GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 3, 2025

Fatima Mayo
813 S. Bond St.
Saginaw, MI 48601

RE: License #: AS730409293
Investigation #: 2025A0623047
A Place Called Home 2

Dear Fatima Mayo:

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.
- Be signed and dated.

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(517) 648-8877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730409293
Investigation #:	2025A0623047
Complaint Receipt Date:	08/18/2025
Investigation Initiation Date:	08/19/2025
Report Due Date:	10/17/2025
Licensee Name:	Fatima Mayo
LicenseeAddress:	813 S. Bond St. Saginaw, MI 48601
Licensee Telephone #:	(989) 482-8989
Administrator:	Fatima Mayo
Licensee Designee:	N/A
Name of Facility:	A Place Called Home 2
Facility Address:	2810 Hampshire Saginaw, MI 48601
Facility Telephone #:	(989) 482-8989
Original Issuance Date:	09/22/2021
License Status:	REGULAR
Effective Date:	03/22/2024
Expiration Date:	03/21/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 08/15/2025, Resident A was found deceased in the AFC home with no staff present.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/18/2025	Special Investigation Intake 2025A0623047
08/19/2025	APS Referral APS complaint was completed.
08/19/2025	Special Investigation Initiated - Telephone I contacted APS worker Jessire Ramos
08/21/2025	Inspection Completed On-site Observation and interviews.
08/22/2025	Contact - Telephone call made I contacted Licensee Fatima Mayo.
08/25/2025	Contact - Telephone call made I contacted Randy Pfau from the Saginaw County Medical Examiner's Office.
08/25/2025	Contact - Document Received Received Case 25-927-73 report from Saginaw County Medical Examiner's Office.
08/26/2025	Contact – Document Received Saginaw Police Report #25-4667
08/26/2025	Contact - Document Received I received AFC documents.
08/27/2025	Contact – Telephone call made I contacted APS worker Jessire Ramos
08/28/2025	Contact - Document Received I received AFC documents.
08/28/2025	Contact – Telephone call made

	I contacted Paramedic Sheldon Perrou
09/03/2025	Contact - Telephone call made I contacted Licensee Fatima Mayo.
09/11/2025	Contact – Document Received. I received an email from APS worker Jessire Ramos.
09/22/2025	Contact - Face to Face I attempted contact with residents at A Place Called Home 2.
09/30/2025	Contact - Document Received I received an email from Licensee Fatima Mayo.
09/30/2025	Contact - Telephone call made I attempted to call volunteer Donte Davis.
09/30/2025	Exit Conference I conducted an exit conference with Licensee Fatima Mayo.
09/30/2025	Inspection Completed-BCAL Sub. Non-Compliance
10/03/2025	I reviewed the Workforce Background Check website for the facility, A Place Called Home 2.

ALLEGATION:
On 08/15/2025, Resident A was found deceased in the AFC home with no staff present.

INVESTIGATION:
On 08/19/2025, I completed an Adult Protective Service (APS) complaint. I shared information with APS.

On 08/19/2025, I contacted APS worker Jessire Ramos. APS Ramos stated that she interviewed staff Daisy Sherman who told her that she was not on the schedule for Saturday night. APS Ramos stated that Staff Sherman told her that she heard other staff in the house, did not see the staff, just heard voices and left the home. APS Ramos stated that Staff Sherman said she did not tell anyone she was leaving the home and didn't know who was supposed to be working. APS Ramos stated that Staff Sherman told her that when she returned to the AFC home, no one was there and later both Resident B and Resident C returned to the home. APS Ramos stated that staff Sherman said she is aware staff are not allowed to leave the home unless there is staff to replace them, and staff are not allowed to sleep while caring for the residents.

On 08/21/2025, I conducted an unannounced onsite inspection of A Place Called Home 2. I interviewed Resident B, Resident C and staff Daisy Sherman.

On 08/21/2025, I interviewed Resident B in his bedroom, which he shared with the now deceased Resident A. I observed Resident B appeared clean, neatly groomed and dressed. Resident B appeared alert and oriented to person, place, time and situation. Resident B stated he is his own guardian, however, has a payee. Resident B stated that he came into the room he shares with Resident A and noticed that Resident A was lying back in the bed (hospital bed), and his mouth was wide open. Resident B stated that Resident A appeared fine earlier that day. Resident B stated that he was concerned and used the house phone to call 911. Resident B stated that the ambulance came and so did the police. Resident B stated that there are no staff at the home at night. Resident B stated that sometimes staff Daisy will spend the night, but she is in the basement when she does. Resident B stated that there were no staff upstairs when Resident A had to go to the hospital, he and Resident C also went to the hospital because there were no staff in the home. Resident B stated that he talked to the doctor at the hospital and told him that he wanted to go back home, so they let him and Resident C go back home.

On 08/21/2025, I interviewed Resident C in his bedroom. Resident C appeared clean, neatly groomed and dressed. Resident C appeared alert and oriented to person, place and time. Resident C stated that he can make his own decisions but has a payee for his money. Resident C stated that an ambulance came for Resident A and took him and Resident B to the hospital too. Resident C stated that they have lived at the home for almost 2 months and there are no nighttime staff at the home. Resident C stated that he likes the home and wants to stay. Resident C stated that Resident A appeared okay earlier in the day.

On 08/21/2025, I interviewed staff Daisy Sherman. Interview of staff Daisy Sherman. Staff Sherman stated that she was in the home that night sleeping in the basement. I observed the basement with a mattress and box spring pushed up against the wall. Staff Sherman stated that she keeps sheets up in the ceiling or in a storage container in a separate room. Staff Sherman stated that she was at the home in the basement and believed that Donte (Davis) was upstairs from 4pm-8pm. Staff Sherman stated that she was downstairs sleeping and usually has her headphones on. Staff Sherman stated that she knows that there must be staff that are not sleeping in the home to care for the residents and stated she understood she is in trouble, however she would not like to get fired. Staff Sherman stated that licensee Fatima Mayo knows that she sleeps in the basement.

Staff Sherman further stated that she does not have any days off and no other are scheduled to replace her. Staff Sherman stated that Donte' Davis may come to fill in however he is not on the schedule. Staff Sherman stated she does not have Donte Davis's phone number. Staff Sherman stated that she calls Fatima Mayo if she needs her to call someone to cover for a few hours. Staff Sherman stated that she

came upstairs later that evening and saw there were no residents at home, so she called Fatima Mayo. Staff Sherman stated that Fatima Mayo got a call from the hospital that they were there. Staff Sherman stated that she opened the door for Residents B and C when they came home from the hospital which was after 11pm. Staff Sherman stated that she interacted with Resident A earlier in the day and he was laughing and watching TV.

On 08/22/2025, I contacted Licensee Fatima Mayo. I discussed the allegation. I discussed staffing requirements. Requested documents. Licensee Mayo stated that staff Daisy Sherman was scheduled to be at the home. I requested documents including an August staff schedule.

On 08/25/2025, I contacted the Saginaw County Medical Examiner's Office. I spoke with the office manager/operations, Randy Pfau. Randy Pfau stated that on examination of Resident A, there were no indication of trauma, abuse or neglect. Randy Pfau stated that the concern was that there was no staff in the AFC home, so for safety the other 2 residents were taken to Covenant Hospital, evaluated and discharged back to the facility with proper staff supervision.

On 08/25/2025, I received and reviewed the report Case 25-927-73, from the Saginaw County Medical Examiner's Office. A follow up with the witness statement with Licensee Fatima Mayo stated she stated that a Daisy person was at the residence the whole night. Per the Police Department, Mobile Medical Response (MMR) and the Saginaw County Medical Examiner Investigator, there were no workers present the whole time so 2 other residents were transported to ER via MMR which she stated she was unaware of.

On 08/26/2025, I received a copy of the Saginaw Police complaint #25-4667. Responding Officer Elisha Schaaf noted that they took a statement from witness (Resident B). Resident A was last seen around 5:00 pm when Resident B brought him his dinner. He didn't appear sick or in pain. Resident B left to go down the street and Resident A was in bed watching TV. When Resident B returned a couple of hours later, he found Resident A unresponsive in his room. Resident B then called 911. Resident B stated staff Daisy was supposed to come in and work today, but she didn't come. Resident B stated a younger, black man came in to work for her but left at 3:00 pm. Resident B stated that staff usually leaves them alone at 8:00 pm every night

On 08/26/2025, I received and reviewed AFC documents.
Incident Report for 8/15/2025, no person directly involved written on form, no time written on form and no location written on form. Resident B and Resident C, and staff Daisy Sherman. Staff came up to check on residents/round check noticing the home was clear staff contacted homeowner seeking assistance/information. Contacted Homeowner (Fatima Mayo). Signed by staff Daisy Sherman on 8-15-2025 and homeowner Fatima Mayo on 8-16-2025.

Incident Report for 8/15/2025 9:00 pm. Bedroom. Resident A and Resident B. Resident B came back after having gone for a family gathering when he made it to his room, he discovered his roommate was deceased instead of notifying staff resident said he panicked without looking for staff and called 911. Notified homeowner Fatima Mayo on 8-15-2025 9:35 pm. Signed by Staff Daisy Sherman 8-15-2025 and homeowner Fatima Mayo on 8-16-2025.

Resident A's health care appraisal dated 04/04/2025. Resident A was born on 10/20/1955 which made him 69 years old. Resident A has a history of schizophrenia, high blood pressure, type 2 diabetes, major depression and bipolar.

Resident A's Assessment Plan was reviewed and is dated 01/01/2025. Resident A uses a walker or cane and can ambulate a short distance and requires light assistance with bathing. Resident A's medication log for August 2025 was reviewed. I observed that Resident A received his medication as prescribed.

On 08/27/2025, I contacted APS Jessire Ramos. APS Ramos stated that she talked with Fatima Mayo and was told that staff Daisy Sherman was there the whole night. APS Ramos stated that she has contacted the residents' case managers to notify them that she is substantiating against Daisy Sherman and Fatima Mayo for neglect as there were no staff working the 3rd shift. APS Ramos stated that both residents wanted to stay in the home, the home was clean, residents were clean, they had food, and there were active utilities.

On 08/28/2025, I received and reviewed AFC documents.
I received a written statement from Licensee Fatima Mayo dated and signed on 08/26/25.
This statement is regarding the incident which occurred at 2810 Hampshire on August 15, 2025. I was informed of the incident via telephone. Daisy left me a message on my cell phone around 11:30pm which a listened to the next morning at approximately 8:30 AM. I was informed of the death of (Resident A).

I received an August Staff Schedule for a Place Called Home 2.
Due to Daisy being a live in staff and this home being a family licensed home: Usually the clients attend Friends for Recovery Monday thru Friday so therefore Daisy is allowed to leave while they attend Friends. 1st shift, 2nd shift, and 3rd shift August Schedule 2025.
Staff Daisy Sherman is the only listed staff except for Fatima Mayo is on call as needed by Daisy. Signed by Fatima Mayo and dated 08/26/2025.

On 08/28/2025, I contacted Mobile Medical Response (MMR) Paramedic Sheldon Perrou. Paramedic Perrou stated that he was at the AFC home with police and Medical Examiner investigator Bobby Knake. Paramedic Perrou stated that they all checked the house, basement and garage and there were no staff at the home. Paramedic Perrou stated that they took the decedent, the two residents, to the

hospital to be evaluated because they did not want to leave them in the home without supervision.

On 09/03/2025, I contacted Licensee Fatima Mayo. I discussed that the home is not licensed as a family home but as a small group home. I discussed the home is licensed for 4 residents with 1 staff present and awake during all shifts. Licensee Mayo stated she intends to hire more staff.

On 09/11/2025, I received an email from APS worker Jessire Ramos. APS worker Ramos has closed out her case and substantiated for neglect.

On 09/22/2025, I attempted an unscheduled face to face with residents of A Place Called Home 2. No one appeared to be at home at midday, however that would not be unusual as they attend day programs and have community access as they are their own guardian.

On 09/30/2025, I received an email from Licensee Fatima Mayo. Licensee Mayo stated that Donte Davis works as a volunteer as needed when she is unavailable. Licensee Mayo stated in 2025 he worked on 01/23/2025-01/26/2025 morning shift and again 08/15/2025 from 4pm-8pm. Since the incident Donte Davis has not been back to volunteer.

On 09/30/2025, I attempted to contact Donte Davis by phone number provided by Licensee Fatima Mayo. The phone number is a non-working number.

On 09/30/2025, I conducted an exit conference with Licensee Fatima Mayo. I explained my investigation and findings. I explained due to the seriousness of the findings I will be recommending placing the home on a 6-month provisional license, with a detailed corrective action plan completed by Licensee Mayo to address these deficiencies. Licensee Mayo stated that she understood and would contact this consultant if she had further questions.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.

ANALYSIS:	Allegation stated that on 08/15/2025, Resident A was found deceased in the AFC home with no staff present. I conducted interviews with Resident B, Resident C, Paramedic Sheldon Perrou, staff Daisy Sherman, and Licensee Fatima Mayo. I obtained and reviewed documentation from the Saginaw County Medical Examiner's office and the City of Saginaw Police Department. I consulted with APS worker Jessire Ramos. According to the evidence obtained during this investigation involving interviews and documentation, there were no staff present at A Place Called Home 2 when Resident A passed away. Resident B called 911 when he noticed Resident A was not breathing. EMS, Law Enforcement and the Medical Examiner's office attempted to locate staff, however, were unable and had Resident B and Resident C transported to the hospital for evaluation. Resident B and Resident C are their own guardians and indicated to hospital staff they wanted to return to the home, so they were transported back to the home. Staff Daisy Sherman was back at the home when they returned. Licensee Fatima Mayo stated that Daisy Sherman was supposed to be at the house and then stated that a volunteer by the name of Donte Davis was there until 8:00 pm. Staff Daisy Sherman stated that she left the home because she thought she heard other staff at the home, however she did not check to be sure and just left the home. I attempted to contact Donte Davis; however, it was unsuccessful. APS substantiated their case for neglect. APS notified the remaining residents' case managers of their findings. The remaining residents are their own guardians and at their request are staying at the home. I conclude there is enough evidence to substantiate this violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A passed away at A Place Called Home 2 with no staff present. Resident B noticed that Resident A was not breathing and called 911. Residents disclosed to the first responders that there were no staff currently in the home and the first responders found no staff when they searched the home. Staff were not available to provide the personal care, supervision and protection required, leaving the residents vulnerable and severely affecting the residents' quality of care. I conclude there is enough evidence to substantiate this violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Fingerprint requirements were not completed for staff.

INVESTIGATION:
On 10/03/2025, I reviewed the Workforce Background Check Website for the facility, A Place Called Home 2. There are currently no staff listed under this home in the system. A profile was created for Daeshanae "Daisy" Sherman on 08/21/2024, however, she was never fingerprinted, and the application was withdrawn on 10/09/2024. Volunteer Donte Davis was working alone without another staff present so he would need to be background checked. Donte Davis would not be considered a volunteer as he is the only staff onsite during a shift.

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 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. Ifan 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:	On 10/03/2025, I reviewed the Workforce Background Check Website for the facility, A Place Called Home 2. There are currently no staff listed under this home in the system. A profile was created for Daeshanae “Daisy” Sherman on 08/21/2024, however, she was never fingerprinted, and the application was withdrawn on 10/09/2024. Volunteer Donte Davis was working alone without another staff present, so he would need to be background checked. Donte Davis would not be considered a volunteer as he was the only staff onsite during a shift. I conclude there is enough evidence to substantiate this violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

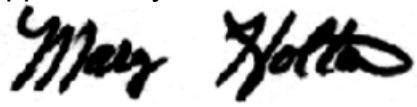
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend a modification of the license to provisional status due to willful and substantial staffing and quality of care violations.

10/03/2025

Cynthia Badour Date
Licensing Consultant

Approved By:



10/03/2025

Mary E. Holton Date
Area Manager