GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 24, 2026

Nakia Woods
Iyana's A.F.C. INC.
1117 Adams
Saginaw, MI 48602

RE: License #: AS730398654
Investigation #: 2026A0572037
Iyana's A.F.C. INC.

Dear Nakia Woods:

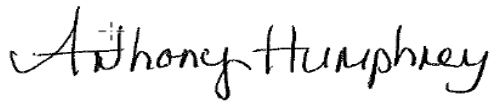
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730398654
Investigation #:	2026A0572037
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	05/29/2026
Report Due Date:	07/27/2026
Licensee Name:	Iyana's A.F.C. INC.
Licensee Address:	1117 Adams Saginaw, MI 48602
Licensee Telephone #:	(989) 401-2290
Administrator:	Nakia Woods
Licensee Designee:	Nakia Woods
Name of Facility:	Iyana's A.F.C. INC.
Facility Address:	1117 Adams Saginaw, MI 48602
Facility Telephone #:	(989) 401-2290
Original Issuance Date:	08/13/2020
License Status:	REGULAR
Effective Date:	02/13/2025
Expiration Date:	02/12/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
There are concerns with medication and whether the residents take them. Resident A meds on were observed on nightstand and staff were not observing Resident A taking their meds.	No
There are concerns about cleanliness of the bathroom in the home.	No
There's a limited food variety with nothing but starchy foods.	No
The phone had been off for about 3 or 4 days, which prevented residents from having access to a phone.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A0572037
05/29/2026	Special Investigation Initiated - Telephone I contacted case manager Hope Oliver.
06/01/2026	APS Referral APS made referral.
06/26/2026	Contact - Face to Face Case Manager's Hope Oliver and Alicia Wood.
07/07/2026	Inspection Completed On-site Staff Ronda Tyler and Resident B.
07/22/2026	Contact - Face to Face Staff, Tonya Bennett and Resident C.
07/22/2026	Contact - Face to Face Resident D
07/22/2026	Contact - Face to Face Resident E.
07/22/2026	Contact - Telephone call made Licensee Designee, Nakia Woods.
07/22/2026	Contact - Telephone call made

	Staff, Richard Long.
07/22/2026	Contact - Telephone call made Resident A's Guardian.
07/22/2026	Exit Conference Licensee Designee, Nakia Woods.
07/23/2026	Inspection Completed-BCAL Sub. Compliance
07/24/2026	Exit Conference Licensee Designee, Nakia Woods.

ALLEGATION:
There are concerns with medication and whether the residents take them. Resident A meds on were observed on nightstand and staff were not observing Resident A taking their meds.

INVESTIGATION:
On 05/28/2026, the local licensing office received a complaint for investigation. Adult Protective Services (APS) also made a referral to licensing on 06/01/2026.

On 05/29/2026, contact was made by Licensing Consultant, Cynthia Badour to initiate the investigation. Cynthia Badour contacted the referral source for additional information.

On 06/26/2026, I met with Resident A's Case Manager, Hope Oliver and Resident E's Case Manager, Alicia Wood.

On 06/26/2026, I interviewed Resident A's Case Manager, Hope Oliver regarding the allegation. She informed me that Resident A is currently in the hospital and there's an upcoming guardianship hearing on 06/30/2026. Hope Oliver informed that she made a visit to the home, and observed staff, Richard Long laying medications on the dining room table in the front area of the home. Resident A picked up the medication and walked towards the kitchen, which is located in the back of the home. It's her assumption that she went to get some water to swallow her medications. There were pills on the table. When she asked Resident A about those pills, she said, "Oh, I take those separately." Then she took those pills to the kitchen. Staff never followed her to the kitchen to see if she took the medication. When Hope Oliver went into Resident A's bedroom, there were two additional pills lying on the nightstand. She is not aware of what kind of pills these were. When she went to visit Resident A again, the pills were gone.

On 07/07/2026, I made an unannounced onsite at Iyana's AFC home, located in Saginaw County Michigan. Present for an interview were, Staff Ronda Tyler and Resident B. Resident A was in the hospital, and the other residents were at program.

On 07/07/2026, I interviewed Staff, Ronda Tyler regarding the allegation. Ronda Tyler informed that when she works, all the residents sit at the front table when she administers medications so she can watch them take their meds. Each resident will go in the kitchen and get their water and then they give them their meds. She informed that this is how all staff are trained to do it in this home.

On 07/07/2026, I reviewed Resident A's medication administration record (MAR). The MARs appeared to be accurate. I asked Ronda Tyler about the (R) initials, and she informed me that those are refusals.

On 07/07/2026, I interviewed Resident B regarding the allegation. Resident B informed that staff administers his medications and he received them today. Resident B says that he received his medication in his bedroom and informed that staff do not watch him take his medication.

On 07/07/2026, I went into Resident A's bedroom and found it to be very clean, and I did not observe any loose pills anywhere in the room.

On 07/22/2026, I made another unannounced onsite at Iyana's AFC Home and interviewed Staff, Tonya Bennett and Resident C.

On 07/22/2026, I interviewed Staff, Tonya Bennett regarding the allegation. She informed that she administers the resident's medications at the table and observes them take their medications because anything could happen, like a pill could drop on the floor. Tonya Bennett denies ever seeing any pills lying around on a table or nightstand. She showed me the key to the medications, and she had it on her person and showed me that the door to the medication was locked.

On 07/22/2026, I interviewed Resident C regarding the allegation. Resident C informed that she takes medications at the front table and that staff administers them to her. The residents all get their own cup of water and come back and take their medications in front of the staff member. She informed that all staff observe the residents taking their medications.

On 07/22/2026, I met with Resident D at her program. I interviewed Resident D regarding the allegation. She informed that all the residents sit at the dining room table in the front room, and the staff make sure that they all take their medications. She informed me that Resident A also took her medications at the table. Resident D informed that the only medication that is not administered at the table is Resident B when he gets his insulin shot in his bedroom.

On 07/22/2026, I went across the parking lot to meet with Resident E at his program. I interviewed Resident E regarding the allegation. Resident E informed that he takes his medications in the front room at the table and the staff watch them take their medications. He's never seen any residents, not take their medications in front of staff.

On 07/22/2026, I interviewed Licensee Designee, Nakia Woods regarding the allegation. Nakia Woods informed that Resident A is known for spitting out her medications or refusing them. There was some obvious tension between Resident A and Staff, Richard Long, but he was trained to administer medications and does not see him not watching Resident A or any other residents not taking their meds.

On 07/22/2026, I interviewed Staff, Richard Long regarding the allegation. Richard Long does not recall this incident occurring. Staff Long informed that Resident A goes into the kitchen to get her water and then comes back to take her medication in the front room, where he observes her. Resident A will refuse her pain medications because they make her mouth feel chalky, so he does not make her take them and indicate it in the med sheet. Resident A will sometimes try to refuse all the medications, but he is always able to encourage her to take the other medications by telling her that these medications are to keep her balanced.

On 07/22/2026, I interviewed Resident A's Guardian regarding the allegation. She informed me that she is not sure if medications are being administered or not. She can only go by what she heard from the case manager and what she observed or what Resident A tells her.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(3) Giving, taking, or applying of prescription medications must be supervised by a licensee, administrator, or direct care staff unless otherwise directed by an appropriately licensed health care professional in writing.
ANALYSIS:	Based on my interviews with staff, residents, case managers, Guardian, and review of Resident A's file, there is not enough to establish a licensing rules violation. The Case Manager stated she witnessed Resident A take her medication to the kitchen and take them, then came back in the front room where she took her other medications that were on the table. All residents except for Resident E, and two of the staff informed that the

	residents go to the kitchen to get their water and return to take their medications in the front room with staff observing. Resident E takes insulin in his bedroom.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
There are concerns about cleanliness of the bathroom in the home.

INVESTIGATION:
On 06/26/2026, I met with Resident A's Case Manager, Hope Oliver and Resident E's Case Manager, Alicia Wood.

On 06/26/2026, I interviewed Resident A's Case Manager, Hope Oliver regarding the allegation. She informed me that she has never seen the bathroom in the home and does not know where it is located.

On 06/26/2026, I interviewed Resident E's Case Manager, Alicia Wood regarding the allegation. She has never seen the bathroom and never heard any of the residents complain about the bathroom being dirty.

On 07/07/2026, I made an unannounced onsite at Iyana's AFC home, located in Saginaw County Michigan. I interviewed Staff Ronda Tyler and Resident B.

On 07/07/2026, I interviewed Staff, Ronda Tyler regarding the allegation. Ronda Tyler denies that the bathroom is ever left dirty and showed me both bathrooms in the home. The downstairs bathroom was clean but had a slight paint peel at the bottom wall, near the shower. The upstairs bathroom was also very clean.

On 07/07/2026, I interviewed Resident B regarding the allegation. Resident B informed that the bathroom is always clean to him. He's never seen it dirty.

On 07/22/2026, I made another unannounced onsite at Iyana's AFC Home and interviewed Staff, Tonya Bennett and Resident C.

On 07/22/2026, I interviewed Staff, Tonya Bennett regarding the allegation. She informed me that the bathrooms are always clean because the residents have chores. Each resident that's physically capable of doing chores is assigned a chore for each day. If the residents don't do a good job, then the staff should be going right behind them to clean it. Tonya Bennett informed that she did the bathrooms today. I observed both bathrooms and they appeared to be clean as they were in my previous onsite visit.

On 07/22/2026, I interviewed Resident C regarding the allegation. Resident C informed that the bathrooms are normally clean. The residents have daily chores which are part of their therapy in order to one day get back out on their own to live independently.

On 07/22/2026, I met with Resident D at her program. I interviewed Resident D regarding the allegation. Resident D informed that the bathrooms are always clean. Each resident who is capable of having chores, may have a day on which they have to clean the bathroom. The bathroom is always clean when a resident or a staff cleans it.

On 07/22/2026, I went across the parking lot to meet with Resident E at his program. I interviewed Resident E regarding the allegation. Resident E informed that each resident has chores, except for the ones who are not capable of completing chores. They all make sure that the bathroom is clean. Resident E explained that chores are part of their plan so they can eventually become independent. He informed me that the next step for him is a semi-independent home.

On 07/22/2026, I interviewed Licensee Designee, Nakia Woods regarding the allegation. Nakia Woods informed me that her bathrooms are always clean. She assumes that because Resident B has a portable commode that has to be dumped, that maybe someone came in after it was dumped and saw feces smeared on seat or went in right after someone came out. But if they see it, they will clean it and disinfect it.

On 07/22/2026, I interviewed Staff, Richard Long regarding the allegation. Richard Long informed that the bathrooms are always clean and that either he or one of the residents will clean the bathrooms as it is part of their chore plan for their step towards independence.

On 07/22/2026, I interviewed Resident A's Guardian regarding the allegation. She informed me that there had been some concerns about the bathroom not being clean and there was also a time when the Nakia Woods was going to give Resident A a shower, but the shower head was not working properly. It appeared to have just happened. There was water coming out, but it lacked pressure.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Based on my interviews with staff, residents, case managers, Guardian, there is not enough to establish a licensing rule violation. Both times I went home, both bathrooms were very clean. The Guardian informed me that there was an issue of the bathroom not being cleaned. Staff and all residents interviewed informed that the bathrooms are always cleaned and never left dirty.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
There's a limited food variety with nothing but starchy foods.

INVESTIGATION:
On 06/26/2026, I met with Resident A's Case Manager, Hope Oliver and Resident E's Case Manager, Alicia Wood.

On 06/26/2026, I interviewed Resident A's Case Manager, Hope Oliver regarding the allegation. Hope Oliver has not observed what food is being served, except for breakfast, so she doesn't know if they have a variety or if they are all starchy foods.

On 06/26/2026, I interviewed Resident E's Case Manager, Alicia Wood regarding the allegation. Alicia Wood is not sure what food is in the home as her client (Resident E) has his own money and buys his own food. When she first moved her client there, she saw a menu, but she hasn't looked at it since then.

On 07/07/2026, I made an unannounced onsite at Iyana's AFC home, located in Saginaw County Michigan. I interviewed Staff Ronda Tyler and Resident B.

On 07/07/2026, I interviewed Staff, Ronda Tyler regarding the allegation. Ronda Tyler informed that there is plenty of food and they have a variety. The residents are eating burgers and fries today and a slice of watermelon. I observed plenty of food in both refrigerators/freezers, cabinets and pantry.

On 07/07/2026, I interviewed Resident B regarding the allegation. Resident B informed that they have a good selection of food in the home and says that they eat very good there.

On 07/22/2026, I made another unannounced onsite at Iyana's AFC Home and interviewed Staff, Tonya Bennett and Resident C.

On 07/22/2026, I interviewed Staff, Tonya Bennett regarding the allegation. Tonya Bennett informed that the residents always get fed a good meal and informed that both refrigerators/freezers are full of food. Tonya Bennett showed the refrigerators/Freezers, pantry and a monthly menu.

On 07/22/2026, I interviewed Resident C regarding the allegation. Resident C informed that the food is decent but wishes that they have more variety. The residents sometimes tell the staff what they want to eat, and they'll make it for them. Resident C informed that they don't have a menu posted. When asked about Resident A, she informed me that Resident A was in the hospital and not in her right mind. She would go wandering off and she would make up false claims.

On 07/22/2026, I met with Resident D at her program. I interviewed Resident D regarding the allegation. They have a variety of food in the home. There's a menu in the kitchen and they can ask staff what they're cooking for meals. When asked about Resident A, she informed that Resident A went to the hospital and after an evaluation it was determined that she needed 1-on-1 services because she would wander off. Resident A would also make things up.

On 07/22/2026, I went across the parking lot to meet with Resident E at his program. I interviewed Resident E regarding the allegation. Resident informed that they have enough food in the home and there's a variety. There's a calendar in the kitchen that they can look at to see what they're eating for the day, or they can just ask staff. When asked about Resident A, he informed me that Resident A used to keep up a lot of chaos in the home by making things up. Resident A also used to wander off a lot.

On 07/22/2026, I interviewed Licensee Designee, Nakia Woods regarding the allegation. Nakia Woods informed that they have a variety of foods, so they are not eating the same thing each day. Resident A has some mental health issues and has mead several complaints.

On 07/22/2026, I interviewed Staff, Richard Long regarding the allegation. Richard Long says that there's a variety of meals and the menus are near the microwave. He informed that sometimes they may switch up the meal for the day to give the residents something different.

On 07/22/2026, I interviewed Resident A's Guardian regarding the allegation. Resident A's Guardian is not sure if all the foods are starchy. She informed me that she doesn't really know what is being implied. She suggests maybe they're saying that they are being served all carbs, but she did not know because she hasn't observed it.

On 07/23/2026, I reviewed Resident A's service plan, and it indicates that she has impaired judgement and a lack of understanding that causes her to demonstrate an unwillingness to voluntarily participate or adhere to treatment that is necessary.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based on my interviews with staff, residents, case managers, Guardian and review of Resident A's file, there is not enough to establish a licensing rules violation. I observed food menus posted and there was a variety of food. Staff and Residents appeared to be pleased with the variety of food, except for Resident C. But Resident C also informed that they can ask staff if they could change what's on the menu and staff will do it.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
The phone had been off for about 3 or 4 days, which prevented residents from having access to a phone.

INVESTIGATION:
On 06/26/2026, I met with Resident A's Case Manager, Hope Oliver and Resident E's Case Manager, Alicia Wood.

On 06/26/2026, I interviewed Resident A's Case Manager, Hope Oliver regarding the allegation. Hope informed that she normally has issues with the home not picking up the phone as nobody normally answers the phone.

On 06/26/2026, I interviewed Resident E's Case Manager, Alicia Wood regarding the allegation. Alicia Wood informed that there have been times when she has called and the phone was disconnected.

On 07/07/2026, I made an unannounced onsite at Iyana's AFC home, located in Saginaw County Michigan. I interviewed Staff Ronda Tyler and Resident B.

On 07/07/2026, I interviewed Staff, Ronda Tyler regarding the allegation. Ronda Tyler informed that they are live-in staff and they each work 15 days straight. During the time she was working the phone was back on. The phone may have been off because it's connected to the internet. She is unaware as to why the phone would be off.

On 07/07/2026, I interviewed Resident B regarding the allegation. Resident B says the phone was off but doesn't know for how long. Resident B indicated that another resident had taken the phone off the receiver and never put it back on. Resident B

does not know if it had anything to do with the bill. Resident B says that this has happened before because the phone was not hung up to charge.

On 07/22/2026, I made another unannounced onsite at Iyana's AFC Home and interviewed Staff, Tonya Bennett and Resident C.

On 07/22/2026, I interviewed Staff, Tonya Bennett regarding the allegation. Tonya Bennett does not know about the phone not working and informed that the phone is working now.

On 07/22/2026, I interviewed Resident C regarding the allegation. Resident D informed that the phone was off because the bill had to be paid, but it was paid that day. It wasn't off for several days. She informed me that sometimes the phone just doesn't get answered, but the phone is normally always on.

On 07/22/2026, I met with Resident D at her program. I interviewed Resident D regarding the allegation. Resident D informed that the phone has been off a couple times due to the phone bill not being paid.

On 07/22/2026, I went across the parking lot to meet with Resident E at his program. Resident E informed that the phone has been off a few times because the bill was not paid.

On 07/22/2026, I interviewed Licensee Designee, Nakia Woods regarding the allegation. Nakia Woods informed that this is false as Resident A took the phone in her bedroom, lost it and the battery died. She texted Resident A's Guardian and informed her that the battery had died. She also informed me that the house number had changed at one point and didn't have the correct number.

On 07/22/2026, I interviewed Staff, Richard Long regarding the allegation. Richard Long denies that the house phone was ever turned off.

On 07/22/2026, I interviewed Resident A's Guardian regarding the allegation. Resident A's Guardian had concerns regarding the phone being off several times because Resident A has been in the hospital multiple times and when the hospital is ready to discharge, they are unable to contact the home, so they would have to contact her. She was told that one of the times, the phone was found in Resident A's bedroom, and the battery had died and there was another time in which the phone number had changed, but she wasn't aware.

On 07/24/2026, I reviewed a text message between Licensee Designee, Nakia Wood and Resident A's Guardian explaining that the phone was in Resident A's bedroom and the battery died.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(e) Have reasonable access to a telephone for private communications, but a licensee may charge a resident for the cost of long-distance telephone calls.**
ANALYSIS:	Based on my interviews with staff, residents, case managers, Guardian and review of text messages, there is enough to establish a licensing rules violation. In speaking with the case managers and the Guardian, they express some difficulties in getting in contact with the home. I received mixed responses from residents regarding the phone. There is evidence that the phone battery had died, leaving some of the residents' contacts unable to contact them and one of the residents informed that the phone is not always answered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:
There are no employees listed on the Workforce background Check for this home.

INVESTIGATION:
On 07/07/2026, I reviewed the Workforce background Check and did not see any staff listed for Iyana's AFC home.

On 07/22/2026, I spoke with Licensee Designee, Nakia Woods regarding the additional findings. She informed me that I had mentioned this to her a while ago and totally forgot to take care of this. She informed me that she would take care of this right away. I will send her a link with instructions on how to add employees.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ

	or independently contract with an individual who has direct access to residents until the adult fostercare facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on my review of the workforce background check, there's enough evidence to establish a licensing rules violation. There were no staff listed in the workforce background check.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/22/2026, and 07/24/2026, an exit conference was held with Licensee Designee, Nakia Woods. Nakia Woods was informed of the results of this special investigation.

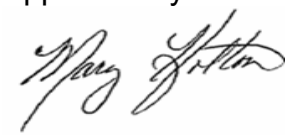
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 3-6).

07/24/2026

Anthony Humphrey — Date
Licensing Consultant

Approved By:



07/24/2026

Mary E. Holton — Date
Area Manager