



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 18, 2025

Justine Mukamusoni
IWACU INTERNATIONAL CORP
3500 S Cedar St Suite
Lansing, MI 48910

RE: License #: AS330418444
Investigation #: 2026A0466005
Just AFC Home

Dear Ms. Mukamusoni:

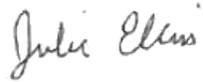
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 feel free to 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 (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Julie Elkins".

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330418444
Investigation #:	2026A0466005
Complaint Receipt Date:	10/30/2025
Investigation Initiation Date:	10/30/2025
Report Due Date:	12/29/2025
Licensee Name:	IWACU INTERNATIONAL CORP
Licensee Address:	3500 S Cedar St Suite Lansing, MI 48910
Licensee Telephone #:	(517) 402-1891
Administrator:	Justine Mukamusoni
Licensee Designee:	Justine Mukamusoni
Name of Facility:	Just AFC Home
Facility Address:	1416 N MLK Blvd Lansing, MI 48915
Facility Telephone #:	(517) 402-1891
Original Issuance Date:	11/20/2024
License Status:	REGULAR
Effective Date:	05/20/2025
Expiration Date:	05/19/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS:

	Violation Established?
Facility does not have heat.	No
On 10/24/2025, Resident A ran out of prescribed medications.	No
Resident A is being discharged even though she is paying the agreed upon rate.	No
Resident A was not provided with transportation when she was discharged from McLaren hospital on 10/22/2025.	No
Additional Findings	Yes

III. METHODOLOGY

10/30/2025	Special Investigation Intake 2026A0466005.
10/30/2025	APS Referral Robert Joyner assigned.
10/30/2025	Special Investigation Initiated – Telephone call to Complainant, interviewed.
10/30/2025	Contact - Document Received from Complainant.
10/31/2025	Inspection Completed On-site.
12/02/2025	Contact- email sent/received to/from JC Abayisenga.
12/15/2025	Contact- email sent to JC Abayisenga.
12/15/2025	Contact - Document Sent to APS Robert Joyner.
12/16/2025	Contact - Document Received from APS Robert Joyner.
12/16/2025	Exit conference with Justine Mukamusoni, message left.

ALLEGATION: Facility does not have heat.

INVESTIGATION:

On 10/30/2025, Complainant reported that the facility does not have heat and there has been no heat in the home for an unknown duration.

On 10/30/2025, adult protective service (APS) worker Robert Joyner reported that he has been out to the facility and it does have heat.

On 10/31/20225, I conducted an unannounced investigation and the facility had heat. I interviewed direct care worker (DCW) Prince Tuyishime who reported that the facility has always had heat. DCW Tuyishime was not aware of a time when the facility did not have heat.

I interviewed Resident A who reported that the facility does have heat but that the other day the heat was not working and the thermostat would not rise above 63 degrees. Resident A reported that there is warm air coming out of the heat registers but that the windows are so bad they do not keep the heat in.

I observed the facilities thermostet which was set at 68 degrees.

JC Abayisenga, director of operations, arrived as I was conducting the investigation and he reported that the heat has always been working at the facility and that Resident A's personal preference is for the heat to be warmer. JC Abayisenga reported that Resident A has adjusted the heat to a higher setting when she wants.

APPLICABLE RULE	
R 400.653	Room temperature.
	Resident-occupied rooms must be heated at no less than 68 degrees Fahrenheit. While air conditioning is not required, precautions must be taken to prevent prolonged resident exposure to noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations must be based on a resident's health care appraisal and addressed in the resident's assessment plan.
ANALYSIS:	On 10/30/2025, APS Joyner reported that the facility had heat. On 10/31/2025, I observed the facilities thermostat to be set at 68 degrees with the heat working.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On 10/24/2025, Resident A ran out of prescribed medications.

INVESTIGATION:

On 10/30/2025, Complainant reported that Resident A, a 65-year-old with multiple health conditions, did not have any medication refills. Resident A ran out of her medications on 10/24/2025 and her guardian was never called to get these refilled.

On 10/30/2025, APS Joyner reported that he has been out to the facility and it appears that Guardian A1 didn't have a complete understanding of what services the facility would provide as they do not have a medical provider, nor is visiting physicians utilized. APS Joyner reported that Guardian A1 was under the belief that this facility had access to medical care at the facility.

On 10/31/2025, I interviewed Resident A who reported that she was admitted to the facility on 10/01/2025 and ran out of her medications on 10/24/2025 because there were no refills. Resident A reported that her medications were restarted on 10/31/25, seven days after there were no refills left.

I reviewed Resident A's record which did not contain a medication administration record (MAR) for October 2025.

Resident A was seen at the ER on 10/22/2025 and Resident A's record contained the following prescription orders dated 10/22/2025:

- Maalox/Mylanta ES GEQ 400mg-400mg-40 mg/5 mL oral. 10 ML oral QID(ACHS) for 10 days.
- Cephalexin 500 mg oral capsule. One cap Oral Q8H for 10 days.
- Carafate 1 g oral tablet. 1 tabs Oral QID for 10 days.

Resident A's record contained "out of stock/partial fill memo" dated 10/23/2025 from Ascension Rx. The memo stated the following:

- "Mintoz susp we send a quantity of 150 and will send the balance of 250 as soon as possible."

While I was conducting the investigation, JC Abayisenga, arrived at the facility and reported that Resident A was admitted to the facility on 10/01/2025 through the Tri County medical program. JC Abayisenga reported that she came with a one-month supply of medications except for Xanax which was a 15-day supply. JC Abayisenga reported that he sent an email to Guardian A1's office on 10/15/2025, asking about scheduling a doctor's appointment/getting additional medication prescriptions but never received a response from Guardian A1. JC Abayisenga reported that on 10/29/2025 Resident A was taken to a physician appointment and her medications were refilled. JC Abayisenga reported that Xanax was the only medication that had a 15-day supply, did not have any refills and it ran it prior to the medical appointment on 10/29/2025. JC Abayisenga reported all other medications had a 30-day supply and therefore did not run out prior to the medical appointment on 10/29/2025.

I reviewed a pharmacy delivery sheet which was dated 10/30/2025 and documented that the following prescriptions were delivered for Resident A:

- ALPRAZOLAM 0.25 MG* TABLET
- AMLODIPINE 5 MG* TAB
- ASPIRIN EC 81 MG* TABLET
- ATORVASTATIN 20 MG* TABLET
- BUSPIRONE HCL 5* MG TABLET
- FLUOXETINE HCL 20MG* CAPS
- FLUOXETINE HCL 10 MG* CAP
- HEALTHYLAX POWDER PACKET
- HYDRALAZINE 10 MG* TABLET
- LEVETIRACETAM 750* MG TAB
- LISINOPRIL 40 MG* TAB

- OMEPRAZOLE DR 20 MG* CAPS
- PREGABKIN 225 MG CAPSUL
- TAB-A-VITETABLET*
- TIZANIDINE HCL 4 MG TABLE

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Resident A was admitted to the facility with a 30-day supply of all medications except Xanax which was a 15-day supply that ran out. None of these prescribed medications contained any refills. Guardian A1 and JC Abayisenga worked together to meet Resident A's medication needs by obtaining updated prescriptions for Resident A to continue her medication regimen on 10/29/2025, prior to any additional medication running out therefore there is not enough evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is being discharged even though she is paying the agreed upon rate.

INVESTIGATION:

On 10/30/2025, Complainant reported that Resident A, a 65-year-old with multiple health conditions, is being pressured to leave her adult foster care (AFC) home due to payment issues despite prior agreements. On or around 10/20/2025, the AFC staff stated that they wanted Resident A placed elsewhere because she can only pay \$202 a month. Complainant reported waiting on additional social security money to make up the difference, but Complainant reported AFC facility staff said this is not enough, even though in writing, they stated that this situation was fine when she moved in.

On 10/31/2025, I conducted an unannounced investigation and Resident A reported that she has asked to leave this facility as she does not like it here. Resident A reported that she had not been provided with a written 30-day notice.

I interviewed JC Abayisenga who denied that Resident A was provided with a 30-day written notice and reported that he does not intend to provide her with a notice.

I reviewed Resident A's record in its entirety and I did not see any written notice in the record.

APPLICABLE RULE	
R 400.687	Resident admission and discharge policy; house rules; change of residency; provision of resident records.
	(4) A licensee shall provide a resident and resident's designated representative with a 30-day written notice before discharge from the facility. The notice must state the reasons for discharge and a copy of it be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Resident A denied that she was provided with a written 30-day discharge notice. JC Abayisenga denied providing Resident A with a written 30-day notice and he denied that he intended to provide her with a discharge notice therefore there is no evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was not provided with transportation when she was discharged from McLaren hospital on 10/22/2025.

INVESTIGATION:

On 10/30/2025, Complainant reported that Resident A, a 65-year-old with multiple health conditions including depression, anxiety, epilepsy, and heart disease (case history also shows multiple sclerosis). Complainant reported that Resident A was left to find her own way home from the hospital and was scolded for being late. Complainant reported that on 10/22/2025, Resident A went to the hospital and was diagnosed with a urinary tract infection (UTI). Complainant reported that Resident A's AFC home stated that they would pick her up, but nobody came. Complainant reported that Resident A ended up taking a bus and walking. Complainant reported that walking takes almost an hour and it is unknown how far the bus took her in the dark. Complainant reported that when Resident A arrived back at the AFC, staff yelled at her that she was past curfew even when they were supposed to pick her up.

On 10/30/2025, APS Joyner reported that he has been out to the facility and that the documents he received show that transportation was supposed to be provided by Spec-Trans for Resident A after her hospital discharge.

On 10/31/2025, I interviewed Resident A who reported that she was not feeling well on 10/22/2025 about 2pm and requested to go to the hospital. Resident A reported that she had diarrhea so direct care staff called emergency medical service (EMS) to transport her to the hospital. Resident A reported that she was diagnosed with a UTI and was discharged around 4pm/5pm. Resident A reported that when no one came

to pick her up, the hospital provided her with a bus pass. Resident A reported that it was a very cold and rainy night. Resident A reported that she was able to make it home safely by taking the bus. Resident A stated she is able to be in the community independently. Resident A reported that when she arrived home, JC Abayisenga was working and he yelled at her.

I interviewed JC Abayisenga who reported that Resident A was transported to the hospital by EMS on 10/22/2025 about 2pm because she was not feeling well. JC Abayisenga reported that when EMS arrived Resident A was advised to be taken to Sparrow Hospital but requested that she be taken to McLaren Hospital. JC Abayisenga reported that he contacted Guardian A1 who reported that her associate would meet Resident A at the hospital but she never made it as she was with another client for the duration of Resident A's ER visit. JC Abayisenga reported that he was told that a medical transportation service would bring Resident A back to the AFC. JC Abayisenga reported that he was then called at 6:42pm and he told the hospital that he would come to get Resident A. JC Abayisenga reported that he arrived at the hospital about 7:30pm but was told Resident A had requested her discharge paperwork and left on the bus. JC Abayisenga reported that Resident A can be in the community independently. JC Abayisenga denied yelling at Resident A when she returned to the AFC.

I reviewed a written *Assessment Plan for AFC Residents* that was dated 10/17/2025 and signed by KD Branson, Tri County Office on Aging (TCOA) which documented that Resident A is able to be in the community unsupervised.

I reviewed the McLaren Greater Lansing *Emergency Department Discharge Instructions* for Resident A that were dated 10/22/2025. Time listed on the report was 15:36 (3:36pm) for admission and 18:02 (6:02pm) for discharge. Resident A was diagnosed with "UTI, diarrhea and GERD without esophagitis."

At the time of the unannounced investigation, Resident A's record did not contain a written *Resident Care Agreement*.

APPLICABLE RULE	
R 400.697	Resident transportation.
	(1) A licensee shall ensure the availability of transportation services as provided for in a resident care agreement. A licensee shall provide or arrange transportation for residents in a certified facility.

ANALYSIS:	JC Abayisenga reported that he was initially told that Resident A would be transported home from McLaren hospital by a medical transportation company. JC Abayisenga reported that he received a second phone call that Resident A had not been picked up so he went to get her from the hospital but upon arrival learned that Resident A left by bus to return to the AFC. Resident A made it back to the facility safely. Resident A can be in the community independently. Although Resident A's record did not contain a written <i>Resident Care Agreement</i> at the time of this investigation, efforts were made to ensure Resident A was provided transportation back from the hospital therefore there is not enough evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/31/2025, I conducted an unannounced investigation and I interviewed Resident A alone in her bedroom. While I was in Resident A's bedroom on the nightstand I observed a medication cup with prescribed medications in it. Resident A reported that DCW Tuyishime had brought her the medications in the cup and he left them on the table for her to take but she forgot. Resident A reported that DCW Tuyishime did not supervise Resident A while administering her medication. While I was discussing these medications with Resident A, JC Abayisenga, entered the bedroom and observed the medications unsecured after I pointed it out to him.

I was unable to further interview DCW Tuyishime as he had left the facility while I was interviewing Resident A after JC Abayisenga arrived.

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(2) Prescribed medication 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 and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.</p> <p>(3) Giving, taking or applying of prescription medications must be supervised by a licensee, administrator, or direct</p>

	care staff unless otherwise directed by an appropriately licensed health care professional in writing.
ANALYSIS:	At the time of the unannounced investigation Resident A had prescribed medications unsecured in her bedroom on the nightstand that had been provided to her by DCW Tuyishime. By DCW Tuyishime leaving the unsecured medications with Resident A, he did not supervise her taking medication as required therefore a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 10/31/2025, Resident A's medications were available for administration however Resident A's MAR for October 2025 was not available for review at the time of the unannounced investigation. DCW Tuyishime and Resident A both reported that DCW Tuyishime administered medications to Resident A prior to my arrival. There was no documentation available for review that documented that DCW Tuyishime completed the medication log.

I interviewed JC Abayisenga who reported that Resident A was admitted to the facility on 10/01/2025 with a one-month supply of medication and 15 days of Xanax. JC Abayisenga also reported that additional medications were prescribed to Resident A on 10/22/2025 when she went to the ER for feeling sick.

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medications by a resident:</p> <p>(b) Complete and individual medication log that contains all of the following:</p> <p>(i) Medication name.</p> <p>(ii) Dosage.</p> <p>(iii) Label instructions for use.</p> <p>(iv) Time to be administered</p> <p>(v) Initials of the individual who administered the medication at the time given.</p>

ANALYSIS:	On 10/31/2025, Resident A's October 2025 MAR was not available for review even though Resident A had prescribed medications being administered to her throughout October 2025.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 10/31/2025, I conducted an unannounced investigation and I reviewed Resident A's record. Resident A's record did not contain a written *Resident Care Agreement* although she had been admitted to the facility on 10/01/2025.

I interviewed JC Abayisenga who reported that Guardian A1 did not accompany Resident A when she was admitted to the facility on 10/01/2025 therefore admission paperwork has not been completed despite his efforts. JC Abayisenga reported that this was an emergency placement but the timeframe allotted to complete paperwork under that circumstance has also elapsed. JC Abayisenga reported that he has reached out to Guardian A1 in an effort to complete this paperwork with no response from her.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	<p>(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following:</p> <ul style="list-style-type: none"> (a) A statement that the facility is licensed to provide foster care to adults. (b) The services to be provided and the fee for those services. (c) Any additional costs in addition to the basic fee that is charged. (d) A resident's rights policy. (e) A discharge policy. (f) Transportation services provided for a basic fee and services that are provided at an extra cost. (g) A refund policy. (h) A resident's funds and valuables policy. (i) An agreement by the licensee to provide care, supervision, and protection to the resident and to ensure

	<p>transportation services as indicated in the resident's assessment plan and resident care agreement.</p> <p>(j) An agreement by the licensee to respect and safeguard the resident's rights.</p> <p>(k) An agreement by the licensee and resident or the resident's designated representative to follow the facility's discharge policy.</p> <p>(l) An agreement by the resident, resident's designated representative, or responsible agency to provide necessary intake information, including health-related information, at the time of admission.</p> <p>(m) An agreement by the resident or the resident's designated representative to provide a current health care appraisal.</p> <p>(n) An agreement by the resident to follow written house rules if any.</p>
ANALYSIS:	On 10/31/2025, Resident A's record did not contain a written <i>Resident Care Agreement</i> despite Resident A being admitted on 10/01/2025 therefore a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 10/31/2025, I conducted an unannounced investigation and when I arrived DCW Tuyishime identified himself as the only direct care worker on duty. DCW Tuyishime reported that there were three residents living at the facility, all who were currently home.

I interviewed Resident A, Resident B and Resident C who all reported that DCW Tuyishime and JC Abayisenga both work at the facility as DCWs.

I conducted a search of the Michigan Workforce Background Check system and did not find that DCW Tuyishime or JC Abayisenga had been fingerprinted or cleared to work with vulnerable adults in an adult foster care setting. Per my review of the Michigan Workforce Background Check system, the only direct care worker fingerprinted and cleared to work in the facility was Andre Mugisha.

On 12/02/2025, JC Abayisenga sent an email that stated the direct care worker on duty on 10/31/2025 was Bertrand Tuyishime and that he has requested fingerprints for him on 12/02/2025 per the attachment to JC Abayisenga's email. Later that same day, JC Abayisenga sent a second email that stated:

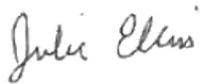
"Hello am sorry I send you a back grand [sic] check for the new hire but on the question day of 10/30/2025 the guy who was working is Andre Mugisha and I have attached his background."

APPLICABLE RULE	
MCL 400.734b	<p>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.</p>
	<p>(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.</p>

ANALYSIS:	At the time of the unannounced investigation, a staff member working alone identified himself as DCW Tuyishime. All residents interviewed reported that both DCW Tuyishime and JC Abayisenga work at the facility as DCWs. The Michigan Workforce Background Clearance did not have clearances for DCW Tuyishime or JC Abayisenga therefore a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan I recommend no change to the current license status.

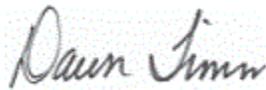


12/18/20225

Julie Elkins
Licensing Consultant

Date

Approved By:



12/18/2025

Dawn N. Timm
Area Manager

Date