GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 8, 2021

Fatima Mayo
813 S. Bond St
Saginaw, MI 48601

RE: License #: AS730409293
Investigation #: 2022A0871004
A Place Called Home 2

Dear Ms. 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.
- 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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730409293
Investigation #:	2022A0871004
Complaint Receipt Date:	10/26/2021
Investigation Initiation Date:	10/29/2021
Report Due Date:	12/25/2021
Licensee Name:	Fatima Mayo
Licensee Address:	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:**	TEMPORARY
Effective Date:	09/22/2021
Expiration Date:	03/21/2022
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Licensee Fatima Mayo removed Resident A from the facility without a 30-day discharge notice. Licensee Mayo took Resident A to a new facility and dropped her off and Resident A was visibly uncomfortable in the new home.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/26/2021	Special Investigation Intake 2022A0871004
10/29/2021	Special Investigation Initiated - Telephone Telephone call to Complainant 1
11/03/2021	Inspection Completed On-site Attempted onsite investigation, no one at facility
11/29/2021	Contact - Telephone call made Telephone contact with Resident A, Family Member 1, and Family Member 2
11/29/2021	APS Referral Through Central Intake to Saginaw County MDHHS
12/02/2021	Inspection Completed On-site Interviewed Licensee Fatima Mayo
12/03/2021	Contact - Telephone call made Telephone call to Complainant 1
12/06/2021	Exit Conference Telephone exit conference with Licensee Fatima Mayo

ALLEGATION:

Licensee Fatima Mayo removed Resident A from the facility without a 30-day discharge. Licensee Mayo took Resident A to a new facility and dropped her off and Resident A was visibly uncomfortable in the new home.

INVESTIGATION:

On October 29, 2021, I interviewed Complainant 1 via telephone. Complainant 1 stated Resident A bonded out of jail and was court ordered to be placed in an AFC home. Complainant 1 indicated Resident A was only at A Place Called Home 2 for one week. Complainant 1 stated Licensee Fatima Mayo called several times and reported that "I cannot handle her anymore." Complainant 1 stated Licensee Mayo took Resident A to a different AFC on Friday, October 22, 2021, at approximately 9:00 pm. The owner of the new AFC did not want Resident A to be placed there until Monday, October 25, 2021 because she was out of town. Complainant 1 indicated she offered to get Licensee Mayo services over the weekend, but Licensee Mayo dropped Resident A off on Friday evening. Complainant 1 stated she was quarantined and could not take Resident A to the new AFC. Complainant 1 stated when Licensee Mayo took Resident A to the new facility, the facility had dogs and Resident A was terrified of the dogs. Licensee Mayo refused to take Resident A back to her home. Resident A's Family Member 1 picked Resident A up from the new AFC and has been with Family Member 1 since this incident.

On November 29, 2021, I interviewed Family Member 1 via telephone. Family Member 1 said Licensee Mayo "literally took all of [Resident A's] belongings and dropped them off at the new home." Family Member 1 reported that Resident A "was terrified of the dogs" at the new home so she took her to her house.

I also interviewed Resident A via telephone. Resident A said Family Member 1 picked her up from the new home because she was afraid of the dogs. Resident A indicated Family 1 has taken care of her.

On December 2, 2021, I interviewed Licensee Fatima Mayo at the facility. Licensee Mayo indicated that she dropped Resident A off at the new AFC because Resident A's case manager had it all set up. Licensee Mayo said she was going to drop Resident A off at the new AFC after dinner but did not get her there until 9 pm. Licensee Mayo indicated she could not handle Resident A and that she was up for the last three days. Licensee Mayo said she was the only one who could handle Resident A and she had no other staff assist. License Mayo indicated she had no services for Resident A, and she did not know the new AFC had dogs. Licensee Mayo said that her case manager knew they had dogs. Licensee Mayo stated it "was a bad situation."

On December 3, 2021, Complainant 1 emailed me and stated that "Fatima absolutely did not give a 30-day notice, the consumer was in her house for maybe a week when she started calling telling me 'I need her out TONIGHT' which is why it was such a scramble to find a new place for her." Complainant 1 indicated she had no idea that the new home had dogs or that Resident A was terrified of them.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.**
ANALYSIS:	Complainant 1 did not receive a 30-day notice, just phone calls from Licensee Fatima Mayo indicating Resident A needed to be moved immediately. Resident A did not meet the criteria of a 24-hour notice. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On December 2, 2021, Licensee Mayo indicated that one-night, Resident A had to go to the emergency room and went by ambulance. Resident A was evaluated and was sent back to her facility.

I looked for an *AFC Licensing Division – Incident/Accident Report* regarding the emergency room trip. Licensee Fatima Mayo did not provide an *AFC Licensing Division – Incident/Accident Report* to the adult foster care licensing division.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible

	agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(ii) Hospitalization.**
ANALYSIS:	An *AFC Licensing Division – Incident/Accident Report* was not received regarding Resident A's emergency room trip. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On December 2, 2021, I asked Licensee Fatima Mayo for a copy of the staff schedule. Licensee Mayo indicated she did not have one because she was the only one working in the home.

APPLICABLE RULE	
R 400.208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes**
ANALYSIS:	Licensee Fatima Mayo did not complete a staff schedule. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On December 6, 2021, I conducted a telephone exit conference with Licensee Fatima Mayo. Ms. Mayo was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-4).

12/8/21

Kathryn A. Huber — Date
Licensing Consultant

Approved By:

12/8/21

Mary E Holton — Date
Area Manager