GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 19, 2026

C.M.G Serenity Home Care LLC
1778 Bridle Creek St SE
Kentwood, MI 49508

RE: License #: AS410418928
Investigation #: 2026A0467014
C.M.G Serenity Home Care LLC

Dear C.M.G Serenity Home Care LLC:

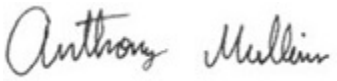
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410418928
Investigation #:	2026A0467014
Complaint Receipt Date:	02/11/2026
Investigation Initiation Date:	02/11/2026
Report Due Date:	04/12/2026
Licensee Name:	C.M.G Serenity Home Care LLC
Licensee Address:	1778 Bridle Creek St SE Kentwood, MI 49508
Licensee Telephone #:	616-655-6571
Administrator:	Egide Mucowingabo
Licensee Designee:	Egide Mucowingabo & Halese Gatete
Name of Facility:	C.M.G Serenity Home Care LLC
Facility Address:	1778 Bridle Creek St SE Kentwood, MI 49508
Facility Telephone #:	(616) 655-6571
Original Issuance Date:	04/21/2025
License Status:	REGULAR
Effective Date:	10/21/2025
Expiration Date:	10/20/2027
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was unsupervised at the home on 02/07/2026.	Yes
On 2/7/26, Resident A did not receive her 8:00pm medication as scheduled.	No
Additional Findings	Yes

III. METHODOLOGY

02/11/2026	Special Investigation Intake 2026A0467014
02/11/2026	Special Investigation Initiated - Telephone Spoke to complainant and he confirmed the allegations
02/12/2026	APS Referral Not warranted based on allegations and findings
02/12/2026	Inspection Completed On-site
02/12/2026	Contact - Telephone call made to Resident A
02/12/2026	Contact – Telephone call made to live-in staff member/co-licensee, Halese Gatete
02/19/2026	Exit conference with co-licensee, Egide Mucowingabo

ALLEGATION: Resident A was unsupervised at the home on 02/07/2026.

INVESTIGATION: On 2/11/26, I received an online complaint through LARA-BCHS. The complaint stated that on Saturday, 2/7/26, Resident A and staff went on separate outings and agreed to return home by 8:00pm. Resident A reportedly returned around 8:00pm and remained outside for approximately one hour before staff arrived sometime after 9:00pm.

On 02/11/26, I spoke with the complainant via phone. He confirmed that staff did not arrive at home until after 9:00pm. The complainant reported that multiple calls were made to AFC staff member Salim Gatete to assist with staff returning home and allowing Resident A entry.

On 2/12/26, I conducted an unannounced onsite investigation at the home and interviewed live-in staff member Salim Gagete. Mr. Gatete confirmed that on 2/7/26, Resident A left the home for an outing and returned around 8:00pm. He stated that

his wife, Halese Gatete, who is also a live-in staff member and the co-licensee, went to the grocery store during that time. Mr. Gatete reported that he asked Resident A what time she planned to return, but she did not provide an answer. Resident A reportedly returned home without prior notice at approximately 8:00pm and waited outside for about one hour until Mrs. Gatete returned shortly after 9:00pm.

Mr. Gatete was adamant that if he and his wife had known Resident A's expected return time, staff would have been present to allow entry. Mr. Gatete acknowledged that Resident A has the right to come and go freely. However, advance communication would be helpful in ensuring staff availability. Mr. Gatete stated that during the time Resident A was waiting outside, her guardian contacted him regarding the situation, and he then contacted Mrs. Gatete to ensure her return as quickly as possible. I explained to Mr. Gatete that Resident A being unsupervised at the house for approximately one hour establishes a preponderance of evidence to substantiate a rule violation. Mr. Gatete stated that he understood. Resident A was away from the home during the inspection and was not interviewed at this time.

On 2/12/26, I left a voicemail for live-in staff member/co-licensee, Halese Gatete requesting a call back. As of the completion of this investigation, she has not returned my call.

On 2/12/26, I spoke to Resident A via phone regarding the allegations. Resident A stated that on 2/7/26, she informed staff member Salim Gatete that she was going on an outing. According to Resident A, Mr. Gatete indicated that he would also be away from the home and stated he would return by 8:00pm. Resident A agreed to return around the same time. As scheduled, Resident A returned home shortly after 8:00pm but found no staff present and she was unable to enter the home. At approximately 8:35pm, Resident A received a text message from Mr. Gatete stating that Mrs. Gatete would arrive within a few minutes. However, Mrs. Gatete did not arrive until after 9:00pm. Resident A stated that she waited outside in her friend's car for about an hour until staff arrived. Resident A also reported similar incidents have occurred six to seven times, including occasions when staff left a key for her to enter the home while they were away. Resident A provided a screenshot of a text message from Mr. Gatete showing a picture of the house keys placed inside the storm door for her use. The exact date of the text is unknown.

Resident A provided additional screenshots of text messages exchanged with Mr. Gatete on 2/7/26. In the messages, Mr. Gatete indicated that he would return home by 8:00pm and Resident A acknowledged this. At approximately 8:05pm, Mr. Gatete texted Resident A stating he would let her know when he arrived home. Resident A responded that she was about to be dropped off and had been told 8:00pm. Mr. Gatete replied that he was not home and that his wife was on her way to let Resident A into the house. Resident A expressed concern about waiting outside in cold weather and stated that the situation was unacceptable. These messages indicate that Mr. Gatete was aware of Resident A's expected return time.

On 02/19/2026, I conducted an exit conference with co-licensee, Egide Mucowingabo. He was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of 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:	Resident A reported that she waited outside for approximately 1 hour on 2/7/26 for staff to return and allow entry to the home. Mr. Gatete also confirmed this. Based on the statements from Resident A and Mr. Gatete, in addition to a text message conversation, there is sufficient evidence to substantiate a violation of this applicable licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 2/7/26, Resident A did not receive her 8:00pm medication as scheduled.

INVESTIGATION: On 2/11/26, I received an online complaint through LARA-BCHS alleging that Resident A received her 8:00pm medication late on 2/7/26 due to staff not being present at the home to administer them.

On 2/12/26, I conducted an unannounced onsite investigation at the home. Upon arrival, I interviewed live-in staff member Salim Gatete regarding the allegation. Mr. Gatete confirmed that Resident A's 8:00pm medications were administered "a few minutes later" because staff did not return to the home until after 9:00pm. The five medications that were scheduled for 8:00pm are: Lo-zumandimi 3-0.02M, Ziprasidone 60MG, Escitalopram 10MG, Clondine 0.1MG, and Benztropine 1MG. Mr. Gatete also noted that Resident A has recently began to refuse her medications.

On 2/12/26, I spoke to Resident A via phone. She confirmed that on 2/7/26, she received her 8pm medications just after 9:00pm due to staff not being present.

On 2/19/26, I received a text message from co-licensee, Egide Mucowinga which included pharmacy labels and discharge instructions from the hospital for Resident A's medications. The pharmacy labels and discharge instructions indicated that all Resident A's medications are to be given once a day, twice a day, at bedtime, and as needed. None of the documentation indicates a specific time the medications must be given. Therefore, as long as Resident A received her medications before bedtime, AFC staff are not in

On 02/19/26, I conducted an exit conference with co-licensee, Egide Mucowinga. He was informed of the investigative findings and denied having any questions.

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:	Resident A disclosed that she did not receive her scheduled 8:00pm medications until after 9:00pm on 2/7/26 due to staff not being at home. Live-in staff member Mr. Gatete also confirmed this. Resident A's pharmacy label and hospital discharge instructions were reviewed and they did not indicate the medications needed to be administered at a specific time. Therefore, there is not sufficient evidence to support this applicable licensing rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, I requested to review Resident A's Medication Administration Record (MAR) for the month of February. In doing so, I observed the MAR did not have any staff initials or documentation of Resident A's refusal of her medications from 2/8/26 to 2/12/26. I informed Mr. Gatete of the importance of the MAR accurately reflecting Resident A's refusal, and he confirmed an understanding of this.

On 2/12/26, I spoke to Resident A via phone and she confirmed that she has refused her medications the last few days. Resident A plans to address her medication concerns with her doctor during her scheduled doctor's appointment on 2/17/26.

On 02/19/26, I conducted an exit conference with co-licensee, Egide Mucowinga. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

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 administrator 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 the time of refusal.**
ANALYSIS:	Resident A's MAR was left blank from 2/8 to 2/12 instead of reflecting her refusal of the medication. Therefore, there is sufficient evidence to substantiate this applicable licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

02/19/2026

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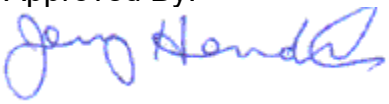
Anthony Mullins, Licensing Consultant Date

Approved By:



02/19/2026

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Jerry Hendrick, Area Manager Date