multiple previous placements. She stated that she formulated Resident A’s Assessment Plan. She stated that the Assessment Plan does not adequately address Resident A’s required behavioral interventions which include 1:1 staff supervision from 7 AM until 10 PM, 5-6 foot staff visual radius, and limiting Resident A’s movement within the community.

On 11/24/2025 I completed an exit conference via telephone with licensee designee Karin Nalunkuuma. She stated she agrees with the findings and has updated Resident A’s Assessment Plan to reflect her need for a higher level of supervision. She stated that she is waiting for Resident A’s guardian and case manager to sign the updated document. She stated that she will submit an acceptable Corrective Action Plan.

APPLICABLE RULE

R 400.641	Resident behavior interventions.
	(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.
ANALYSIS:	<p>Resident A's Assessment Plan states that Resident A moves independently in the community.</p> <p>Resident A's Behavior Program Plan states that Resident A has a history of "self-harm, elopement and suicidal ideation" and that staff should provide a "5-6 foot radius when 1:1 staffing is needed". The plan indicates that "Resident will receive fifteen hours of 1:1 support during her normal waking hours of 7 AM-10 PM in her home and community" and that "staff should follow behind Resident A with a 5-6 ft radius to ensure safety".</p> <p>Licensee designee Karin Nalunkuuma acknowledged that Resident A's Assessment Plan does not adequately address Resident A's required behavioral interventions which include 1:1 staff supervision from 7 AM until 10 PM, 5-6 foot staff visual radius and limiting Resident A's movement in the community.</p> <p>Case manager Heather Bullock acknowledged that Resident A's Assessment Plan does not adequately address Resident A's required behavioral interventions which include 1:1 staff supervision from 7 AM until 10 PM, 5-6 foot staff visual radius, and limiting Resident A's movement within the community.</p> <p>A preponderance of evidence was discovered during the special investigation to indicate a violation of the applicable rule occurred. Resident A's Assessment Plan does not adequately address required behavioral interventions to safeguard her wellbeing.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS: Resident A's Assessment Plan is incomplete and lacks the amount of personal care, supervision, and protection required.

INVESTIGATION: On 11/19/2025 Ms. Nalunkuuma stated via telephone that at Resident A's admission, a Formal Behavior Program Plan was implemented which consists of "1:1" staffing during the hours of 7 AM until 10 PM and staff must have Resident A within a 5-6 foot visual radius. She confirmed that Resident A is not permitted to move independently within the community.

On 11/19/2025 I observed Resident A's Assessment Plan states that Resident A moves independently in the community. However, Resident A's Community Mental Health Formal Behavior Program Plan states that Resident A has a history of "self-harm, elopement and suicidal ideation" and that staff should provide a "5-6 foot radius when 1:1 staffing is needed". The plan indicates that "Resident will receive fifteen hours of 1:1 support during her normal waking hours of 7 AM-10 PM in her home and community" and that "staff should follow behind Resident A with a 5-6 ft radius to ensure safety".

While onsite on 11/20/2025, Ms. Nalunkuuma acknowledged that Resident A's Assessment Plan is incomplete because it does not include the amount of personal care, supervision, and protection Resident A requires which includes 1:1 staff supervision from 7 AM until 10 PM, 5-6 foot staff visual radius, and limiting Resident A's movement within the community. Ms. Nalunkuuma confirmed that the Assessment Plan requires revision to implement interventions to ensure the safety of Resident A given her complex history of suicidal ideation and elopement.

On 11/20/2025 Heather Bullock stated via telephone stated that she formulated Resident A's Assessment Plan. She acknowledged the Assessment Plan does not adequately reflect the amount of personal care, supervision, and protection required by Resident A. She stated that Resident A is not free to move independently within the community and currently requires 1:1 staffing from 7 AM until 10 PM.

On 11/24/2025 I completed an exit conference via telephone with licensee designee Karin Nalunkuuma. She stated that she agreed with the findings and has updated Resident A's Assessment Plan to reflect her need for a higher level of supervision. She stated that she is waiting for Resident A's guardian and case manager to sign the updated document. She stated that she will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: (a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.

ANALYSIS:	<p>Resident A's Assessment Plan states that Resident A moves independently in the community.</p> <p>Resident A's Community Mental Health Formal Behavior Program Plan states that Resident A has a history of "self-harm, elopement and suicidal ideation" and that staff should provide a "5-6 foot radius when 1:1 staffing is needed". The plan indicates that "Resident will receive fifteen hours of 1:1 support during her normal waking hours of 7 AM-10 PM in her home and community" and that "staff should follow behind Resident A with a 5-6 ft radius to ensure safety".</p> <p>Licensee designee Karin Nalunkuuma confirmed the Assessment Plan requires revision and lacks the amount of personal care, supervision and protection required by Resident A.</p> <p>Case manager Heather Bullock acknowledged the Assessment Plan does not adequately reflect the level of supervision required to adequately supervise Resident A. She stated that Resident A is not free to move independently within the community and currently requires 1:1 staffing from 7 AM until 10 PM. She stated that facility staff must follow Resident A's Formal Behavior Program Plan and the facility receive additional funding to provide required 1:1 staff supervision.</p> <p>A preponderance of evidence was discovered during the special investigation to support violation of the applicable rule occurred. Resident A's Assessment Plan is incomplete because it does not state the amount of personal care, supervision, and protection required by the resident.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.



11/24/2025

Toya Zylstra, Licensing Consultant

Date

Approved By:

Jerry Hendrick

11/24/2025

Jerry Hendrick, Area Manager

Date