GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 17, 2025

Olivier Ruhumuriza
Winter Wood Inc.
307 Broadway
Middleville, MI 49333

RE: License #: AM080007779
Investigation #: 2026A1024003
Middleville Afc

Dear Mr. Ruhumuriza:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On December 2, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM080007779
Investigation #:	2026A1024003
Complaint Receipt Date:	10/28/2025
Investigation Initiation Date:	10/31/2025
Report Due Date:	12/27/2025
Licensee Name:	Winter Wood Inc.
Licensee Address:	307 Broadway Middleville, MI 49333
Licensee Telephone #:	(269) 795-3011
Administrator:	Olivier Ruhumuriza
Licensee Designee:	Olivier Ruhumuriza
Name of Facility:	Middleville Afc
Facility Address:	307 Broadway Middleville, MI 49333
Facility Telephone #:	(269) 795-3011
Original Issuance Date:	12/08/1989
License Status:	REGULAR
Effective Date:	03/02/2024
Expiration Date:	03/01/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is yelled at and mistreated by staff members.	Yes
Resident A does not take his insulin as prescribed.	Yes
Staff do not properly monitor Resident A's blood sugar levels as instructed by physician.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/28/2025	Special Investigation Intake 2026A1024003
10/31/2025	APS Referral-not warranted
10/31/2025	Special Investigation Initiated - Face to Face with direct care staff member Shirley Molloy and Resident A
10/31/2025	Contact - Telephone call made with administrator and licensee designee Olivier Ruhumuriza
10/31/2025	Contact - Document Received- *After Visit Summary*
10/31/2025	Contact - Telephone call made with Guardian A1
11/24/2025	Inspection Completed-BCAL Sub. Compliance
11/24/2025	Corrective Action Plan Requested and Due on 12/12/2025
12/02/2025	Corrective Action Plan Received
12/02/2025	Corrective Action Plan Approved

ALLEGATION: Resident A is yelled at and mistreated by staff members.

INVESTIGATION:

On 10/28/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A is yelled at and mistreated by staff members.

On 10/312025, I conducted an onsite investigation at the facility with direct care staff member Shirley Molloy who stated that she works regularly in the home along with licensee designee Olivier Ruhumuriza and she does not believe either of them has ever

mistreated Resident A. Shirley Molloy stated there has been times she has raised her voice at Resident A because he does not like to listen to her when she makes attempts to help him when he has low blood sugar. Shirley Molloy stated Resident A is diabetic and he needs to consume beverages that are high in sugar such as Kool Aid however Resident A will refuse and will often drink diet pop. Shirley Molloy stated that Resident A is not on a special diet, however he has been told by medical providers that drinks with high sugars can help raise his blood sugar levels where they need to be. Shirley Molloy stated during one particular recent incident, Resident A was encouraged to drink Kool Aid with his meal after one of his emergency room visits for having low blood sugar. Shirley Molloy stated licensee designee Olivier Ruhumuriza moved Resident A's diet pop out of his reach and placed a cup of Kool Aid in front of him to encourage him to consume a drink with higher sugar content. Shirley Molloy stated at this time she raised her voice however did not yell at Resident A to drink the Kool Aid to assist Resident A with raising his blood sugar. Shirley Molloy stated it is very challenging to help Resident A keep his blood sugar under control when he chooses not to listen to guidance however, she provides verbal prompting for encouragement.

While at the facility I also interviewed Resident A who stated that both Shirley Molloy and Olivier Ruhumuriza will yell at him when he does something wrong and he does not like to be yelled at. Resident A stated staff will get mad and yell at him especially when he does not drink Kool Aid beverage. Resident A stated he does not like to drink Kool Aid and prefers to drink diet pop. Resident A further stated there was an incident when staff took his diet soda away from him when he was eating and told him that he had to drink Kool Aid instead at which time the staff became upset and yelled at him because he refused to drink the Kool Aid.

On 10/31/2025, I conducted an interview with administrator and licensee designee Olivier Ruhumuriza who stated that he sometimes must raise his voice when Resident A refuses to cooperate with his instructions such as drinking Kool Aid with his meals instead of diet pop to keep his blood sugar at a normal level. Olivier Ruhumuriza stated that he tries to help Resident A keep his blood sugar levels under control and has moved Resident A's diet soda away from him out of his reach during mealtime so he can drink Kool Aid. Olivier Ruhumuriza stated that instead Resident A still refuses to drink beverages to help with his low blood sugar which makes it challenging to help Resident A.

On 10/31/2025 I conducted an interview with Guardian A1 who stated that she has not seen or heard any staff member mistreat Resident A directly, however a hospital social worker recently contacted her and reported that they were concerned about Resident A because staff was heard yelling at him regarding his blood sugar levels. Guardian A1 stated that Resident A has also mentioned that staff gets upset and yells at him.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(3) A licensee shall ensure that interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Based on my investigation which included interviews with direct care staff member Shirley Molloy, administrator/licensee designee Olivier Ruhumuriza, Guardian A1 and Resident A there is evidence to support the allegation Resident A is yelled at by staff members. Shirley Molloy and Olivier Ruhumuriza both stated that they raise their voice when Resident A does not follow their instructions to address his low blood sugar. Resident A further stated that staff yell at him when they are upset with him. Shirley Molloy and Olivier Ruhumuriza both stated that they have taken a drink from Resident A against his wishes in attempts to get him to cooperate with them. In addition, Guardian A1 stated that a hospital social worker contacted her recently to report staff was heard yelling at Resident A while at a hospital visit regarding his blood sugar levels. Therefore, staff interactions with Resident A do not promote and encourage cooperation, self-direction and independence.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is not administered his insulin medication as prescribed.

INVESTIGATION:

This complaint also alleged that Resident A is not administered his insulin medication as prescribed.

On 10/312025, I conducted an onsite investigation at the facility with direct care staff member Shirley Molloy who stated that Resident A is diagnosed with diabetes and is supposed to take insulin medication once a day however sometimes he forgets to take his insulin. Shirley Molloy stated that Resident A is usually good about taking the initiative to get his insulin injection pen from staff however there are times staff must remind Resident A to take his insulin. Shirley Molloy stated that staff monitors and supervises Resident A when he takes his insulin and to her knowledge Resident A takes his insulin on most days, however there are times Resident A has missed taking it which causes his blood sugar level to drop.

While at the facility, I also interviewed Resident A who stated that he takes his insulin medication most of the time however there are days he forgets to take his insulin and there are days staff members forget to prompt him to take his insulin therefore he has gone without taking his insulin. Resident A stated that when he does not take his insulin

medication, he gets low blood sugar levels which causes him to have to go the emergency room to get his blood sugar levels under control. Resident A stated that he has been going to the emergency room quite often lately due to having low blood sugar.

While at the facility, I reviewed Resident A's Medication Administration Record (MAR) for August, September and October of 2025. According to August 2025 MAR, Resident A takes Lantus Solos INJ 100 ML to be injected 20 units once daily. According to this MAR, staff initials were recorded every day except for the days of 8/29/2025, 8/30/2025 and 8/31/2025. A circle was recorded on these days to reflect the code "other" however no explanation was noted. According to September 2025 MAR, Resident A did not take his Lantus Solos injection from 9/24/2025 through 9/30/2025 as there were no recorded staff initials to indicate this medication was taken. According to October 2025 MAR, Resident A took his Lantus Solos injection for 7 days out of the month as staff initials were recorded on the 9th, 10th, 11th, 12th, 13th, 15th, and 20th. It should be noted there was no explanation recorded for the missing initials on the other days of the month.

I also reviewed Resident A's physician script for which documented that Resident A should take Lantus SoloStar 100 units per ML Subcutaneous Solution Pen-Injector to be injected 20 units under the skin daily with an effective date of 6/2/2025. I also observed Resident A's Insulin Lispro KwikPen Injection 100 units per ML stored in a locked refrigerator. It should be noted that I was not able to review a physician order that states that Resident A is allowed to administer is own medications independently.

On 10/31/2025, I conducted an interview with administrator and licensee designee Olivier Ruhumuriza who stated that Resident A is supposed to take insulin medication to manage his blood sugar levels daily and to his knowledge Resident A takes his insulin everyday however there may be times Olivier Ruhumuriza has forgotten to initial Resident A's MAR to verify that he has taken it. Olivier Ruhumuriza stated as of recently, Resident A has been in and out of the emergency room due to low blood sugar levels.

On 10/31/2025 I conducted an interview with Guardian A1 who stated that Resident A has been going to the hospital emergency room lately due to having low blood sugar levels because staff have not been giving Resident A his insulin on a regular basis. Guardian A1 stated that staff members stay in contact with her regularly and staff has communicated to her that Resident A has not been getting his insulin medication as prescribed. Guardian A1 stated that Resident A also reported to her that he has not been taking insulin medication regularly as prescribed. It should be noted that Guardian A1 was not able to confirm that a physician order allows Resident A to administer his own medication including insulin.

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:	Based on my investigation which included interviews with direct care staff member Shirley Molloy, administrator/licensee designee Olivier Ruhumuriza, Guardian A1, Resident A, review of Resident A's physician script and review of Resident A's MAR there is evidence to support the allegation that Resident A is not administered his insulin medication by direct care staff as prescribed. Shirley Molloy stated that staff monitor and supervise Resident A when he takes his insulin medication. There was no physician's order allowing Resident A to administer his medication independently. Shirley Molloy also stated there are times Resident A has missed taking his insulin which causes his blood sugar level to drop. Resident A also reported that he or staff forget to ensure that he takes his insulin medication regularly. According to Resident A's physician script, Resident A should take Lantus SoloStar 100 units per ML Subcutaneous Solution Pen-Injector to be injected 20 units under the skin daily with an effective date of 6/2/2025. According to Resident A's MAR, Resident A has not consistently taken his insulin medication regularly for the months of August, September and October of 2025. Guardian A1 also stated that staff and Resident A have reported to her that Resident A does not take his insulin medication regularly which has caused increased hospital visits for having low blood sugar.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff do not properly monitor Resident A's blood sugar levels as instructed.

INVESTIGATION:

This complaint also alleged staff do not properly monitor Resident A's blood sugar levels as instructed.

On 10/312025, I conducted an onsite investigation at the facility with direct care staff member Shirley Molloy who stated that Resident A is required to keep track of his blood sugar levels therefore staff are required to assist Resident A in monitoring this as instructed by his medical provider. Shirley Molloy stated they are supposed to monitor Resident A's blood sugar level because those are the instructions he is given after he has medical visits. Shirley Molloy stated that she has not been able to consistently monitor Resident A's blood sugar levels because Resident A takes his blood sugar test

strips and loses them. Shirley Molloy stated staff recently ordered more test strips due to Resident A's repeated hospital visits for having low blood sugar and she has been doing a better job of monitoring his blood sugar levels more consistently.

While at the facility I also interviewed Resident A who stated that he forgets to test his blood sugar levels therefore he hasn't been monitoring his blood sugar levels as instructed by his physician and staff members do not prompt him to do so which contributes to him going to the emergency room for having low blood sugar.

While at the facility, I reviewed Resident A's MAR for September 2025. According to this MAR, Resident A should have his blood sugar checked three times a day. According to the MAR, Resident A's blood sugar was checked at 8am on 9/22/2025. 9/27/2025, and 9/29/2025. According to the MAR, Resident A's blood sugar was checked at Noon on 9/24/2025, 9/29/2025 and 9/30/2025. According to this MAR, Resident A's blood sugar was checked at 5pm on 9/21/2025, 9/24/2025, 9/26/2025, and 9/29/2025.

I also reviewed Resident A's MAR for October 2025 which documented that Resident A should have his blood sugar checked in the morning at 8am and in the evening at 9pm. According to this MAR Resident A's blood sugar was checked at 8am on 10/10/2025, 10/13/2025, 10/14/2025, 10/15/25, 10/20/2025, and on 10/21/2025. Resident A's blood sugar was also checked at 9pm on 10/10/2025, 10/12/2025, 10/13/2025, 10/14/2025, and 10/16/2025.

While at the facility, I also reviewed Resident A's hospital *After Visit Summary* dated 4/23/2025 which documented instructions for Resident A to start taking Blood Glucose Monitoring Supply.

I reviewed Resident A's *After Visit Summary* dated 6/02/2025 which documented instructions for Resident A to change how he takes Blood Glucose Monitoring Supply to taking OneTouch Ultra 2, OneTouch Delica Plus Lancet 30G, and Lite Blood Glucose Test Strips.

I reviewed Resident A's *After Visit Summary* dated 10/21/2025 which documented instructions for Resident A to continue to take a daily log of morning his sugar level.

I reviewed Resident A's *After Visit Summary* dated 10/22/2025 which documented instructions for Resident A to check his glucose measurement before administering insulin before meals and avoid giving insulin if blood sugar is less than 70.

On 10/31/2025, I conducted an interview with administrator and licensee designee Olivier Ruhumuriza who stated that staff members have recently started monitoring Resident A's blood sugar levels with test strips as of 10/10/2025 because the emergency room physician gave instructions for staff to test his blood sugar levels at least three times a day before meals. Olivier Ruhumuriza stated staff did not consistently monitor Resident A's blood sugar levels prior to this date although

physician instructions have been given in the past for Resident A to monitor and track his blood sugar levels to manage his diabetes.

On 10/31/2025 I conducted an interview with Guardian A1 who stated that she does not believe Resident A is checking his blood sugar level and managing his diabetes properly which includes checking his blood sugar levels regularly as he continues to seek medical attention at the hospital emergency room for having low blood sugar levels.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based on my investigation which included interviews with direct care staff member Shirley Molloy, administrator/licensee designee Olivier Ruhumuriza, Guardian A1, Resident A, review of Resident A's MAR and review of Resident A's *After Visit Summary* there is evidence to support the allegation that direct care staff do not properly monitor Resident A's blood sugar levels as instructed. Resident A stated he and staff members forget to test his blood sugar levels therefore he hasn't been monitoring his blood sugar levels as instructed by his physician. Shirley Molloy stated staff are supposed to monitor Resident A's blood sugar level because those are the instructions he was given after he his medical visits. However, Shirley Molloy stated she has not been able to consistently monitor Resident A's blood sugar levels because Resident A takes his blood sugar test strips and loses them. I reviewed 4 *After Visits Summaries* dated 4/23/2025, 6/2/2025, 10/21/2025 and 10/22/2025 which all documented physician instructions for Resident A to test and monitor his blood sugar levels daily. According to Resident A's MAR, Resident A has not consistently tested and monitored his blood sugar levels therefore staff has not followed his physician's instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While at the facility, I observed multiple garbage bags and rubbish overflowing in the facility's dumpster container that was not covered with a tight-fitting lid located in front of the facility.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(5) Garbage and rubbish that contains food waste must be maintained in leakproof, non-absorbent containers. Containers must be covered with tight-fitting lids and removed from the facility daily and from the premises at least weekly.
ANALYSIS:	While at the facility, I observed multiple garbage bags and rubbish overflowing in the facility's dumpster container that was not covered with a tight-fitting lid located in front of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

According to direct care staff member Shirley Molloy, Resident A goes to the emergency room quite often due to having low blood sugar levels. Shirley Molloy stated this has resulted in changes to how often Resident A should take insulin and how many units he should take, however staff do not record these changes in the MAR. Shirley Molloy stated staff members can look at the *After Visit Summary* to read instructions regarding medication changes. Shirely Molloy could not explain protocols that are in place when Resident A refuses his insulin medication.

While at the facility, I reviewed Resident A's MARs for August, September and October of 2025. These MARs did not consistently record the actual medication name of the insulin, dosage, label instructions, time to administered, and initials of the individual who administered the medication at the time given. The MARs also do not consistently record Resident A's refusal to accept his insulin and procedures at the time of refusal nor did the MARs record the reason for why the medication is prescribed. I was also not able to verify medication training for direct care staff member Shirley Malloy.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff shall document and follow the instructions given by the licensed health professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.**
ANALYSIS:	While at the facility, I reviewed Resident A's MARs for August, September and October of 2025, and determined these MARs which do not consistently record the medication name of the insulin, dosage, label instructions, time to administered, and initials of the individual who administered the medication at the time given. The MARs also did not consistently record Resident A's refusal to accept his insulin and what was done after Resident A refused his insulin medication. I was also not able to verify medication training for direct care staff member Shirley Malloy.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I reviewed Resident A's written assessment plan dated 6/23/2024. Shirley Molloy and Olivier Ruhumuriza both stated that Resident A's care needs have changed tremendously, however a new assessment plan has not been completed.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	While at the facility, I reviewed Resident A's written assessment plan dated 6/23/2024. Shirley Molloy and Olivier Ruhumuriza both stated that Resident A's care needs have changed tremendously, however a new assessment plan has not been completed to reflect those changes or annually as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Shirley Molloy and Olivier Ruhumuriza both stated that staff do not get physician scripts for Resident A's insulin medication and will get instructions from reading his *After Visit Summary* paperwork or when talking to medical providers over the phone. Shirley Molloy also stated that although Resident A has had changes made to insulin medication since his original physician script written in June 2025, staff have not obtained any additional physician scripts or statements to reflect those changes.

I reviewed four *After Visit Summaries* for Resident A that provided limited instructions for Resident A's insulin medication and blood sugar monitoring program.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: **(d) Health care information including all of the following:** **(v) Statements and instructions for supervising prescribed medication including dietary supplements and medical procedures.**

ANALYSIS:	Shirley Molloy and Olivier Ruhumuriza both stated that staff do not get physician scripts for Resident A's insulin medication and will get instructions from reading his *After Visit Summary* paperwork or when talking to medical providers over the phone. Shirley Molloy also stated that although Resident A has had changes made to insulin medication since his original physician script written in June 2025, staff have not obtained any additional physician scripts or statements to reflect those changes. I reviewed four *After Visit Summaries* for Resident A that provided limited instructions as it pertains to Resident A's insulin medication and blood sugar monitoring program.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/24/2025, I conducted an exit conference with licensee designee Olivier Ruhumuriza. I informed Olivier Ruhumuriza of my findings and allowed him an opportunity to ask questions or make comments. On 12/02/2025, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action was accepted; therefore, I recommend the current license status remain unchanged.

Ondrea Johnson

12/12/2025

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn Timm

12/17/2025

Dawn N. Timm
Area Manager

Date