GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 22, 2026

Augustin Muhizi
Pathways Residential Care LLC
2522 Windview Street SW
Wyoming, MI 49519

RE: License #: AS410419539
Investigation #: 2026A0583059
Pathways Residential Care

Dear Mr. Muhizi:

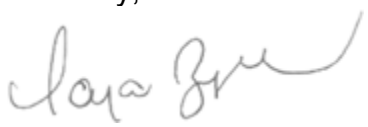
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410419539
Investigation #:	2026A0583059
Complaint Receipt Date:	09/10/2026
Investigation Initiation Date:	09/10/2026
Report Due Date:	10/10/2026
Licensee Name:	Pathways Residential Care LLC
Licensee Address:	2522 Windview Street SW Wyoming, MI 49519
Licensee Telephone #:	(616) 375-0740
Administrator:	Merveille Umutoni
Licensee Designee:	Augustin Muhizi
Name of Facility:	Pathways Residential Care
Facility Address:	2522 Windview Street SW Wyoming, MI 49519
Facility Telephone #:	(616) 375-0740
Original Issuance Date:	09/18/2025
License Status:	REGULAR
Effective Date:	03/18/2026
Expiration Date:	03/17/2028
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents are left without staff supervision at the facility.	Yes
Staff failed to serve dinner to residents.	No
Staff failed to administer medications to residents.	No
Additional Findings	Yes

III. METHODOLOGY

09/10/2026	Special Investigation Intake 2026A0583059
09/10/2026	Special Investigation Initiated - Telephone
09/14/2026	APS Referral
09/15/2026	Inspection Completed On-site
09/22/2026	Exit Conference Licensee designee Augustin Muhizi

ALLEGATION: Residents are left without staff supervision at the facility.

INVESTIGATION: On 09/10/2026 I received a telephone call from Network 180 supervisor Saicia Jones and opened Special Investigation 2026A0583059. She reported that she was recently informed by case manager Breanna Burrows and case manager Lillian Pells-Rock that they were at the facility on 09/08/2026 3:00 PM and no staff were present for approximately forty-five minutes. Ms. Jones stated that she was informed that Resident A and Resident B were the only residents home during the incident. Ms. Jones stated that Ms. Burrows is currently on a “thirty-to-forty-five-day medical leave”.

On 09/15/2026 I interviewed Resident A at the Hope Network day program. Resident A confirmed that on 09/08/2026 staff left he and Resident B alone at the facility while they met with Ms. Burrows and Ms. Pells-Rock. He stated that staff were absent from the facility for approximately forty-five minutes. He stated staff routinely leave he and Resident B alone for up to an hour and half at a time.

On 09/14/2026 I referred the allegation to Adult Protective Services.

On 09/15/2026 I completed an unannounced onsite investigation at the facility and privately interviewed staff Patrick Kiruhura, staff Frank Ngabonziza, and staff Zahabu Kidiha. While onsite I observed the well-being of Resident C who appeared

clean and appropriately groomed. Resident C was unable to be interviewed because of his limited communication and developmental delays.

Mr. Kiruhura stated that staff routinely leave residents alone and unsupervised at the facility because they have been assessed as “independent”. He stated that residents are left alone at the facility for up to an hour at a time. He stated he was unaware that staff must always be present while residents are at the facility.

Mr. Ngabonziza and Ms. Kidiha both stated they worked at the facility on 09/08/2026 and at around 3:00 PM they left Resident B alone at the facility while they took Resident C for a drive. They both stated that they returned to the facility an hour later and observed Resident B, Ms. Burrows, and Ms. Pells-Rock were present. Mr. Ngabonziza and Ms. Kidiha both stated that Resident A was not at the facility during the incident. Mr. Ngabonziza and Ms. Kidiha both stated that it is common practice to leave residents alone at the facility for up to an hour.

On 09/16/2026 I interviewed Resident B via telephone. He stated that staff routinely leave he and Resident A alone at the facility for up to an hour at a time. He stated that on 09/08/2026 Mr. Ngabonziza and Ms. Kidiha left he and Resident A alone while they took Resident C for a car ride. He stated that Ms. Burrows and Ms. Pells-Rock arrived at the facility shortly after Mr. Ngabonziza and Ms. Kidiha left and remained at the facility until Mr. Ngabonziza and Ms. Kidiha arrived back.

On 09/16/2026 I interviewed Ms. Pells-Rock via telephone. She stated that on 09/08/2026 at around 3:00 PM she visited the facility with Ms. Burrows. She stated that Resident A and Resident B invited them into the facility and no staff were present. She stated that staff arrived at the facility after approximately twenty minutes with Resident C.

On 09/22/2026 I completed an exit conference via telephone with licensee designee Augustin Muhizi. He did not dispute the finding and stated that he would submit an acceptable corrective action plan.

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.

ANALYSIS:	Resident A and Resident B both stated that on 09/08/2026 staff left them at the facility alone and unsupervised. Case manager Lillian Pells-Rock stated that on 09/08/2026 at around 3:00 PM she visited the facility and Resident A and Resident B invited her into the facility and no staff were present. She stated staff arrived after approximately twenty minutes. A preponderance of evidence supports that violation of the appliable rule occurred. On 09/08/2026 staff left Resident A and Resident B alone at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff failed to serve dinner to residents.

INVESTIGATION: On 09/10/2026, Ms. Jones reported by telephone that on 09/08/2026, an unidentified resident told Ms. Burrows and Ms. Pells-Rock that staff failed to provide dinner and evening medications on an unknown night.

On 09/15/2026 Resident A stated that on one occasion within the past month a female staff did not provide he or Resident B with dinner. Resident A stated that Resident B ordered pizza for the two residents to share due to the lack dinner provided by staff. Resident A stated he could not identify the staff's name because she only worked a single shift.

On 09/15/2026 Mr. Kiruhura, Mr. Ngabonziza and Ms. Kidiha both stated that they have no knowledge of any staff not providing dinner to residents and disputed the allegation as false. They both stated there was no female staff that worked at the facility for only one day. They stated that Resident B often orders pizza to share with Resident A and that staff provide three meals daily.

On 09/16/2026 Resident B stated that "a couple of weeks ago" a "very old" female staff worked and did not provide he or Resident A dinner. Resident B stated that he ordered a pizza for himself and Resident A to share because dinner was not served. Resident B did not know the staff's name or the exact date of the incident, but he noted that staff usually serve three meals a day.

On 09/16/2026, Ms. Pells-Rock stated she did not remember speaking with Resident A or Resident B about a missed dinner during her 09/08/2026 visit.

On 09/22/2026 I completed an exit conference via telephone with licensee designee Augustin Muhizi. He stated that he agreed with the finding.

APPLICABLE RULE

R 400.663	Nutrition; adoption by reference.
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Resident A and Resident B stated that a female staff failed to serve dinner to them on one occasion within the past month. Mr. Kiruhura, Mr. Ngabonziza, and Ms. Kidiha each stated that they have no knowledge of any staff who did not provide dinner to residents and disputed the allegation as false. A preponderance of evidence does not support that violation of the appliable rule occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff failed to administer medications.

INVESTIGATION: On 09/10/2026, Ms. Jones reported that during a site visit on 09/08/2026, an unidentified resident told Ms. Burrows and Ms. Pells-Rock that staff had failed to provide dinner and evening medications on an unknown night.

On 09/15/2026 Resident A stated on one occasion in the past month a female staff worked and did not provide he or Resident B with dinner or evening medications.

On 09/15/2026 Mr. Kiruhura, Mr. Ngabonziza and Ms. Kidiha each stated that they have no knowledge of any staff not providing medications to residents and disputed the allegation as false.

While onsite I observed Resident A and Resident B's Medication Administration Records from 06/01/2026 until current. The records indicate that Resident A and Resident B received all medications as prescribed.

On 09/16/2026 Resident B stated that "a couple of weeks ago" a "very old" female staff worked and did not provide he or Resident A with their evening medications. Resident B did not know the staff's name or the exact date of the incident, but he noted that staff usually administer his medications as prescribed.

On 09/16/2026 Ms. Pells-Rock stated that on 09/08/2026 she could not recall having a conversation with Resident A or Resident B regarding them not receiving their medications.

On 09/22/2026 I completed an exit conference via telephone with licensee designee Augustin Muhizi. He stated that he agreed with the finding.

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:	Mr. Kiruhura, Mr. Ngabonziza and Ms. Kidiha each stated they have no knowledge of any staff not providing medications to residents and disputed the allegation as false. Resident A and Resident B both stated a female staff failed to administer their medications on one occasion in the past month. I observed Resident A and Resident B's Medication Administration Records from 06/01/2026 until current. The records indicate that Resident A and Resident B received all medications as prescribed. A preponderance of evidence does not support that violation of the appliable rule occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Staff fail to complete fire drills at least once a quarter during each shift.

INVESTIGATION: While onsite I observed the facility's fire drill log indicates that staff completed fire drills on 03/06/2026 at 7:00 PM and 06/10/2026 at 7:00 AM.

Mr. Kiruhura stated that staff complete fire drills once per quarter. He admitted the facility did not run quarterly fire drills for each shift because he was unaware of the licensing requirement.

On 09/22/2026 I completed an exit conference via telephone with licensee designee Augustin Muhizi. He did not dispute the finding and stated that he will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.619	**Emergency preparedness plan.**
	(8) A licensee shall practice the emergency preparedness plan, including the fire safety plan, at least once a quarter per calendar year during each shift, 7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. A record of the practices must be maintained for 2 years.

ANALYSIS:	I observed the facility's fire drill log indicates that staff completed fire drills on 03/06/2026 at 7:00 PM and 06/10/2027 at 7:00 AM. Mr. Kiruhura admitted the facility did not run quarterly fire drills for each shift because he was unaware of the licensing requirement. A preponderance of evidence supports that a violation of the appliable rule occurred. Staff fail to complete fire drills at least once per quarter during each shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff fail to follow the posted menu and document substitutions.

INVESTIGATION: While onsite I observed the facility lacked the chicken and apples needed to prepare the posted dinner menu of chicken pasta and baked apples.

Mr. Kiruhura, Mr. Ngabonziza and Ms. Kidiha each stated the facility serves three healthy meals daily but does not document substitutions. They noted that an alternative protein would be used for dinner but could not provide a specific plan for what would be substituted.

On 09/22/2026 I completed an exit conference via telephone with licensee designee Augustin Muhizi. He did not dispute the finding and stated that he would submit an acceptable corrective action plan.

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:	I observed that the facility lacked the chicken and apples needed to prepare the posted dinner menu of chicken pasta and baked apples. Mr. Kiruhura, Mr. Ngabonziz and Ms. Kidiha each stated that the facility serves three healthy meals daily but does not document substitutions. They noted that an alternative protein would be used for dinner but could not provide a specific plan for what would be substituted.

	A preponderance of evidence supports that violation of the appliable rule occurred. Staff fail to follow the posted menu and document substitutions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff failed to document residents' weights monthly.

INVESTIGATION: While onsite I observed Resident A, Resident B and Resident C's monthly weight records. The facility did not have Resident A's 06/2026, 07/2026, and 08/2026 monthly weight records or Resident B's 07/2026 and 08/2026 monthly weight records.

Mr. Kiruhura stated that staff did weigh Resident A and Resident B monthly, however he could not locate documentation to verify they had been completed.

On 09/22/2026 I completed an exit conference via telephone with licensee designee Augustin Muhizi. He did not dispute the finding and stated that he will submit an acceptable corrective action plan.

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: (g) Admission and monthly weight record.
ANALYSIS:	The facility did not have Resident A's 06/2026, 07/2026 and 08/2026 monthly weight records or Resident B's 07/2026 and 08/2026 monthly weight records. A preponderance of evidence supports that a violation of the appliable rule occurred. Staff failed to complete monthly weight records.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: The facility's fire detector was not operable.

INVESTIGATION: While onsite I observed the facility's hard-wired basement fire detector was chirping and not in proper working order. I observed the additional fire detectors were interconnected and working properly.

Mr. Kiruhura stated the fire detector had been chirping for approximately three days.

He stated that the facility had not taken steps to obtain repairs.

On 09/22/2026 I completed an exit conference via telephone with licensee designee Augustin Muhizi. He did not dispute the finding and stated that he will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.715	**Facility environment; fire safety, adoption by reference.**
	(1) A facility that has a capacity of 4 to 6 residents shall be equipped with an interconnected multi-station smoke detection system that is powered by the facility's electrical service. When activated, the system must initiate an alarm that is audible in all areas of the facility. The smoke detection system must be installed on all levels, including basements, common activity areas, and outside each sleeping area, excluding crawl spaces and unfinished attics, to provide full coverage of the facility. The system must include a battery backup to ensure that the system is operable if there is an electrical power failure and accommodate the sensory impairments of residents living in the facility, if needed. A fire safety system must be installed in accordance with the manufacturer's instructions by a licensed electrical contractor and inspected annually. A record of the inspections must be maintained at the facility for 2 years.
ANALYSIS:	The facility's hard-wired basement fire detector was chirping and not in proper working order. A preponderance of evidence supports that a violation of the appliable rule occurred. The fire alarm is not in working order and staff failed to secure timely repairs.
CONCLUSION:	**VIOLATION ESTABLISHED**

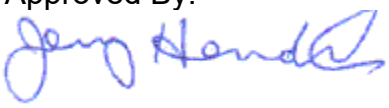
IV. RECOMMENDATION

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

Toya Zylstra 09/22/2026

Toya Zylstra, Licensing Consulta Date

Approved By:



09/22/2026

_____

Jerry Hendrick, Area Manager Date