GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 23, 2025

Joanita Mutebi
MTB Homes, LLC
15093 Oak Knoll Ct
Sterling Heights, MI 48312

RE: License #: AS630418549
Investigation #: 2026A0605003
MTB Homes-Waldon

Dear Joanita Mutebi:

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 (248) 972-9136.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418549
Investigation #:	2026A0605003
Complaint Receipt Date:	11/19/2025
Investigation Initiation Date:	11/19/2025
Report Due Date:	01/18/2026
LicenseeName:	MTB Homes, LLC
Licensee Address:	6210 Waldon Rd Clarkston, MI 48346
Licensee Telephone #:	(989) 402-8039
Administrator/ Licensee Designee:	Joanita Mutebi
Name of Facility:	MTB Homes-Waldon
Facility Address:	6210 Waldon Rd Clarkston, MI 48349
Facility Telephone #:	(989) 402-8039
Original Issuance Date:	12/16/2024
License Status:	REGULAR
Effective Date:	06/16/2025
Expiration Date:	06/15/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility misrepresented itself as an insurance-billable adult foster care (AFC) home, charged $7,000 to hold a bed for Resident A, and is now demanding $14,000 without providing an itemized bill.	Yes
Staff living in the basement and not supervising the residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/19/2025	Special Investigation Intake 2026A0605003
11/19/2025	Special Investigation Initiated - Telephone Discussed allegations with licensee designee Joanita Mutabi
11/25/2025	Inspection Completed On-site Conducted on-site investigation
11/25/2025	Contact - Document Received Email from licensee designee Joanita Mutabi
12/01/2025	Contact - Telephone call made Discussed allegations with Resident A's guardian and left messages for direct care staff (DCS) to return my call
12/02/2025	Contact - Telephone call received Discussed allegations with DCS
12/02/2025	Contact - Document Received Emails to and from licensee designee Joanita Mutebi
12/08/2025	Contact - Telephone call made Discussed allegations with DCS
12/08/2025	Contact - Telephone call made Follow-up with licensee designee Joanita Mutebi
12/16/2025	Contact - Telephone call received Resident A's sister/guardian seeking update

12/17/2025	Contact - Telephone call received Karla Okaiye with Oakland County Michigan Department of Health and Human Services (MDHHS)
12/22/2025	Exit Conference Conducted exit conference with licensee designee Joanita Mutebi via telephone with my findings.

ALLEGATION:

The facility misrepresented itself as an insurance-billable adult foster care (AFC) home, charged $7,000 to hold a bed for Resident A, and is now demanding $14,000 without providing an itemized bill.

INVESTIGATION:

On 11/19/2025, intake # 208195 was assigned for investigation regarding licensee designee Joanita Mutebi overcharging for the cost of care and there are staff living in the basement.

On 11/19/2025, I contacted licensee designee Joanita Mutebi to obtain information regarding which resident these allegations were pertaining to as there was minimal information provided. Ms. Mutebi stated that there are currently two residents residing at this home; however, Resident A was moved out by Resident A's sister this past weekend. Resident A's sister is also the guardian of Resident A and brought police to the home and moved Resident A out of the home. Resident A moved in sometime in June 2025 and the sister agreed to the cost of care, paid for the first month, but then stopped paying. The sister refused to connect Resident A to Community Mental Health (CMH) to help with the cost of care; therefore, Resident A was private pay. Ms. Mutebi agreed to meet at this home on 11/25/2025.

On 11/25/2025, I conducted a scheduled on-site investigation. Licensee designee Joanita Mutebi and Resident B were present; Resident C was in the hospital during this visit. I interviewed Ms. Mutebi regarding the allegations. Resident A moved in on 06/21/2025 and it was discussed with Resident A's sister/guardian the cost of care of $1400 per month plus $115 per day. The $1400 is the cost for room and board including meals and utilities and the $115 was the cost of care for Resident A that included laundry, personal care, and medication administration. Ms. Mutebi stated, "if Resident A was receiving services with CMH, Resident A would probably not have to pay anything because CMH will pay a per diem that would cover the room and board plus the cost of care." Ms. Mutebi stated she explained this to Resident A's sister, however, Resident A's sister refused to connect Resident A with CMH. Resident A was diagnosed with Bipolar Disorder, Schizophrenia and is Developmentally Disabled. During the assessment, Resident A's sister did not disclose that Resident A was incontinent and required a "higher level of care." Resident A had limited mobility in her upper extremities

and required staff to help her with showering, dressing, and sometimes ambulating. This was discovered after Resident A moved into this home. When Ms. Mutebi asked Resident A's sister why she did not disclose that Resident A was incontinent, the sister stated, "I lied because I wanted you to take her." Resident A's sister also chose the "bigger single room," that is usually used for residents with equipment instead of sharing a room with another resident; therefore, the cost was higher.

Ms. Mutebi showed me the invoice she sent to Resident A's sister in the amount of $6350.00 for room and board and cost of care from 06/21/2025-07/31/2025. Resident A's sister paid this amount; therefore, according to Ms. Mutebi, Resident A's sister was aware of the cost it would take to provide care for Resident A at this home and the sister agreed to the amount since this invoice was paid.

When Resident A was residing with her sister, the sister was receiving home help from Michigan Department of Health and Human Services (MDHHS). However, a spend down was now required so the sister decided to move Resident A into Ms. Mutebi's home and wanted Ms. Mutebi to bill Medicaid directly, which Ms. Mutebi knew she could not. Ms. Mutebi called Lansing asking if she could bill insurance directly and was told no, adult foster care (AFC) homes cannot. Ms. Mutebi told the sister she could not bill Medicaid and the sister was upset. Ms. Mutebi believed that the sister was trying to continue getting paid from MDHHS for caring for Resident A when Resident A was residing at MTB Homes. Ms. Mutebi will email me the invoice showing that the sister paid the invoice sent to her initially and the amount that is still owed by the sister for the care of Resident A from 08/01/2025-11/15/2025 totaling $11,215.

I attempted to interview Resident B in her bedroom, but she stated, "I'm not feeling well, and I don't want to talk because I didn't sleep well."

On 12/01/2025, I interviewed Resident A's sister/guardian regarding the allegations via telephone. Resident A lived with her sister for eight years before the sister decided to place Resident A in an AFC home. The sister was receiving home help services from MDHHS for caring for Resident A; however, the sister was informed that Resident A had a spenddown of $647 in medical services which Resident A would not have since Resident A did not have many medical needs. Resident A's sister and her husband toured this home sometime in June 2025. The sister informed the licensee designee Joanita Mutebi that Resident A is on a fixed income of $1300 per month. The sister stated, "the owner (Ms. Mutebi) of the home sold it to us that the only room available is a single bedroom. I told the owner Resident A was on a fixed income and told her Resident A's physical and mental condition at the time we toured the home. She (Ms. Mutebi) knew all the issues, and I did not need to withhold anything regarding Resident A." Ms. Mutebi expressed that the sister needed to "lock in," the bedroom because calls were coming through and Resident A can potentially lose the room. Resident A's sister stated that Ms. Mutebi never informed her of the cost of care for the room. Ms. Mutebi told the sister, "there would not be any out-of-pocket expenses once all the paperwork is completed and submitted." The sister stated she never signed any documents, nor did she receive any documents other than the invoice she paid to secure the room. The

sister believed that Ms. Mutebi would send the paid invoice to MDHHS as a medical expense to meet the spenddown but, Ms. Mutebi stated she was not going to send the paid invoice to MDHHS and that the sister had to send it to them. The sister was not sure why she would need to send the invoice since Resident A was residing at this group home, and the case was now transferred to Ms. Mutebi.

I advised Resident A's sister that I was provided by Ms. Mutebi a signed resident care agreement (RCA) dated 06/21/2025. Resident A's sister denied signing the RCA and stated she does not know what that document is. I advised her that there is a signature on the RCA, but the name is printed. The sister stated, "when I sign a document, I print and then I sign my name." I emailed the RCA to the sister and requested the sister to send me a copy of her driver's license to compare the signatures. While on the telephone with the sister, she emailed me a copy of her driver's license. I reviewed the driver's license, and it does NOT match the signature on the RCA. The sister stated, "why would I agree to the cost of care of $1400 per month plus $115 per day if Resident A is on a fixed income of $1300 per month. Does that make any sense?" Resident A's sister also informed Ms. Mutebi of Resident A's incontinence and having limited upper extremities. She did not see any benefit of not reporting Resident A's needs to Ms. Mutebi. Resident A's sister stated that she never completed an assessment plan with Ms. Mutebi, and she never signed the assessment plan either. She had not received any documents from Ms. Mutebi regarding Resident A's care/needs after moving into this home. Resident A cannot afford to reside at this home; therefore, the sister was not paying the invoices because she was never informed of the cost of care. In addition, Resident A's sister stated that Resident A was not being cared for properly; therefore, the sister moved Resident A out of the home on 11/15/2025.

Resident A's sister reported several concerns she had about Resident A and the care she was receiving. There was a direct care staff (DCS) named Charlotte that was living in the basement of the home. Charlotte was rarely upstairs providing care to the residents as she was the only staff member on shift and was always in the basement. One day she arrived at this home unannounced and saw a male DCS at this home, name unknown but believes it was Ms. Mutebi's relative as he was driving Ms. Mutebi's car. Resident A's sister stated, "I never gave permission for a male staff to provide care to my sister." I advised the sister that according to the RCA, the box "agree," was checked regarding the opposite sex DCS providing care to Resident A. Resident A's sister stated, "I never saw nor signed the RCA and never agreed to a male staff providing care to my sister."

Resident A's sister stated that after she picked up Resident A on 11/15/2025, she notice Resident A had gained weight. After taking Resident A to the doctor, she learned that Resident A had gained about 30 pounds. Resident A was not fed properly at this home. Resident A's sister had brought some snacks initially after Resident A moved in but did inform Ms. Mutebi that Resident A "normally does not eat these types of snacks," and that these snacks were just for Resident A to feel comfortable being at a new placement. It appeared that snacks were the only form of food fed to Resident A given her significant weight gain.

Resident A's sister informed me that Resident B found a vape outside, brought it inside and Resident C, who has a room across from Resident A showed Resident A how to use the vape. Resident C was taken to jail because he was fighting with police. Resident A's sister is concerned about the lack of supervision by staff when Resident A was residing at this home.

Note: Ms. Mutebi provided the resident care agreement (RCA) she completed with Resident A's sister dated 06/21/2025. I reviewed the RCA, and the cost of care is $1400 plus $115 per day. Resident A's sister's name is on the RCA, but the name is printed, not signed by the sister. The "agree," box is checked regarding the opposite sex providing care to Resident A.

Note: I reviewed the assessment plan, and the name again was printed, not signed by Resident A's sister. According to the assessment plan dated 06/21/2025, Resident A's sister did report that "Resident A has occasional incontinence of bowel and bladder; frequent continence checks," was written under "Toileting and Needs." In addition, the assessment plan also stated that "Resident A has limited mobility of bilateral upper extremities; staff will assist as needed."

On 12/02/2025, I interviewed DCS Magoola Kakaire regarding the allegations via telephone. Mr. Kakaire has been working for this corporation for one month. He works the midnight shift. All the residents, including Resident A, would be sleeping during that shift. He worked alone during his shift. He would assist Resident A by reminding her to use the bathroom, ambulate if needed and if Resident A had an accident, he stated that Ms. Mutebi would change her and help with showers during the day. Resident A never had any accidents during his midnight shifts. He has never toileted, nor has he helped shower Resident A. Mr. Kakaire does not know what the cost of care is for any resident including Resident A as that is Ms. Mutebi's responsibility.

Mr. Kakaire has never weighed Resident A when she lived at the home but stated he did notice her gain weight and was informed by Ms. Mutebi that it was due to "her sister bringing snacks."

Mr. Kakaire does not know anything about Resident C showing Resident A how to use a vape. He has never seen the vape at the house.

On 12/02/2025, I interviewed DCS Kenneth Mutebi regarding the allegations via telephone. Mr. Mutebi is the licensee designee's husband. He has worked for this corporation since April 2025. He works some weekends and some nights. Mr. Mutebi stated he does not deal with cost of care of any of the residents so he would not have any information regarding Resident A's cost of care agreement. He provided care to Resident A; helped with laundry, administered medications, and cleaned her room. He stated that Ms. Mutebi would assist Resident A with toileting and showering. Resident A is incontinent so if she had an accident, then Ms. Mutebi would have to change her. He stated, "when Joanita was not working, I would tell Resident A what to do while she was

in the bathroom and I would stand outside the door." He has never helped Resident A toilet or take a shower.

Mr. Mutebi noticed Resident A's weight gain and stated he reported this weight gain to Ms. Mutebi. Resident A was eating too many snacks and Resident A's sister purchased these snacks that were in a cabinet so Resident A would sneak the snacks in her bedroom which resulted in her gaining weight. He is unsure how much she gained as he was not responsible for weighing her.

Mr. Mutebi has not heard anything about Resident C showing Resident A how to use a vape. He stated, "nobody smokes or vapes in this house, and nobody told me anything about anyone showing Resident A how to use a vape." He had not seen any vapes inside this house.

On 12/08/2025, I interviewed DCS Charlotte Natukunda regarding the allegations via telephone. Charlotte worked for this corporation from September 2025-November 4, 2025. She worked alone during the midnight shifts. She does not have any information regarding cost of care for Resident A or any other resident. When she worked, she prepared meals and would check on the residents. Charlotte stated she did not work at this home for long, so she did not have much information to provide.

On 12/08/2025, I followed up with licensee designee Joanita Mutebi regarding the additional allegations brought by Resident A's sister. Ms. Mutebi was adamant that Resident A's sister signed both the RCA and the assessment plan dated 06/21/2025 even after I advised her that Resident A's sister's signature on her driver's license did not match the printed signature on the RCA and the assessment plan. Ms. Mutebi stated, "I believe she signed differently on purpose because this was her strategy all along." Ms. Mutebi stated she provided a copy of the RCA and the assessment plan to Resident A's sister at the time of the admission.

Ms. Mutebi acknowledged that Resident A gained weight and stated that it was because Resident A's sister brought snacks into this home for Resident A and due to Resident A eating these snacks, she gained weight. Ms. Mutebi will email me a copy of Resident A's weight records. Ms. Mutebi does not know anything about a vape found at home or anything about Resident C showing Resident A how to use a vape.

On 12/09/2025, I received and reviewed Resident A's weight records from Ms. Mutebi via email. Resident A moved in on 06/21/2025 and weighed 114.2 pounds. On 07/21/2025, Resident A weighed 116 pounds; on 08/20/2025, she weighed 118.3 pounds, on 09/21/2025. She weighed 128 pounds and on 10/22/2025, she weighed 146 pounds. According to these weight records, Resident A gained approximately 28 pounds between 08/20/2025-10/22/2025.

On 12/09/2025, I received the following email from Joanita Mutebi. "In regard to the phone call earlier, MTB does not hold any beds for anyone unless they are already a resident with us. Resident A's sister stating that she only paid to hold a bed sounded

very new to me. Stating that she never signed any of the documents. When she came to inspect the home, I was very clear about our charges which she agreed to, paid up to the few days that were remaining in June. I told her there could be some help if she signed up with any CMH which she was never interested in. I was only trying to share what I know about the mental health recipients. Resident A's sister told me Resident A has a spend-down which she (Resident A's sister) could not be billed on because she is not licensed and asked me to bill on it. This sounded strange due the fact that AFC homes are not allowed to bill Medicaid directly. I called Lansing to make sure this was acceptable and it was confirmed that the rules are the same; AFC Homes do not bill Medicaid directly. I called Resident A's sister back and told her what the response was. She told me that it did not make sense. She always sounded doubtful, but I was not ready to go against rules on billing. Resident A's sister then paid for the month of July without any complaints. She convinced me to reach out to Medicaid again, so I requested her to give me the case worker on Resident A's case, the case worker did not know how billing works. It felt like what she wanted must work out one way or the other. At this point I had nothing else to do about the issue. One weekend Resident A's sister called me and said Resident A had been qualified for straight Medicaid because she is in an AFC home, I was happy for her but now leaves me with a question; was this the motive behind enrolling her into our home. This is when Resident A's sister's attitude completely changed.

Resident A had no diet regulations during her stay with us. Resident A's sister dropped her off with just a few snacks, saying she loved those. A few days later, Resident A visited with multiple bags of groceries full of snacks. Told us her sister was okay to eat the snacks as a way of transitioning to a new environment; these instructions were given in front of the resident. Because it was a lot of snacks, I cleared out the top cabinets to create space for Resident A also alerting the caregivers to watch other residents not touch them, especially the one diabetic resident I was so concerned about. Yes, I noticed a change in Resident A's weight, and this was brought to Resident A's sister's attention in a phone call, but she stated we are not feeding her well, at this point I could not hold back - I asked her what she expected if she kept bringing her all the snacks. She shut off the conversation by saying the snacks will only be for a short while. Because I am not a dietician or a doctor, there was no way I could put the residents on strict diet. The very first day I took Resident A to her primary doctor's appointment I met Resident A's sister at the doctor's she ignored me the entire time until after the appointment she called me outside to tell me she would be bringing Resident A meals, and it was our responsibility to make sure that's all she ate. I told her that it would be fine with us, and we all departed. She brought Resident A prepacked meals enough for a few days, I called all the caregivers and told them about the changes in Resident A's meals. Then one day Resident A's sister brought a lot of food, it took up all the space in the refrigerator. Charlotte called and told me that Resident A's sister walked into the house with an attitude, but I instructed her to not say anything until I got to the house. With that amount of food, I called Resident A's sister and reminded her that the house is a shared living space, I told her it was unfair to the other residents whose families buy a few things that need refrigeration at this point I told her I am trying my best to accommodate most of what she wants but it is getting way beyond. She did

not sound pleased at all. I told her if she is to bring that much food plus snacks, it would be best to get Resident A her own refrigerator. I told her the refrigerator can be put in the basement and staff will be serving Resident A her meals at the time she wants. She did not want my suggestion either. Then last thing was to show up with police picking Resident A up from the house hence where we are now.

Resident A's sister dropped medications in non-labelled containers or sometimes with handwritten instructions and expected us to administer them to Resident A. I reached out to her and requested that all medications be brought in directly from the pharmacy if she did not want to use the house pharmacy. Resident A's sister was not pleased with that either. I told her that this is something we were not willing to compromise on. I told her the non-labelled medications would be available to take back whenever she passed by. Resident A's sister spent weeks without any visitations after being told that. Regarding the vape/smoking. This is something that I am hearing for the first time. For everyone who has ever interviewed, I asked if they smoked anything. I am not judging anyone that does but it is not a good fit for our space or at our premises. There has never been a smoking incident at our home. Resident A was always supervised, and I am hoping she is not trained to make false accusations."

On 12/15/2025, I emailed licensee designee Joanita Mutebi asking her if she discussed Resident A's almost 30-pound weight gain with Resident A's sister and Resident A's primary physician and if so, had she recorded these conversations.

On 12/16/2025, I received an email from Ms. Mutebi stating that she never recorded any phone calls she had with Resident A's sister and never got any opportunity to speak to Resident A's doctor because the one time she thought she would talk to the doctor was at the appointment but the conversation with the doctor never happened because Resident A's sister asked Ms. Mutebi to wait in the lobby.

On 12/16/2025, I received a telephone call from Resident A's sister/guardian seeking an update. I advised the sister/guardian that I was still investigating; however, I would be substantiating my findings thus far. The sister/guardian was upset that I would only be requesting a corrective action plan from licensee designee Joanita Mutebi and that I was not "shutting her down." I made several attempts to explain the AFC process to the sister/guardian, but she continued expressing her frustration with how Resident A was not cared for properly at this home. The sister/guardian stated that Resident A gained significant amount of weight because she was not fed properly and that she was unaware of the weight gain until she picked up Resident A from this home on 11/15/2025 and followed up with her doctor. The sister/guardian denied any conversation with Ms. Mutebi about Resident A's weight gain and confirmed that Ms. Mutebi waited in the lobby when she accompanied them to Resident A's doctor's appointment but stated that Ms. Mutebi never mentioned the weight gain to Resident A's sister/guardian nor to anyone at the doctor's office. Ms. Mutebi told Resident A's sister/guardian during one of their conversations that should Resident A's weight "fluctuates, it has to be reported." This never happened.

Resident A's sister/guardian stated she wanted to know what I would do about the vape that was found in Resident A's closet. This vape was found by the sister/guardian's husband when they were moving Resident A out of the home on 11/15/2025. The husband did not bring it to her attention until after getting back to the sister/guardian's home with Resident A. The sister/guardian and her husband began questioning Resident A about the vape and that's when Resident A disclosed that she was walking outside with another resident, without staff and the other resident found it on the ground and brought it inside the home. Then Resident C showed Resident A how to use the vape. I requested again to come out to her home so I can interview Resident A as the sister/guardian kept asking Resident A questions on the phone and Resident A would respond. I advised the sister/guardian that I cannot accept her interview and that I would like to speak with Resident A to get additional information about the vape. The sister/guardian declined. I advised her that I did not have enough information regarding the vape to state there were any rule violations since I was unable to interview Resident A. Again, she expressed her frustration and was not pleased with the potential outcome that this would only be a request for a corrective action plan. I again attempted to explain AFC's policy and that the department must allow the licensee designee to come into compliance with the rule violations and there was not enough to "shut her down." The sister/guardian stated she is not going to stop until Joanita Mutebi's group home is shut down.

On 12/17/2025, I received a telephone call from Karla Okaiye with Oakland County MDHHS regarding Resident A. Ms. Okaiye stated that the case was transferred in Joanita Mutebi's name after Resident A was placed in her care on 06/21/2025, but after reviewing Ms. Mutebi's provider ID, she was not authorized to receive home help services through MDHHS. There are issues between Resident A's sister/guardian and Joanita Mutebi that the sister/guardian reported to Ms. Okaiye. Resident A gained a significant amount of weight at this home because "Resident A was left to her own devices. No one was monitoring her." Other concerns reported were the vape around the house and a male resident that "comes and goes." Ms. Okaiye did not have further information, just what Resident A's sister/guardian reported to her. Resident A's sister/guardian stated she called Adult Protective Services (APS) and reported these issues to them.

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:	Based on my investigation and information gathered, licensee designee Joanita Mutebi did not complete the assessment plan dated 06/21/2025 with Resident A's designated representative, which is her sister/guardian. During Ms. Mutebi's interview on 11/25/2025, she stated that Resident A's sister/guardian never reported Resident A's limited upper extremities nor Resident A's incontinence. According to the assessment plan completed on 06/21/2025 assumed between Ms. Mutebi and Resident A's sister/guardian, the sister/guardian did report Resident A's needs. However, I interviewed Resident A's sister/guardian who confirmed that she did report Resident A's needs to Ms. Mutebi, but that she never completed nor signed the assessment plan. Resident A's sister/guardian stated the printed signature on the assessment plan was not signed by her as she would never print her name on a document. Resident A's sister/guardian emailed me a copy of her driver's license and the signature on her driver's license does not match the signature on the assessment plan. Ms. Mutebi denied forging Resident A's sister/guardian's signature and stated that the sister/guardian must have purposely printed her name because it was the sister/guardian's "strategy." Due to difference in the signatures, the assessment plan was not completed nor was it signed by Resident A's sister/guardian at the time of admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(8) A resident care agreement must be signed by all applicable parties. A copy of the signed resident care agreement along with copies of the policies listed in subrule (6) of this rule must be provided to the resident or the resident's designated representative and maintained in the resident's record.
ANALYSIS:	Based on my investigation and information gathered, Resident A's sister/guardian did not sign the resident care agreement (RCA) dated 06/21/2025 agreeing to the cost of care for Resident A. Licensee designee Joanita Mutebi stated she completed the RCA with Resident A's sister/guardian on 06/21/2025, at the time of admission and that the sister/guardian agreed to pay $1400 per month plus $115 per day for Resident

	A's care. The $1400 only covers room and board plus meals and the $115 per day covers personal care, supervision, and protection of Resident A. Resident A only receives about $1300 in social security disability; so Resident A would not be able to afford residing at this AFC home. In addition, Resident A's sister/guardian's name on the RCA did not match the sister/guardian's name on her driver's license. Therefore, Resident A's sister/guardian did not sign the RCA on 06/21/2025, nor did she receive a copy of the RCA informing her of the cost of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on my investigation and information gathered, licensee designee did not obtain immediate health care for Resident A when she gained 28 pounds between 08/20/2025-10/22/2025. Ms. Mutebi stated she discussed this weight gain with Resident A's sister/guardian who denied this conversation. Also, Ms. Mutebi stated she accompanied Resident A along with Resident A's sister/guardian to a doctor's appointment, but because the sister/guardian had Ms. Mutebi wait in the lobby, Ms. Mutebi never reported this sudden adverse change in Resident A's weight to her doctor or to anyone in the doctor's office. Neither the conversation with Resident A's sister/guardian about the weight gain nor the visit to the doctors was recorded by Ms. Mutebi.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff living in the basement and not supervising the residents.

INVESTIGATION:

On 12/08/2025, I interviewed Kenneth Mutebi regarding the allegations. Mr. Mutebi acknowledged that DCS Charlotte was living in the basement but then stated she had moved out. Charlotte moved in after Ms. Mutebi hired her. He has no other information.

On 12/08/2025, I interviewed Charlotte Natukunda regarding the allegations. She reported that when she worked during the midnight shifts, she would sleep when all the residents were sleeping including Resident A and then would periodically wake up to check on them. She would sleep in the living room, but this did not occur often.

On 12/08/2025, Ms. Mutebi stated that Charlotte moved in once she was hired in September 2025 but has since moved out in November 2025. She did not report this change to her assigned licensing consultant as she did not know she had to report this. I advised Ms. Mutebi that according to Charlotte, she was sleeping in the living room during her midnight shifts when all the residents were asleep. Ms. Mutebi did not know this was happening as she has trained all staff so that they must be awake during their working shifts. She will be advising all staff that they must stay awake during their shifts.

APPLICABLE RULE	
R 400.611	**Required information; fee; posting of license; change of information.**
	(4) An applicant or licensee shall give written notice to the department within 10 business days after a change occurs in information that was previously submitted in or with an application for a license.
ANALYSIS:	DCS Charlotte Natukunda was hired in September 2025 and at the time of her hire, she moved into this group home. Licensee designee Joanita Mutebi did not inform the department of this change within 10 business days of Charlotte moving in. Charlotte moved out on 11/04/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	During my interview with DCS Charlotte Natukunda on 12/08/2025, she disclosed that during the midnight shift she worked alone and at times, she would sleep in the living room when the residents were sleeping. Charloette stated this would not occur often, but that it did occur, and Residents A, B, and C would be left unsupervised.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the unannounced on-site investigation on 11/25/2025, I observed Resident B's prescription medication sitting in her bedroom on a chair. Ms. Joanita was not aware there was prescription medication in Resident B's bedroom. She went into Resident B's bedroom and retrieved the box of prescription medication and placed it in her possession. She was advised that all medications must be locked up unless a doctor has authorized the resident to take their medications unsupervised. She acknowledged.

On 12/02/2025, I received the following email from Joanita Mutebi. "When I asked Resident B how she got the patches in the room and never said anything, she stated she got them from her family. I reached out to the family (ex-sister)-in-law, she said yes, she gave them to her that morning and was okay with it. I needed to confirm because that is not part of her medications list. All medications are locked up in the medications box." I emailed Ms. Mutebi back advising her that all medications must be prescribed by Resident B's physician and on the medication log. She emailed back stating, "The resident said she doesn't need them. So, I requested family to take them back because they are not necessary. Sister-in-law is to take them back tomorrow, Resident says she is okay without them. And more emphasis has been made to declare everything they buy the resident especially over the counter medications, any supplements or anything herbal etc."

On 12/22/2025, I conducted the exit conference with licensee designee Joanita Mutebi via telephone with my findings. Ms. Mutebi agreed to submit an acceptable corrective action plan and did not have any questions.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(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.
ANALYSIS:	Resident B's pain patch prescription medication was not in a locked cabinet as I observed it sitting on Resident B's chair in her bedroom during my unannounced on-site investigation on 11/25/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

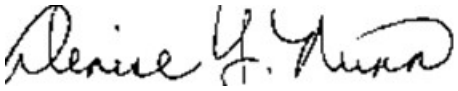
IV. RECOMMENDATION

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

12/22/2025

Frodet Dawisha — Date
Licensing Consultant

Approved By:



12/23/20225

Denise Y. Nunn — Date
Area Manager