GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2026

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

RE: License #: AM080007779
Investigation #: 2026A1024039
Middleville Afc

Dear Mr. Ruhumuriza:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality of care and physical plant violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM080007779
Investigation #:	2026A1024039
Complaint Receipt Date:	06/16/2026
Investigation Initiation Date:	06/17/2026
Report Due Date:	08/15/2026
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:	03/02/2026
Expiration Date:	03/01/2028
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS:

	Violation Established?
The facility has electrical hazards which jeopardize Resident A's, who is a hospice patient, use of his oxygen concentrator.	Yes
Resident A does not have access to his personal food due to the refrigerator being locked.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/16/2026	Special Investigation Intake 2026A1024039
06/17/2026	APS Referral not warranted because APS is already involved.
06/17/2026	Special Investigation Initiated - On Site with Residents A, B, C, and licensee designee Olivier Ruhumuriza
06/18/2026	Inspection Completed On-site with direct care staff member Sheryl Molloy, Resident A, Resident B
06/18/2026	Contact - Telephone call made with *Bureau of Fire Safety Services* (BFS)- made referral to inspect electrical concerns.
06/18/2026	Contact - Telephone call made with APS Specialist Rebecca Karrar
06/18/2026	Contact - Telephone call made with Resident A's case manager Kailee Kruse
06/22/2026	Contact - Telephone call made with *Bureau of Fire Safety Services* (BFS) Fire Marshall Inspector J-C Sicard
06/22/2026	Contact - Telephone call made with licensee designee Olivier Ruhumuriza
06/22/2026	Contact - Document Received-Physician Script for Resident B, AFC Care Agreement for Resident A and Resident B and Health Care Appraisal (HCA) for Resident A and Resident B
06/22/2026	Contact - Document Received *Bureau of Fire Safety Services (*BFS) Report
06/22/2026	Exit Conference with licensee designee Olivier Ruhumuriza
06/23/2026	Inspection Completed-BCAL Sub. Non-Compliance.

06/29/2026	Inspection Completed On-site with licensee designee Olivier Ruhumuriza

ALLEGATION: The facility has electrical hazards which jeopardize Resident A's, who is a hospice patient, use of his oxygen concentrator.

INVESTIGATION:

On 6/16/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged there are multiple electrical hazards in the facility which make is challenging for Resident A's oxygen concentrator to work as required. The complaint noted that Resident A is a hospice patient and needs oxygen at all times.

On 6/17/2026, I conducted an unannounced onsite investigation at the facility and interviewed Residents A, B, and C. Resident A stated that he has not been residing at the facility long and recently started using an oxygen concentrator. Resident A stated after he started using the plug-in oxygen concentrator, he started having issues with the electrical outlets not working in his bedroom. Resident A stated that he eventually found one electrical outlet that worked and was able to use his oxygen tank equipment without any issues. Resident A stated that his case manager discussed this electrical concern with licensee designee Olivier Ruhumuriza after Resident A initially discovered the electrical issues with the outlets in his bedroom. Resident A stated he believes this issue will be getting revolved soon. It should be noted that I reviewed Resident A's resident record and was not able to determine when Resident A was prescribed oxygen as there was no documentation in the file to verify this date.

Resident B stated that he has also had electrical problems in his bedroom for "awhile now" therefore uses the two working outlets in his bedroom by adding power strips to each outlet and plugging all his devices into those power strips. Resident B stated that Resident A also has issues with his electrical outlets in his bedroom, however he does not believe licensee designee Olivier Ruhumuriza has found an electrician to fix these issues yet. Resident A and Resident B each have their own private resident bedrooms.

Resident C stated that he has not any issues with his electrical outlets, however he has witnessed Resident A and Resident B have electrical issues in their respective bedrooms.

I also interviewed administrator/licensee designee Olivier Ruhumuriza who stated that he is aware of the electrical outlets that are not working in Resident A's and Resident B's bedrooms, however an electrician has not been able to come out to fix these issues yet. Olivier Ruhumuriza stated he contacted an electrician about two weeks ago (from the date of this investigation) but nothing has been fixed as of the date of this onsite investigation. Olivier Ruhumuriza stated that he spoke with Resident A's case manager about these electrical issues as well and advised her that he was going to rectify the situation as soon as he could get an electrician out to the facility. I provided consultation to Olivier Ruhumuriza regarding the dangers of the electrical hazards in the resident bedrooms, especially when multiple power strips are used to power multiple devices,

and advised Olivier Ruhumuriza to have an electrician inspect his electrical system immediately. I also informed Olivier Ruhumuriza to disconnect the multiple power strips and extension cords until an electrician has inspected and fixed the issue. Olivier Ruhumuriza stated that he would have someone come out by the next business day and immediately remove the excess, loose extension cords however the cords were never removed.

While at the facility on 06/17/2026, I inspected Resident A and Resident B's private bedrooms and noted that in Resident A's bedroom within one outlet there was a fan and a power strip plugged in. Additionally, the power strip had multiple electrical devices, chargers, power strips and extension cords positioned near combustible materials, including bedding, pillows, towels, clothing, paper products and wooden furnishings. The electrical cords were loosely draped and unsecured creating the potential for damage, overheating, or accidental disconnection. In Resident B's private bedroom, I observed multiple power strips, at least three, plugged into each other along with multiple devices plugged into each power strip.

On 6/18/2026, I conducted an onsite investigation at the facility with direct care staff member Sheryl Molloy, Resident A, and Resident B who all stated that licensee designee Olivier Ruhumuriza went out of town to New York and did not have an electrician come out to the inspect the facility prior to leaving to inspect and fix the facility's electrical issues. Consequently, all three stated electrical issues remain despite Olivier Ruhumuriza's assurances on 06/17/2026 the issue would be immediately addressed by the next business day. Sheryl Molloy and Resident B both stated that they tried to advise Olivier Ruhumuriza of the seriousness of electrical issues in the facility, however they believe that Olivier Ruhumuriza does not understand the AFC administrative rules and regulations therefore does not know how to operate an adult foster care home adequately. Sheryl Molloy stated that Olivier Ruhumuriza had planned to go to New York in advance and left earlier in the day without securing an electrician to inspect the facility.

While at the facility, I observed no changes to the electrical hazards that were initially observed on 6/17/2026 in Resident A's and Resident B's bedroom including all power strips and extension cords connected with multiple devices plugged into each.

On 6/18/2026, I made a referral to the Bureau of Fire Services (BFS) Fire Marshall Inspector J-C Sicard regarding the facility's electrical system and the concerns observed.

On 6/18/2026, I conducted an interview with Resident A's case manager Kailee Kruse who stated that Resident A participates in hospice services and has issues with the electrical outlets in his bedroom which he needs to operate his oxygen tank equipment. Kailee Kruse stated that Resident A can only utilize one electrical outlet in his bedroom, so he plugs an extension cord into that outlet to run his oxygen machine and other devices in his bedroom. Kailee Kruse stated that she brought these safety concerns to licensee designee Olivier Ruhumuriza at the beginning of June 2026 when Resident A

began using oxygen tank equipment because she believed this is a fire hazard however no corrections were made.

On 6/22/2026, I conducted an interview with BFS Fire Marshall Inspector J-C Sicard who stated that multiple cords and power cords were observed in two resident bedrooms (Resident A and Resident B's bedrooms) along with other electrical issues that pose a fire hazard to residents. J-C Sicard stated he immediately advised licensee designee Olivier Ruhumuriza to remove all unapproved extension cords. J-C Sicard stated he also required that licensee designee Olivier Ruhumuriza call an electrician while he was onsite and waited and watched Olivier Ruhumuriza immediately contact and schedule an electrician to inspect the facility.

On 6/22/2026, I reviewed the facility's *Bureau of Fire Safety Services (*BFS) Report dated 6/22/2026. According to this report, a fire safety inspection was completed, and the following electrical deficiencies were identified:

"Kitchen: Ice maker on an unapproved RPT (RPT stands for Relocatable Power Tap, commonly known as a power strip or multi-outlet connection, used to safely extend electrical power to multiple devices)
Room #1: 5 RPT plug in series and A/C unit on one RPT
Room #6: Unapproved RPT
Basement laundry room: Freezer chest plug on an unapproved RPT."

APPLICABLE RULE	
R 400.649	**Electrical service.**
	Electrical service must be maintained in a safe condition. Where conditions indicate a need for inspection, and on all new or remodeled projects, the electrical service must be inspected by a qualified electrical inspection service and a copy of the inspection report must be maintained for 2 years.

ANALYSIS:	Based on my investigation which included interviews with direct care staff member Sheryl Molloy, administrator/licensee designee Olivier Ruhumuriza, Residents A, B, and C, Resident A's case manager Kailee Kruse, and BFS Fire Marshall Inspector J-C Sicard, along with an inspection of the facility's electrical system, and review of the facility's BFS Report there is evidence that multiple electrical hazards exist in the facility that jeopardize the safety of all residents including Resident A's ability to safely and consistently use his oxygen concentrator. Resident A and Resident B confirmed these electrical issues during interviews. During my unannounced onsite investigation on 06/17/2026, I observed Resident A's and Resident B's bedroom and noted that each bedroom contained multiple electrical devices, charges, power strips and extension cords positioned in close proximity to combustible materials, including bedding pillows, clothing, paper products and wooden furnishings. The electrical cords were loosely draped and unsecured creating the potential for damage, overheating, or accidental disconnection and posed a safety hazard to residents. I made a referral to BFS Inspector J-C Sicard who conducted an onsite inspection of the facility and found multiple electrical deficiencies that pose as a fire hazard to residents. In addition, the BFS Report documents electrical concerns in various areas of the facility which includes two resident bedrooms, the kitchen and the basement. Fire safety concerns for the facility's electrical system were brought to Olivier Ruhumuriza's attention by Kailee Kruse and the consultant in early June 2026 and on 06/17/2026 specifically. However, no immediate action to correct these issues were taken, including having the facility's electrical service inspected by a licensed professional. The accumulation of clutter and combustible materials around the electrical equipment increases the risk of an electrical malfunction, overloaded circuit or overheating device which could ignite nearby materials and result in a fire. These electrical conditions do not promote a safe living environment and present an increased risk to the health and safety of residents in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A does not have access to his personal food due to refrigerator being locked.

INVESTIGATION:

This complaint also alleged that Resident A does not have access to his personal food due to the facility refrigerator being locked.

On 6/17/2026, I conducted an onsite investigation at facility with Resident A who stated that he has personal food items that he keeps in the refrigerator and/or freezer and there have been occasions when he is not able to have access to these items due to the refrigerator being locked. Resident A stated that he usually has to wait for licensee designee Olivier Ruhumuriza to unlock the refrigerator and stated he has waited many hours at times. Resident A stated that he has no knowledge of anyone else who has a key to unlock the refrigerator.

I interviewed Resident B who stated that he “manages things” around the house therefore he has a key to unlock the refrigerator which he unlocks whenever a resident needs access to the refrigerator. Resident B stated that they started putting a lock on the refrigerator a long time ago to make sure residents didn’t take excessive amounts of food out of the refrigerator. Resident B stated that he was not aware that Resident A was not able to gain access to his personally purchased food items because it was never brought to his attention.

I also interviewed with Resident C who stated that there have been times when he needed to get his food items from the refrigerator and was not able to do so due to the refrigerator being locked. Resident C stated that he usually has to wait to gain access to refrigerator.

I interviewed licensee designee Olivier Ruhumuriza who stated that he has always locked the refrigerator but did not provide a specific reason for doing so. He stated he believes the only reason this allegation was made is because Resident A’s case manager mentioned this issue to him. Olivier Ruhumiriza stated that Resident A should have informed him that he needed to gain access to the refrigerator but never did.

While at the facility, I reviewed a lock on the refrigerator and observed Resident B use the facility keys that he keeps in his possession to unlock the refrigerator.

On 6/18/2026, I conducted an interview with Resident A’s case manager Kailee Kruse who stated that Resident A reported to her that he has not been able to access his frozen dinners and other food items purchased by his family members that he keeps in the facility’s refrigerator due to the refrigerator and freezer being locked. Kailee Kruse stated that she visits Resident A regularly and has also observed the lock on the refrigerator.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(k) Have reasonable access to and use of personal clothing and belongings.**
ANALYSIS:	Based on my investigation which included interviews with Olivier Ruhumuriza, Residents A, B, and C, and Resident A's case manager Kailee Kruse, along with an inspection of the facility, there is evidence that Resident A cannot freely access food purchased with his own funds because the facility refrigerator is locked with no easy access to a key. Resident A and Resident C both stated that they have not been able to gain access to their food items because the refrigerator has been locked and they have to wait hours at times for licensee designee Olivier Ruhumuriza to unlock the refrigerator. Resident B further stated that he is the only resident given full access to the refrigerator because he has a key to unlock the refrigerator and the other residents in the facility must seek permission from him to gain access to their food. Therefore, residents do not have reasonable access to their personal food that they purchased.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/29/2026, I conducted an unannounced onsite investigation at the facility with Olivier Ruhumuriza and reviewed Residents A, C, D, E, F and G's Medication Administration Records (MARs) and observed their respective medications in the original prescription bottles/packaging. According to Resident A's MAR for the month of June 2026 there were at least 16 days that had no direct care staff initials on the MAR to verify that the medications were administered. Additionally, there were five days (day 2 through day 6) that recorded a line drawn across with no further explanation of what the line across each day meant. I observed the following medications in Resident A's medication compartment that were not listed on Resident A's June 2026 MAR:

- four used half-full bottles of Hydrocodone-Acetaminophen (Norco) 5 MG/325 Tablets to be taken three times daily as needed for pain,
- three slightly full bottles of Acetaminophen 500 MG to be taken twice by mouth for pain, and

- Senna Plus 8.6 MG to be taken once by mouth as needed for constipation.

Because these medications were not listed on Resident A's most recent MAR, I was not able to determine if these medications were administered as prescribed. It should be noted there was no MAR for May 2026 available to review for Resident A who was admitted on 5/20/2026 according to his written care agreement.

Resident B had no MAR to review as Olivier Ruhumuriza stated that Resident B administers his own medication. I reviewed a physician script written by Corewell Health Pennock Hospital dated 11/28/2025 which documented that Resident B can self-administer all his medications except for any controlled medications which should be administered by AFC staff.

My review of Resident C's MAR for May 2026 and June 2026 noted both months were documented on the same record and in total there were 23 days with no direct care staff initials verifying that each of these medications were left blank with no initials or further explanation for each of the following medications:

- Magnesium Oxide 400 MG to be taken by mouth in the morning for supplement,
- Melatonin 3 MG to be taken at bedtime for sleep, and
- Risperdal 1 MG to be taken by mouth once a day was listed on the MAR.

It should be noted that these medications were not at the facility at the time of my inspection on 06/29/2026. Licensee designee Olivier Ruhumuriza stated that he ran out of these medications as of 6/22/2026 and needed to contact Resident C's physician to obtain these medications.

My review of Resident D's MAR for May 2026 and June 2026 documented five days that were recorded with staff initials verifying medications were administered while the remaining days had a line drawn across the date with no explanation of what the line through each day meant. This applied to the following medications:

- Melatonin CAP 10MG to be taken once daily,
- Paliperidone ER 3 MG to be taken once per evening,
- Rosuvastatin 20 MG to be taken once at bedtime and
- Tizanidine 4 MG to be taken three times daily as needed for pain.
-

Again, even though these medications were listed on the MARs, none of these medications were in the facility at the time of the investigation on 06/29/2026. Olivier Ruhumuriza stated that Resident D ran out of these medications as of 6/22/2026 and he needed to call the pharmacy to pick up new medications.

My review of the May 2026 and June 2026 MARs for Residents E, F, and G documented six days with staff initials verifying medication was administered to each resident, eight days that did not have any direct care staff initials to verify medications were administered and the remaining days had a line drawn across the date, with no further explanation what the meant, for each medication. Olivier Ruhumuriza stated that

he administered the medications on the days he worked, however failed to record this on log.

While at the facility, I conducted interviews with Residents A, B, C, D, and E who all stated that they take their medication regularly and have no concerns about medication administration.

Special Investigation Report # 2026A1024003 dated 12/17/2025 cited R 400.675 (1) (4), after it was determined a resident's medications were not administered as prescribed and this resident's MAR did not record the name of the medication, dosage, label instructions for use, time to be administered and the initials of the individual who administered the medication and the time it was administered. According to the Corrective Action Plan dated 11/28/2025 and written by Olivier Ruhumuriza, all residents will receive their medications as prescribed by the physician and documented at the time of administration. Staff will receive refresher medication training immediately, and records will be updated, and reviewed immediately.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medications must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional. **(2) Prescribed medications must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer refrigerated if required. Equipment necessary to administer medication must be easily accessible and used**

	only for the resident for whom it is prescribed unless generally used for all residents. **(4) A licensee, administer, or direct care staff shall comply with the following when supervising the taking of medication by a resident.** **(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.** **(c)Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	The May 2026 and June 2026 Medication Administration Records for Residents A, C, D, E, F, and G, did not consistently record the medication name of the resident medications, dosage, label instructions for use, time to be administered and initials of the individual who administered the medication at the time given. Further, Resident A's controlled narcotic medications that were not recorded on Resident A's MAR. Also, medications were not available in the facility for Residents C and D as required. Based on the lack of documentation and ability to reconcile physical medications with each resident's medication administration records, it is unclear how consistently and accurately residents are receiving medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/16/2026, when I arrived at the facility, I was greeted by Resident B who stated that he "manages the facility" and takes care of staff responsibilities such as cooking, cleaning and maintenance duties when licensee designee Olivier Ruhumuriza is away from the facility or on the lower level of the facility. Resident B stated that he cooks regularly and tries to clean the facility at least twice per week, however he stated that sometimes he has issues with his back and needs to rest. Resident B stated that he is compensated for taking on these "staff responsibilities" by paying a reduced monthly AFC room and board fee of $700. Resident B stated that he has been working at the facility since Olivier Ruhumuriza became the licensee designee of the facility in September of 2025. Resident A stated that he is very comfortable managing the facility, however stated he had advised Olivier Ruhumuriza that he was not comfortable

administering medications to any of the residents. Resident B confirmed that he does not administer resident medications.

On 6/17/2026, I interviewed direct care staff member Sheryl Molloy who stated that she stopped working regularly at the facility in December 2025 because licensee designee Olivier Ruhumuriza stated that he could not pay her to work at the facility any longer. Sheryl Molloy stated she previously agreed to work the weekend of 6/17/2026 for $100 a day while licensee designee Olivier Ruhumuriza went out of town on a trip, so that was the reason for her presence during the unannounced onsite investigation. Sheryl Molloy stated that she and Resident B are “working together” during this weekend and they both will “take turns” cooking meals for the residents. Sheryl Molloy stated that Resident B is a very good worker and he cleans the facility and does all the maintenance around the facility. Consequently, Sheryl Molloy stated she has no concerns that she is the only trained direct care staff member working for three days while licensee designee Olivier Ruhumuriza is out of town.

On 6/22/2026, I interviewed licensee designee Olivier Ruhumuriza who stated that Resident B is “like a staff member” that performs staff duties such as cooking, cleaning, and maintenance for which he is compensated for by having a reduced monthly rental fee of $700 from $1100.

It should be noted that I reviewed Resident B’s *Health Care Appraisal* (HCA) dated 10/28/2025 which documented that Resident B is diagnosed with Type 2 Diabetes, Obesity, HTN, and COPD. Resident B also has chronic back pain and uses a cane. Despite these heath conditions Resident B is asked to perform staffing duties and responsibilities as if he is a direct care staff member.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(3) Staff shall be individuals who are not residents.
ANALYSIS:	Olivier Ruhumuriza, Sheryl Molloy and Resident B all confirmed that Resident B regularly completes staff responsibilities such as cooking, cleaning and maintenance duties at the facility in lieu of a direct care staff member completing these tasks.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Olivier Ruhumuriza stated that he has not obtained any documentation such as reference checks or criminal background checks for either direct care staff member Pitie Mudari or Merveille Umutoni therefore he was not able to verify if these staff members are capable of meeting the physical, emotional, intellectual, and social needs of each resident or can handle emergency situations appropriately. Olivier Ruhumuriza further

stated that neither of these staff members completed required training to verify competence in performing resident personal care, supervision, and protection. Olivier Ruhumuriza stated that he was under the impression that his family members who work as staff members did not need to meet required direct care staff qualifications and training requirements. Olivier Ruhumuriza stated he did not believe this was a “big deal”. Olivier Ruhumuriza confirmed that both Pitie Mudari and Merveille Umutoni are family members.

It should be noted that consultation and technical assistance was provided to Olivier Ruhumuriza on numerous occasions as it pertains to staff qualifications and training. Specifically, on 1/23/2026, I emailed Olivier Ruhumuriza a direct link to LARA’s YouTube channel to review training videos on direct care staff requirements, qualifications, and training in AFC homes. I also emailed a checklist to review the AFC Required Policies, Procedures and Information.

On 3/2/2026, I provided further consultation and technical assistance via telephone and followed up by email reminding Olivier Ruhumuriza that he must have at least one other employee who works at the facility with him and this employee must meet all licensing requirements such as background checks, training, reference checks etc. as there were no employee fingerprint results listed in the Michigan Workforce Background Check website. I advised Olivier Ruhumuriza that his facility has been flagged in the Michigan Workforce Background Check portal as having no employee fingerprint results attached to this facility and that he had until 3/15/2026 to update the portal. Olivier Ruhumuriza stated that he anticipates having his father be his and employee and plans to start his application process as soon as possible. It should be noted that I have verified Sheryl Molloy staff records in previous on-site investigations that meet direct care requirements.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.** **(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently:** **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases including recognizing signs of illness.** **(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.** **(i) Nutrition and special diets.** **(7) Documentation of training must be maintained in the staff's record to determine that the training has been completed and is current.**
ANALYSIS:	Olivier Ruhumuriza stated he does not have any documentation verifying that either direct care staff member Pitie Mudari or Merveille Umutoni had completed and were competent and capable in all required training prior to working independently with residents. Olivier Ruhumuriza confirmed that neither of these staff members received training of any kind to verify competence and capability prior to providing personal care, supervision and protection to residents. Despite consultation and technical assistance provided on numerous occasions regarding direct care staff qualifications and training, Olivier Ruumuriza did not take action to assure residents were cared for by trained, competent and capable direct care staff members.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.734(b)	**400.734b Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	Neither Pitie Mudari nor Merveille Umutoni completed the required Michigan Workforce Background Check fingerprint prior to working independently with residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Olivier Ruhumuriza stated that he did not obtain any documentation signed by a licensed physician attesting to the physical health of direct care staff members Pitie Mudari or Merveille Umutoni prior to either direct care staff member working independently with residents.

Renewal Licensing Study Report dated 3/11/2024 cited R 400.14205 after it was determined that direct care staff members did not have a health status review attesting to the physical health of staff. Adult foster care home rules were updated and promulgated on 11/3/2025 and Rule R 400.14205 is equivalent to Rule R 400.631(2).

APPLICABLE RULE	
R 400.631	**Health screenings.**
	(2) A licensee shall have on file a statement signed by a licensed physician or physician's designee attesting to the physical health of the licensee, staff, and members of the household. Statements for the licensee and administrator must be signed no more than 6 months before the issuance of a temporary license and at any other time requested by the department. Statements for staff and members of the household must be obtained within 30 days of employment start date, assumption of duties, or occupancy in the facility.
ANALYSIS:	Olivier Ruhumuriza did not obtain any documentation signed by a licensed physician attesting to the physical health of direct care staff members Pitie Mudari or Merveille Umutoni prior to either direct care staff member working independently with residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Olivier Ruhumuriza stated that his mother, who is not trained, competent or fingerprinted as a direct care staff member, volunteers to provide supervision to residents when he has had to leave the facility. Olivier Ruhumuriza stated there were no

trained direct care staff working during the times she volunteered and she was at the facility independently. Olivier Ruhumuriza stated he did not obtain any documentation to ensure this volunteer's physical and mental health did not negatively affect the residents or the quality of the residents' care.

Olivier Ruhumuriza stated that he left residents alone in the facility with his mother, who he does not consider a direct care staff member, however volunteers to be in the at the facility with residents to provide supervision and care as needed when he leaves the facility to run errands. Olivier Ruhumuriza stated that his mother does not meet the qualifications of a direct care staff member.

Resident B stated that he has seen Olivier Ruhumuriza's mother at the facility to provide supervision to the residents without any other staff present when Olivier Ruhumuriza leaves the facility.

APPLICABLE RULE	
R 400.631	**Health screenings.**
	(3) A licensee shall ensure that the volunteer's physical and mental health will not negatively affect the residents or the quality of the residents' care.
ANALYSIS:	Olivier Ruhumuriza stated that his mother, who is not a direct care staff member, has volunteered in the home providing supervision to residents while he was away from the facility. Olivier Ruhumuriza stated that he did not obtain any documentation to ensure this volunteer's physical and mental health did not negatively affect the residents or the quality of the residents' care.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(3) An individual, including a volunteer, cook, or private duty staff shall not be considered in determining the ratio of direct care staff-to-residents unless the individual meets the qualifications of a direct care staff member and is providing direct care to residents on behalf of the licensee.

ANALYSIS:	Olivier Ruhumuriza stated that he has left residents alone in the facility with his mother who he does not consider a direct care staff member however volunteers to be in the at the facility with the residents to provide supervision and care as needed when he leaves the facility to run errands. Olivier Ruhumuriza stated that his mother does not meet the qualifications of a direct care staff member. Resident B stated that he has seen Olivier Ruhumuriza's mother at the facility to provide supervision to the residents without any other staff present when Olivier Ruhumuriza leaves the facility. Therefore, Olivier's Ruhumuriza relatives should not be considered in determining the ratio of direct care staff-to-residents as they do not meet the qualifications of a direct care staff member.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Olivier Ruhumuriza stated that he has not obtained any documentation of a baseline screening for communicable diseases and records of illnesses at the time of hire for direct care staff members Pitie Mudari or Merveille Umutoni. Olivier Ruhumuriza confirmed that both have worked independently in the facility with residents.

APPLICABLE RULE	
R 400.631	**Health screenings.**
	(5) A licensee shall maintain documentation of a baseline screening for communicable diseases and records of illness on hiring. Staff who have direct physical contact with residents or resident food may perform those duties only when they are noninfectious or when proper precautions are taken to prevent the spread of a communicable disease. A licensee shall follow a staff's health care professional or local health department guidance on controlling the spread of a communicable disease when identified.

ANALYSIS:	Olivier Ruhumuriza did not obtain a baseline screening for communicable diseases and records of illness at the time of hire for direct care staff members Pitie Mudari or Merveille Umutoni. Both have worked independently with residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/18/2026, Sheryl Molloy stated that she left nine residents alone at the facility without any direct care staff members present on multiple occasions when she had to go to the store or “run a quick errand” however she stated she left Resident B in charge to manage the facility during those occasions.

Resident B stated that he and the other eight residents in the home have been left alone at the facility on multiple occasions for various periods of time when Olivier Ruhumuriza went to the grocery store to purchase ingredients that he needed to cook with for dinner. Resident B further stated that there are other times when he cannot determine if a direct care staff member is at the facility or if they are alone because Olivier Ruhumuriza has family members who visit him on the lower level of the facility and sometimes they remain in the facility when Olivier Ruhumuriza leaves. However, Resident B stated he does not visibly see them.

Licensee designee Olivier Ruhumuriza stated that he has left residents alone in the facility when his family members, who are not qualified to be direct care staff members, are on the lower level of the facility. Olivier Ruhumuriza stated he does not believe this was a “big deal” to have residents without sufficient direct care staff on duty.

APS Specialist Rebecca Karrar stated that she has an active investigation currently for an unrelated allegation and has been out to the facility at least on three separate occasions to find all residents alone on the main level of the home for at least 15 minutes. APS Specialist Rebecca Karrara stated she had to request a resident call Olivier Ruhumuriza who eventually came up from the lower level of the facility.

Case Manager Kailee Kruse stated that Resident A receives hospice services therefore she visits the facility weekly since May 2026 and has never seen any staff members present while visiting with Resident A.

On 06/17/2026, I conducted an inspection of the facility for at least 20 minutes with no staff member present with residents on the main level of the facility. After 20 minutes, I requested Resident B call Olivier Ruhuumuriza to come to the main level of the home. Olivier Ruhumuriza was downstairs on the lower level of the home.

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: **(b) 12 residents for small group and family homes.**
ANALYSIS:	Sheryl Molloy stated that she has left nine residents alone at the facility without any direct care staff members present on multiple occasions while running errands. Sheryl Molloy also stated she left Resident B, who is a resident of the facility and not a direct care staff member, in charge of managing the facility and supervising residents while she was not present. Resident B stated that he and the other eight residents have been left alone at the facility on multiple occasions without any direct care staff present while Olivier Ruhumuriza went to the grocery store to purchase ingredients that Resident B needed to cook dinner. Olivier Ruhumuriza stated that he has left residents alone in the facility when his family members, who are not qualified or trained direct care staff members, while he leaves the facility. Olivier Ruhumuriza stated he did not believe this was “big deal” to have residents without sufficient direct care staff on duty. Additionally external agency staff members have conducted routine visits to the facility to find residents without sufficient staff on duty.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed Resident A’s *AFC Resident Care Agreement* dated 5/20/2026 which documented that Resident A and his designated representative did not receive a copy of the home’s written refund policy, resident’s rights policy, and discharge policy.

Olivier Ruhumuriza stated that although he has a written refund policy, resident rights policy and discharge policy maintained at this facility, he did not provide these written policies to Resident A and his designated representative because the designated representative did not ask for a copy.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal**
	(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following; **(d) A resident's rights policy** **(e) A discharge policy** **(g) A refund policy**
ANALYSIS:	I reviewed Resident A's *AFC Care Agreement* dated 5/20/2026 which documented that Resident A and his designated representative did not receive a copy of the home's written refund policy, resident's rights policy, and discharge policy. Olivier Ruhumuriza stated that although he has a written refund policy, resident rights policy and discharge policy maintained at this facility, he did not provide these written policies to Resident A and his designated representative because the designated representative did not ask for a copy.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility I reviewed direct care staff member's Merveille Umutoni's staff record which only contained her driver's license, education verification, and social security card. No documentation was available for direct care staff member Pitie Mudari.

Olivier Ruhumuriza stated that he has not had a chance to obtain all required documentation for these two staff members and did not know he needed to have these records since they are family members.

It should be noted that consultation and technical assistance was provided to Olivier Ruhumuriza on numerous occasions as it pertains to staff records. On 1/23/2026, I emailed Olivier Ruhumuriza a direct link to LARA's YouTube channel to review training videos on direct care staff requirements, qualifications, and training in AFC homes. I also emailed a checklist to review the AFC Required Policies, Procedures and Information. On 3/2/2026, I provided consultation and technical assistance via telephone followed up by an email reminding Olivier Ruhumuriza of obtaining staff records for his employees upon hire.

APPLICABLE RULE	
R 400.639	**Staff records.**
	(1) A licensee shall maintain a record for each staff that contains all of the following: **(a) Name, address, telephone number, and Social Security number.** **(b) Copy or number of a professional or vocational license, certification, or registration if staff provides professional or vocational services.** **(c) Copy of a driver's license if staff provide transportation services.** **(d) Verification of age.** **(e) Verification of experience, highest level of education completed, and training.** **(f) Verification of not less than 2 reference checks. If reference checks cannot be obtained, documentation verifying reference checks were attempted must be maintained.** **(g) Beginning and ending dates of employment on separation.** **(h) Health information as required by these rules.** **(i) Verification of the receipt by the staff of personnel policies and job descriptions.**
ANALYSIS:	While at the facility I reviewed direct care staff member's Merveille Umutoni's staff record which only contained her driver's license, education verification, and social security card and no other required staff documentation. No required staff documentation was available to review for direct care staff member Pitie Mudari. Olivier Ruhumuriza stated that he has not had a chance to obtain all required documentation for these two staff members and did not know he needed to have these records since they are family members even though consultation and technical assistance about staff records was provided to Olivier Ruhumuriza on multiple occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, staff schedules were not made available for the department to review. Sheryl Molloy stated that since Oliver Ruhumuriza is the only staff member that routinely works at the facility, so there is no staff schedule.

Renewal Licensing Study Report dated 3/11/2024 cited staff record violation R 400.14208 violation under previous administrative rules which is no longer in effect following the promulgation of the rules after it was determined that the licensee did not maintain a daily schedule of staff work assignments in the home. Adult foster care home rules were updated and promulgated on 11/3/2025 and Rule 400.639 is equivalent to Rule 400.14208.

APPLICABLE RULE	
R 400.639	**Staff records.**
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: **(a) Names of staff on duty.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Scheduling changes when made.**
ANALYSIS:	While at the facility, staff schedules were not made available for the department to review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I observed that the facility's dining room and kitchen floor were unclean and "sticky" to walk on. I observed the kitchen stove was also unclean along with a dirty pot positioned on the stove that appeared to have old food and old grease in it. I observed the exterior doors and resident bedroom doors were unclean and in need of fresh paint. I observed a mop bucket located in the kitchen with dirty water. The facility's side patio and ramp that leads to the patio is in poor condition and in need of repair/repainting. The patio is cluttered with a screen door that was detached from the exterior side door, a bucket and a large spa that was observed to be enclosed with a protective covering, however extremely unclean. The facility had an unpleasant odor.

Sheryl Molloy and Resident B both stated that Resident B routinely cleans the facility. Resident B stated that he tries to clean regularly however sometimes he has issues with his back which stops him from cleaning. Resident B stated that he makes a fresh bucket of water with soap and leaves the bucket of water in the kitchen so residents can mop the floor in the event they accidently urinate on the floor or spill other things on the floor. Resident B stated that he changes this mop bucket water once a week. Resident B further stated that the wood patio is in poor condition due to an infestation of termites and he has discussed this issue with Olivier Ruhumuriza who refuses to fix it. Resident B further stated that he has discussed the need for the nonworking spa to be either

removed or cleaned, due to its poor condition, however Olivier Ruhumuriza also refuses to fix this issue.

On 6/22/2026, I reviewed the facility's *Bureau of Fire Safety Services (*BFS) Report dated 6/22/2026. According to this report, a fire safety inspection was completed, and the following deficiencies were identified:

- "Outside smoking area needs to change cigarette trash containers.
- Basement has an unapproved dryer exhaust vent.
- Emergency procedures missing at the time of inspection.
- At the time of inspection the fire alarm system was found to be in the OFF position and had been shut off at the main breaker panel in the basement. Per the owner the system OFF for at least two months.
- Room #3 missing a smoke detector.
- Basement has an unapproved lock on the emergency exit door.
- Basement extinguisher with over 1 year inspection tag.

BFS Fire Marshall Inspector J-C Sicard stated that he found multiple fire safety concerns at the facility's onsite inspection which includes the fire panel being completely turned off. J-C Sicard stated that the Olivier Ruhumuriza reported he had not paid the fire alarm service bill since December 2025 which is why the fire alarm system was turned off and not working.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants. **(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.**

ANALYSIS:	While at the facility, I observed the facility's dining room and kitchen floor to be unclean and "sticky" to walk on. I observed the kitchen stove to be unclean along with a dirty pot positioned on the stove that appeared to have old food and old grease in it. I observed the exterior doors and resident bedroom doors of the facility to be unclean and in need of fresh paint. I observed a mop bucket located in the kitchen with dirty water. The facility's side patio and ramp that leads to the patio is in poor condition and in need of repair/repainting. The patio is cluttered with a screen door that was detached from the exterior side door, a bucket and a large spa that was observed to be enclosed with a protective covering, however extremely unclean. The facility had an unpleasant odor. Sheryl Molloy and Resident B both stated that Resident B routinely cleans the facility. Resident B stated that he tries to clean regularly but issues with his back stop him. Resident B stated that he makes a fresh bucket of water with soap and leaves the bucket of water in the kitchen so residents can mop the floor in the event they accidently urinate on the floor or spill other things on the floor. Resident B stated that he changes this mop bucket once a week. Resident B further stated that the wood patio is in poor condition due to an infestation of termites and he has discussed this issue with Olivier Ruhumuriza who refuses to fix these issues. Resident B further stated that he has discussed the need for the nonworking spa to be either removed or cleaned, due to its poor condition, however Olivier Ruhumuriza also refuses to fix this issue. Multiple fire safety concerns were also found at the facility's onsite inspection performed by BFS Inspector J-C Sicard which included the fire panel being completely turned off due to Olivier Ruhumuriza neglecting to pay the fire alarm service bill since December 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I observed that the main hallway that leads to residents' bedrooms was very dark and poorly lit. It appeared that previously a ceiling light fixture had been installed in the hallway as the shadow of the fixture was present but had been removed with no replacement.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(3) Living, sleeping, hallway, storage, bathroom, and kitchen areas must be well-lighted and ventilated.
ANALYSIS:	While at the facility, I observed the main hallway leading to resident bedrooms was very dark and poorly lit.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I observed a bedroom's ceiling in a non-occupied resident bedroom in poor condition. There was clear damage as it was drooping with peeling paint. According to Sheryl Molloy and Resident B, the bedroom ceiling was damaged due to roofing issue and poorly repaired by previous owners, however Olivier Ruhumuriza refuses to fix this issue.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(5) Floors, walls, and ceilings must be cleanable, maintained clean, and in good repair.
ANALYSIS:	While at the facility, I observed a resident bedroom's ceiling in poor condition as it was drooping with peeled paint. According to Sheryl Molloy and Resident B, the bedroom ceiling was damaged and poorly repaired by previous owners, however Olivier Ruhumuriza refuses to fix this issue.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I observed no menus posted. Sheryl Molloy stated that they do not rely on menus when she prepares meals. Sheryl Molloy stated that she and Resident B usually "just wing it" and work together to prepare meals. Resident B also stated that he does not rely on menus when he prepares meals for the facility and has not seen any menus at the facility.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.

ANALYSIS:	While at the facility, I observed no posted menus. Sheryl Molloy stated neither she nor Resident B rely on menus when preparing meals. Sheryl Molloy stated that she and Resident B usually “just wing it” and work together to prepare meals. Resident B also stated he has not seen any menus at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I did not observe any thermometers in the refrigerator or freezer. Sheryl Molloy stated that she has not seen any thermometers at the facility.

Renewal Licensing Study Report dated 2/26/2026 cited R 400.665 violation after it was determined that refrigerators and freezers were not equipped with thermometers at the time of inspection. According to the Corrective Action Plan dated 2/18/2026 written by Olivier Ruhumuriza, thermometers will be installed in the refrigerator and freezer effective 2/23/2026.

APPLICABLE RULE	
R 400.665	**Food service.**
	(5) Refrigerators and freezers must be equipped with thermometers.
ANALYSIS:	While at the facility, I did not observe any thermometers in the refrigerator or freezer. Sheryl Molloy stated that she has not seen any thermometers at the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE LSR dated 02/26/2026 and CAP dated 02/18/2026]**

INVESTIGATION:

While at the facility, I observed the bedding in resident bedrooms to be unclean with grime or missing. This included unclean, stained pillowcases.

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following: **(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.** **(b) At least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident.**
ANALYSIS:	While at the facility, I observed the bedding in resident bedrooms to be unclean, or missing which includes unclean, stained pillowcases.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Upon my arrival at the facility, Resident B answered the facility door and gave me a tour of the facility at which time he informed me that he manages the facility and tries to make sure the facility stays clean and in order. Resident B also showed me a set of keys which he used to open the medication cart, which I observed to include controlled medications such as Norco, located in the dining room of the facility. Resident B stated that he has access to all resident medications, however he does not administer medications to the other residents, and he only opens the medication cart when he needs to obtain his own medications. It should be noted that Resident B's physician script documents that Resident A can administer and have access to his own medications excluding controlled medications which should be administered and supervised by AFC staff. Resident B also demonstrated that he utilizes the gas grill located on the patio on the side of the facility by manually igniting the grill with a lighter. Resident B stated that even though the gas grill is plugged into an electrical outlet he must manually ignite the grill to produce flames because the built-in electric igniter doesn't work.

Olivier Ruhumuriza stated that Resident B is allowed to administer his own medication, so he did not "think it was a big deal" for Resident B to have access to all resident medications, which includes having access to controlled medications, by giving him a key to the resident medication cart. Olivier Ruhumuriza also stated that to his knowledge the facility's grill does not work and it is not used. He was not aware that residents are using the gas grill to cook resident meals.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Resident B was not protected, safe and free from exploitation after licensee designee Olivier Ruhumuriza provided Resident B with keys to the resident medication cart. Resident B used these keys to open the medication cart in my presence demonstrating full access to all resident medications which I observed to include controlled medications such as Norco. It should be noted that Resident B's physician script documents that Resident A can administer and have access to his own medications excluding controlled medications which should be administered and supervised by AFC staff. He also demonstrated use of a gas grill by manually igniting the grill with a lighter. Resident B stated that even though the gas grill is plugged into an electrical outlet he must manually ignite the grill to produce flames because the built-in electric igniter doesn't work. Resident B stated that he likes to use the grill to prepare meals on occasion. Licensee designee Olivier Ruhumuriza had no knowledge that Resident B used the grill to cook resident meals as he believed the grill was broken. Resident B is not monitored by any direct care staff member when using flame producing equipment or accessing the resident medication cart leaving Resident B and the remaining residents not protected or safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Olivier Ruhumuriza and Resident B both stated that Resident B performs work around the facility which includes cooking, cleaning and maintenance tasks. I attempted to determine if the performance of these tasks/chores were documented in Resident B's written *Assessment Plan for AFC Residents* (assessment plan) however, licensee designee Olivier Ruhumuriza did not have a completed copy of Resident B's assessment plan available for review and did not disclose if any written assessment plans was completed for Resident B.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(2) Work that is performed by a resident must be in accordance with the resident's assessment plan.
ANALYSIS:	Olivier Ruhumuriza and Resident B both stated that Resident B performs work around the facility which includes cooking, cleaning and maintenance tasks, however, these services performed by Resident B were not documented in his assessment plan. It should be noted that Resident B's written assessment plan was not made available for the department to review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Olivier Ruhumuriza was not able to provide a copy of Resident A's and Resident B's written *Assessment Plan for AFC Residents* for my review because the document had not been completed as required.

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:	Olivier Ruhumuriza was not able to provide a copy of Resident A's and Resident B's written assessment plan for the department to review upon request because the document had not been completed as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed Resident B's *AFC-Resident Care Agreement* which documented that Resident B agrees to pay the basic monthly fee of $1100 which includes medication administration, laundry and meals.

Both Olivier Ruhumuriza and Resident B stated that Resident B performs cleaning, cooking, and maintenance and compensated by paying a reduced monthly fee of $700. This reduced monthly fee was not reflected in his written care agreement nor were the expectations of work completed.

Renewal Licensing Study Report dated 2/26/2026 cited R 400.685 after it was determined that the licensee did not have updated written resident care agreements for residents for the department to review at the time of inspection. According to the Corrective Action Plan dated 2/18/2026 written by Olivier Ruhumuriza, the *Resident Care Agreement* will be completed effective 2/23/2026.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident, resident's designated representative, or responsible agency at least annually or more often if necessary. Any changes to the resident care agreement must be re-signed by all applicable parties. If the annual review results in no changes to the resident care agreement the resident care agreement does not need to be re-signed but the licensee shall document that all applicable parties were contacted and agreed that no changes were necessary.
ANALYSIS:	I reviewed Resident B's *AFC-Resident Care Agreement* which documented that Resident B agrees to pay the basic monthly fee of $1100 which includes administering medication, laundry and meals. Both Olivier Ruhumuriza and Resident B stated that Resident B performs services of cleaning, cooking and maintenance therefore is compensated by Resident B paying a reduced monthly fee of $700. This was not reflected in Resident B's written *Resident Care Agreement.*
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE LSR dated 02/26/2026 and CAP dated 02/18/2026]**

INVESTIGATION:

Olivier Ruhumuriza stated his volunteers and direct care staff members have not received any written policies and procedures at the time of hire or their appointment.

Consequently, there was no verification of receipt of the policies and procedures maintained in staff records for the department to review.

Licensing Study Report dated 2/26/2026 cited R 400.701 violation after it was determined that the licensee failed to provide verification of written policies and procedures maintained in the staff's individual records at the time of inspection. According to the Corrective Action Plan dated 2/18/2026 written by Olivier Ruhumuriza, written policies and procedures will be completed and maintained for review effective 2/23/2026

APPLICABLE RULE	
R 400.701	**Required personnel policies.**
	(2) Written policies and procedures must be given to staff and volunteers at the time of hire or appointment. A verification of receipt of the policies and procedures must be maintained in the individual's personnel record.
ANALYSIS:	Olivier Ruhumuriza stated his volunteers and direct care staff members who have worked with residents in the facility have not received any written policies and procedures at the time of hire or their appointment therefore a verification of receipt of the policies and procedures were not maintained in staff records for the department to review.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE LSR dated 02/26/2026 and CAP dated 02/18/2026]**

INVESTIGATION:

Licensee designee and administrator Olivier Ruhumuriza is not administratively capable of operating this adult foster care facility. As previously described, Olivier Ruhumuriza has not fixed multiple serious electrical issues throughout the facility and even voluntarily stopped paying the fee to keep the interconnected smoke detection panel working leaving residents unsafe. He also repeatedly allows a resident to perform the duties of a direct care staff member including cooking, cleaning and maintenance and voluntarily provided Resident B with his own set of keys for the resident medication cart and refrigerator. Olivier Ruhumuriza also has not maintained critical resident records to assure residents are receiving care per their written *Assessment Plan for AFC Residents, Resident Care Agreements or Medication Administration Records.* Olivier Ruhumuriza also has not assured that resident medications are refilled timely leading to two residents going without medication for at least seven days. Lastly, Olivier Ruhumuriza has not assured that trained, competent, and capable direct care staff are providing care to residents. Rather he has allowed residents to be left unsupervised on multiple occasions or in the care of individuals who have not been fingerprinted through

the Michigan Workforce Background Check system, assessed by a health care professional or fully trained.

APPLICABLE RULE	
R 400.623	**Applicant, licensee and administrator qualifications; licensee, administrator and staff requirements; parole or probation or convicted of felony.**
	(1) An applicant, licensee, and administrator shall have the financial and administrative capability to operate a facility as specified in the act and these rules.
ANALYSIS:	Licensee designee and administrator Olivier Ruhumuriza has continuously made decisions that do not meet the personal care, supervision and protection needs of the residents since taking on these roles in September 2025. Despite receiving consultation and technical assistance on multiple occasions, Olivier Ruhumuriza continues to be in non-compliance with required rules and often see issues as “no big deal” with little change made to fix or address quality of care or physical plant issues within the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/22/2026, 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 and make comments. On 6/29/2026, Olivier Ruhumuriza stated that he plans to issue all his residents a 30-day written discharge notice and would like to voluntarily close his license.

IV. RECOMMENDATION

Due to the severity of the quality of care and physical plant violations cited, revocation of the license is recommended.

Ondrea Johnson 6/29/2026

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 06/30/2026

Dawn N. Timm Date
Area Manager