



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 20, 2026

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

RE: License #: AS410418928  
Investigation #: 2026A0467026  
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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Anthony Mullins".

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**

<b>License #:</b>	AS410418928
<b>Investigation #:</b>	2026A0467026
<b>Complaint Receipt Date:</b>	04/06/2026
<b>Investigation Initiation Date:</b>	04/06/2026
<b>Report Due Date:</b>	06/05/2026
<b>Licensee Name:</b>	C.M.G Serenity Home Care LLC
<b>Licensee Address:</b>	1778 Bridle Creek St SE Kentwood, MI 49508
<b>Licensee Telephone #:</b>	616-655-6571
<b>Administrator:</b>	Egide Murowingabo
<b>Licensee Designee:</b>	Egide Murowingabo & Halese Gatete
<b>Name of Facility:</b>	C.M.G Serenity Home Care LLC
<b>Facility Address:</b>	1778 Bridle Creek St SE Kentwood, MI 49508
<b>Facility Telephone #:</b>	(616) 655-6571
<b>Original Issuance Date:</b>	04/21/2025
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/21/2025
<b>Expiration Date:</b>	10/20/2027
<b>Capacity:</b>	4
<b>Program Type:</b>	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS



## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A was left unsupervised in the home on Easter Sunday, 4/5/26.	Yes

## III. METHODOLOGY

04/06/2026	Special Investigation Intake 2026A0467026
04/06/2026	Special Investigation Initiated - Telephone Spoke to Resident A's guardian via phone
04/06/2026	APS referral – received from Kent County APS
04/20/2026	Exit conference with co-licensee, Egide Murowingabo

**ALLEGATION: Resident A was left unsupervised in the home on Easter Sunday, 4/5/26.**

**INVESTIGATION:** On 4/6/26, I received a complaint from Kent County Adult Protective Services (APS) alleging that Resident A had been left unsupervised in the home on Easter Sunday, 4/5/26. While alone, Resident A reportedly accessed her prescription medications and overdosed. Resident A reportedly has a known history of suicide attempts.

On 4/6/26 I spoke to Toren Kamerling, guardian for Resident A via phone. Mr. Kamerling confirmed that the incident took place on 4/5/26. He reported that staff left Resident A alone in the home to attend church. According to Mr. Kamerling, Resident A told him she was able to access her prescription medications because they had been left out on the counter rather than being secured as required by licensing rules. After obtaining access to her prescription medications, Mr. Kamerling stated that Resident A reportedly overdosed on her medications. Mr. Kamerling stated that staff at Network 180 called EMS after Resident A informed them of her overdose. EMS arrived at the home at 6:30pm and Resident A was found without staff supervision and was transported to Trinity Health Hospital in Grand Rapids, where she completed a psychiatric evaluation. Resident A was medically cleared and Mr. Kamerling determined that she did not meet inpatient psychiatric criteria. A safety plan was developed and Resident A returned home. Mr. Kamerling is currently seeking a new adult foster care home placement for Resident A.

On 4/6/26 I conducted an unannounced onsite investigation at the home. Upon arrival, staff member Emmanuel Gupani answered the door and allowed entry into the home. During the interview, Mr. Gupani confirmed that he had been scheduled to

work on 4/5/26 from 8:00am to 8:00pm. He reported that during his shift, Resident A told him she planned to have friends over for a party at 7:00pm. Mr. Gupani acknowledged that he left the home at 5:00pm to “get some gas,” leaving Resident A alone. I informed Mr. Gupani that licensing rules require staff to be present in the home whenever a resident is present. Mr. Gupani stated that he understands.

Mr. Gupani reported that he returned to the home between 7:30pm and 7:45pm and Resident A was not there. Prior to returning to the home, Mr. Gupani received a call from co-licensee, Egide Murowingabo informing him that Resident A was in the hospital. Mr. Gupani stated that Resident A returned home from the hospital at approximately 8:10pm. He requested to see her discharge paperwork and asked about her condition, but Resident A did not wish to discuss the incident. Although he acknowledged leaving Resident A unsupervised, Mr. Gupani denied leaving any medications out on 4/5/26 or any other day. Mr. Gupani insisted that Resident A must have “hoarded pills” from previous med passes or obtained them elsewhere since he always locks the medications after passing them to residents. Mr. Gupani was adamant that Resident A has not gained access to any of her prescription medications in the home while he was working.

I then spoke to co-licensee, Egide Murowingabo regarding the allegation. Mr. Murowingabo reported that yesterday at 5:38pm, Resident A texted him stating that her friend might come over between 7:00pm and 8:00pm to help her organize in preparation for moving and Mr. Murowingabo acknowledged her message. At 7:52pm, Mr. Murowingabo stated that he received a call from hospital staff at Trinity Health Hospital informing him that Resident A was on her way home. Mr. Murowingabo stated that hospital staff did not disclose the reason for Resident A’s hospitalization. At 8:00pm, Mr. Murowingabo texted Resident A to inform her that he received a call from the hospital and asked her if she needed anything. Resident A responded by telling Mr. Murowingabo that she is doing okay and on her way home. Mr. Murowingabo reported that he did not find out why Resident A was in the hospital until today, after speaking with Kent County Recipient Rights officer, Michael Kuik.

Mr. Murowingabo was present during my interview with his staff member Mr. Gupani and acknowledged the fact that Resident A was left alone in the home on 4/5/26. I informed Mr. Murowingabo that leaving Resident A unsupervised is a violation of licensing requirements and reminded him that the home was previously cited for the same violation on 2/19/26. I then reviewed Resident A’s medication with both Mr. Murowingabo and Mr. Gupani, which were observed to be in a locked cabinet in the living room. I was unable to determine whether any medication was missing, especially since the Vistaril is prescribed on an “as-needed” basis.

Prior to concluding my onsite investigation, Resident A arrived at the home and I interviewed her in the backyard for privacy. Resident A stated that on 4/5/26, she was transported to the hospital after a crisis team member from Network 180 called an ambulance after she informed them she had “overdosed” on her prescription

medication. She reported that she had taken an “overdose” of 10 vistaril tablets and 2 trazadone tablets, both of which are prescribed to her. According to Resident A, the medications had been left out by Mr. Gupani on 4/4/26, and she took them upstairs, storing them in a jar before taking them the following morning with the intention of dying. She confirmed that she was alone at the home when EMS arrived and she was unaware of Mr. Gupani’s location. She also added that staff often leave medications out, essentially allowing her to dispense her own medications. Resident A was unable to provide evidence beyond her reported observations. Resident A stated that after being assessed at the hospital, she returned home without any lab work being completed to confirm the overdose. She reported that after returning, Mr. Gupani left the home and there were no staff working again. She stated that being left at the home with no staff working is common at the home. When asked what led to the reported overdose, Resident A said, “I just have a lot of mental health issues.” She added that her guardian is aware of the situation.

On 04/20/26 I conducted an exit conference with co-licensee, Egidge Murowingabo. He was informed of the investigative findings and made aware that a corrective action plan is due within 15 days of receipt of this report. Due to this being a repeat violation, I also informed him that a provisional license is being recommended and that he must state in writing whether he accepts the provisional license. If he contests the recommendation, an administrative hearing will be scheduled.

<b>APPLICABLE RULE</b>	
<b>R 400.633</b>	<b>Staffing requirements.</b>
	<p><b>(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></p> <p><b>(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.</b></p> <p><b>(b) 12 residents for small group and family homes.</b></p>
<b>ANALYSIS:</b>	Resident A, staff member Emmanuel Gupani and co-licensee Mr. Murowingabo all confirmed that Resident A was left unsupervised in the home on 4/5/26 and was subsequently transported to the hospital for a reported overdose. Based on this, there is a preponderance of evidence to support this applicable licensing rule violation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b> <b>(Repeated violation from SIR #2026A0467014 dated 2/19/26).</b>

