



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 24, 2026

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

RE: License #:	AS730409293
Investigation #:	2026A1039017
	A Place Called Home 2

Dear Fatima Mayo:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730409293
Investigation #:	2026A1039017
Complaint Receipt Date:	01/16/2026
Investigation Initiation Date:	01/16/2026
Report Due Date:	03/17/2026
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:	1ST PROVISIONAL
Effective Date:	11/03/2025
Expiration Date:	05/02/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 01/13/2026, Mobile Medical Response (MMR) returned Resident C to A Place Called Home 2 and no staff were present in the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/16/2026	Special Investigation Intake 2026A1039017
01/16/2026	Special Investigation Initiated - Letter Emailed Saginaw ORR Kentara Patterson regarding the complaint.
01/16/2026	APS Referral APS denied complaint and referred to BCHS.
01/20/2026	Contact - Document Received Saginaw ORR Patterson emailed back concerning complaint.
02/03/2026	Inspection Completed On-site Interviewed DCW Daisy Sherman, Resident A and Resident B.
02/03/2026	Contact - Face to Face Interviewed Licensee Fatima Mayo at A Place Called Home 1.
02/03/2026	Contact - Face to Face Attempted onsite interviews were unsuccessful as no resident or staff were home.
02/04/2026	Contact - Telephone call made Phone interview with Case Manager RoShawnda Brown.
02/04/2026	Contact - Telephone call made Phone call with Licensee Mayo. Informed her that Staff Henley's WBC was pending and not yet approved.
02/05/2026	Contact - Document Sent

	Received contact information for Residents Guardians via Fatima Mayo.
02/06/2026	Contact - Document Received IPOS received from Case Manager RoShawnda Brown.
02/10/2026	Contact - Face to Face Interview with Resident C.
02/11/2026	Contact - Document Received Licensee Mayo sent eligibility letter for Staff Henley.
02/17/2026	Contact - Telephone call made Attempted phone call with Resident D's case manager. No answer left message.
02/17/2026	Contact - Telephone call made Attempted phone call with Resident B's case manager. No answer left message.
02/17/2026	Contact - Telephone call made Phone call with Case Manger RoShawnda Brown.
02/17/2026	Exit Conference Completed with Licensee Mayo.
02/17/2026	Contact - Telephone call made Phone interview with DCW Latesha Henley.
02/18/2026	Contact - Telephone call made Phone interview with Case Manager Tomekia Lawson.
02/18/2026	Contact - Telephone call made Phone interview with Case Manager Juan Ramirez.
02/18/2026	Contact - Telephone call made Phone interview with MMR supervisor Sheldon Perrou.
02/18/2026	Contact - Telephone call received Phone interview with MMR EMT Nicholas Boyd.
02/20/2026	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION:

On 01/13/2026, MMR returned Resident C to A Place Called Home 2 and no staff were present in the home.

INVESTIGATION:

On 01/16/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that on 01/13/2026, MMR returned Resident C to A Place Called Home 2 and there was no staff present in the home.

On 01/16/2026, a referral was made to Adult Protective Services. The Department of Health and Human Services Adult Protective Services denied the complaint.

On 01/20/2026, Saginaw County Community Mental Health Office of Recipient Right (ORR) Worker Kentera Patterson was contacted. ORR Patterson stated that they do not have an active contract with A Place Called Home 2 and will not be investigating the allegation.

On 02/03/2026, I attempted to complete an unannounced investigation at A Place Called Home 2 but there was no staff or residents at the home at the time of my investigation. I then headed to A Place Called Home 1 to see if Licensee Fatima Mayo was at that facility. When I arrived at A Place Called Home 1, Licensee Fatima Mayo was at the home and available for an interview.

On 02/03/2026, I completed an interview with Licensee Fatima Mayo at A Place Called Home 1 concerning the allegations. Licensee Mayo stated that she was not aware of the allegations but she did not believe they were true. Licensee Mayo stated that she was aware that Resident C went to the hospital for treatment but she was not aware that when he came back there was reportedly no staff in the home. Licensee Mayo stated that they have one staff in the home at night as they only have three residents in the home. Licensee Mayo stated that she hired an additional staff in December of 2025 for A Place Called Home 2. Licensee Mayo stated that she does not know why staff would not have been at the home when Mobile Medical Response (MMR) brought Resident C back to the home. Licensee Mayo stated that Direct Care Worker (DCW) Daisy Sherman was working that day. Licensee Mayo stated that DCW Sherman is the lead staff at A Place Called Home 2. Licensee Mayo stated that she goes back and forth between A Place Called Home 1 and 2 to check on things at each home. Licensee Mayo stated that there is always staff working in the home since they were cited in November 2025 for not having staff in the home. Licensee Mayo stated that they have worked hard to ensure that there is always staff at the home with the residents to provide appropriate care. Licensee Mayo stated that she hired DCW Latesha Henley in December 2025 and that she has been doing a good job and has been rotating with DCW Sherman to make sure that there is always staff in the home.

On 02/03/2026, I returned unannounced to A Place Called Home 2 to attempt to complete my investigation. I interviewed the following people: Direct Care Worker Daisy Sherman, Resident C and Resident D. Resident B was not home at the time of my investigation. Resident B was interviewed on 02/10/2026.

On 02/03/2026, I completed an interview with Direct Care Worker (DCW) Daisy Sherman concerning the allegations. DCW Sherman stated that she was aware of the allegations but did not believe they were true. DCW Sherman stated that she was the one who called for MMR for Resident C earlier in the day. DCW Sherman stated that Resident C was not feeling very well that day and that she called MMR to address his health concerns. DCW Sherman stated that she was at the home when MMR brought Resident C back around 10:00 or 10:30 p.m. DCW Sherman stated that the reason that she did not hear them and open the door for them was because she was outside in the garage cleaning up trash that had been torn up by some cats. DCW Sherman stated that she left the phone in the house as she did not think that she would need it while she was outside. DCW Sherman stated that she was getting ready for a shift change with DCW Latesha Henley and wanted to get the trash cleaned up before she got there. DCW Sherman stated that she did not hear the ambulance pull up to the home and she only came out of the garage when she saw DCW Henley pull into the driveway for her shift. DCW Sherman stated that she along with DCW Henley went into the home and spoke with the MMR staff concerning Resident C. DCW Sherman stated that Resident C was still having issues with dizziness and standing and MMR took him back with them to the hospital. DCW Sherman stated that they have not had any recent issues with staffing since DCW Henley was hired in December 2025.

I reviewed the January 2025 staff schedule and it contained staff names, times and dates. There did not appear to be any issues with the staff schedule.

I reviewed an Incident Report (IR) dated 01/13/2026. The incident report notes that MMR brought Resident C back to the home and Resident C tried to get off of the stretcher to walk but kept losing his balance, was not stable and still seemed confused. Staff and MMR staff suggested that Resident C go back to hospital for additional treatment. Licensee Mayo was notified and incident report was completed.

I reviewed Resident C's Individual Plan of Service (IPOS) dated 03/04/2025. Resident C does not have any family or friends and is living in an AFC home. Resident C reports that he has no natural supports. Resident C reports that he would like to get a job and housing. Resident C has been diagnosed with Major depressive disorder and Traumatic Brain Injury. Resident C struggles with memory and being a poor historian.

On 02/03/2026, I completed an interview with Resident C concerning the allegations. Resident C was on his bed at the time of our interview. Resident C appeared neat and clean and was able to communicate. Resident C is diagnosed with the following: Major depressive disorder and Traumatic Brain Injury. Resident C stated that he was aware of the allegations and he believes they were true. Resident C stated that earlier in the day staff called MMR because he was having issues with dizziness. Resident C stated

that MMR took him to Covenant Cooper Hospital to get checked on and was sent home the same day. Resident C stated that when MMR brought him back to the home that there was no staff in the home and another resident had to open the door for them. Resident C stated that DCW Sherman showed up later and talked to MMR and he ended up going back to Covenant Cooper Hospital for the night. Resident C stated that he does not know where DCW Sherman came from as he was still dizzy and that's why he ended up going back to the hospital. Resident C stated that he feels better now and that he hasn't had any issues with dizziness since he has been back at the home. Resident C stated that he does not like it in the home and wants to move back towards Flint, Michigan. Resident C stated that the staff make sure he gets his food and medicine every day. Resident C stated that the staff treat him okay but they aren't there after like 6:00 p.m. and don't usually come back until the morning. Resident C stated that if something happens at night then the residents would have to look out for each other. Resident C stated that he told his Case Manager RoShawnda Brown that he wants to move out of the home and back to Flint, Michigan.

On 02/03/2026, I completed an interview with Resident D concerning the allegations. Resident D was on his bed at the time of our interview. Resident D appeared neat and clean and was able to communicate. Resident D stated that he was aware of the allegations and he believes they are true. Resident D stated that MMR came to the home around 10:30 p.m. Resident D stated that he is the one who opened the door for MMR because there was no staff around. Resident D stated that DCW Henley came in the side door a few minutes later and talked to MMR about Resident C. Resident D stated that MMR took Resident C back with them when they left. Resident D stated that staff are always there during the day and sometimes they are there at night. Resident D stated that it's usually DCW Henley who works at night. Resident D stated that he gets his food and medication daily and he likes how the staff treat him. Resident D stated that he has only been in the home for a few months but he likes it there and doesn't want to leave.

On 02/04/2026, I completed a phone interview with Hope Network Case Manager (CM) RoShawnda Brown concerning the allegations. CM Brown is the case manager for Resident C. CM Brown stated that she was not familiar with the allegations but was aware that the home had been previously cited for a rule violation for not having staff in the home to provide care to the residents. CM Brown stated that she sees Resident C on a regular basis and her contact day is usually on Tuesdays. CM Brown stated that Resident C has stated that he wants to move from the home and move back towards Flint, Michigan. CM Brown stated that her only concern is making sure that there is staff in the home to provide care for the residents. CM Brown stated that she has had no other issues with the care that the staff provide besides the rule violation for them not having staff in the home. CM Brown stated that when she sees Resident C that staff give her updates concerning his care and communicate with her if there are any issues. CM Brown stated that Resident C is his own guardian. CM Brown stated that Resident C does not have a history of making false statements and believes that if he stated that there were no staff in the home then there may not have been. CM Brown stated that

Resident C is diagnosed with Major depressive disorder, Unspecified anxiety disorder and Traumatic brain injury (TBI).

On 02/10/2026, I completed an unannounced follow up visit to A Place Called Home 2 so that I could interview Resident B who was not at the home when I completed my initial investigation interviews. I completed an interview with Resident B on the couch of the living room. Resident B appeared neat and clean and was able to communicate. Resident B stated that he was not familiar with the allegations and does not remember the incident described in the allegations. Resident B stated that staff do leave the home when it gets dark and come back in the morning before they need to get their food and medication. Resident B stated that if there is an emergency then one of the residents would have to call 911 themselves. Resident B stated that staff do come back sometimes at night to check on them, but mostly they are gone. Resident B stated that he has been at the home for two years and he gets his food and medication on time from the staff. Resident B stated that there was a new staff member hired a little while ago but he does not remember her name. According to the staff schedule submitted by Licensee Mayo, DCW Sherman and DCW Henley was the only staff scheduled for January 2025.

On 02/17/2026, I completed a phone interview with Direct Care Worker (DCW) Latesha Henley concerning the allegations. DCW Henley stated that she was familiar with the allegations but did not believe they were true. DCW Henley stated that she does not know when MMR got to the home to drop off Resident C but that when she pulled up to the home for her shift that they were already there. DCW Henley stated that she did not know what was going on so she called DCW Sherman and she said that she was in the back yard cleaning up some trash or something like that. DCW Henley stated that she went inside the home with DCW Sherman and spoke to the MMR staff concerning Resident C. DCW Henley stated that Resident C was having issues standing up and was still dizzy so the MMR staff decided to take him back to the hospital. DCW Henley stated that she has only been working at the home for a few months and that she likes working there and that Licensee Mayo explained to her that when she was hired that they needed dependable people and she takes pride in working a lot and always being there when she is needed. DCW Henley stated that she has not seen the residents left alone without staff since she was hired. DCW Henley stated that Licensee Mayo told her that she was working on hiring more staff for the home.

On 02/18/2026, I completed a phone interview with Saginaw Psychological Case Manager (CM) Tomekia Lawson concerning the allegations. CM Lawson is the case manager for Resident B. CM Lawson stated that she was not familiar with the allegations and was not sure if they were true or not. CM Lawson stated that when she goes to see Resident B there are always staff in the home. CM Lawson stated that she has no issues with the care that the staff have provided for Resident B. CM Lawson stated that the staff coordinate all of his appointments and communicate well with her if there are any issues they need to discuss. CM Lawson stated that Resident B is his own guardian since his brother passed away. CM Lawson stated that her only concern is that they make sure that there is enough staff in the home to take care of the

residents properly. CM Lawson stated that Resident B is diagnosed with Major depressive disorder and Alcholosim. CM Lawson stated that Resident B is truthful and has no past history of making false statements.

On 02/18/2026, I completed a phone interview with Hope Network Case Manager (CM) Juan Ramirez concerning the allegations. CM Ramirez is the case manager for Resident D. CM Ramirez stated that he was not familiar with the allegations and was not sure if they were true or not. CM Ramirez stated that he was not aware that the home had been cited for any previous rule violation of not having appropriate staffing to care for the residents. CM Ramirez stated that Resident D has only been at the home for a few months and that he has only visited the home twice but both times there has been staff present in the home. CM Ramirez stated that the staff have always communicated well with him concerning the care of Resident D and that he has never had any concerns for his care until today. CM Ramirez stated that Resident D is his own guardian and has not told him of any staffing problems in the home. CM Ramirez stated that Resident D is credible and if he stated that there were no staff in the home then he would have no reason not to believe him.

On 02/18/2026, I completed a phone interview with Mobile Medical Response (MMR) paramedic supervisor Sheldon Perrou concerning the allegations. MMR Perrou stated that he was not familiar with the allegations but they have had multiple incidents of going to the home and there not being staff present and they have to contact Licensee Mayo or bring the resident back to the hospital. MMR Perrou stated that he is not sure how many times this has happened but off the top of his head he stated that it has happened several times. MMR Perrou stated that he was not working the night of the specific incident so he will have to get me the information regarding the staff that worked that night. MMR Perrou stated that the staff working that night was MMR Nicholas Boyd and he would have him contact me.

On 02/18/2026, I completed a phone interview with Mobile Medical Response (MMR) emergency medical technician Nicholas Boyd concerning the allegations. MMR Boyd stated that he was aware of the allegations and believe they were true. MMR Boyd stated that when he arrived to the home with Resident C no one answered the door. MMR Boyd stated that he called the facility and no one answered. MMR Boyd stated that he then walked around the home to see if he could see if anyone was in the home and he did not see anyone there. MMR Boyd stated that a resident finally opened the door and let him in with Resident C. MMR Boyd stated that staff showed up a little while later through the side door. MMR Boyd stated that Resident C was too weak to get off the cot and stand on his own so he spoke with staff and it was decided that Resident C would go back to the hospital for further treatment.

SIR #2025A0623047 dated 10/03/2025 cited violation to Rule 400.14206 and recommended a provisional license be issued, pending the receipt of an appropriate corrective action plan. This violation was due to the residents being left unsupervised. A resident was deceased and another resident had to call 911 due to no staff being present. The corrective action plan dated 10/29/2026 and signed by Licensee Mayo

stated Licensee Mayo had conducted interviews and has hired 3 potential employees that were cleared through milpartnership.org and were waiting for fingerprints. As of 10/01/2025, Licensee Mayo will verify employees have a complete file for employment before working with residents. Licensee Mayo will assure there is adequate staff on each shift to accommodate the 1 staff per 6 residents ratio. Adequate staffing will be maintained by continuing the inter process by Licensee Mayo interviewing and hiring staff as needed to maintain the 1 staff to 6 residents ratio. The fingerprint process should take approximately 3 to 4 weeks and will be monitored by Licensee Mayo through milpartnership.org.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	<p>(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:</p> <p>(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.</p> <p>(b) 12 residents for small group and family homes.</p>
ANALYSIS:	<p>On 01/13/2026, MMR returned Resident C to A Place Called Home 2 and there was no staff present in the home.</p> <p>I completed an unannounced investigation and interviewed Licensee Mayo, DCW Sherman, DCW Henley, CM Brown, CM Lawson, CM Ramirez, MMR Supervisor Perrou and MMR EMT Boyd.</p> <p>I reviewed the Incident Report, Resident C's Individual Plan of Service (IPOS), staff files, and the staff schedule for January 2025.</p> <p>According to the evidence obtained during this investigation involving interviews and documentation, there were no staff present at A Place Called Home 2 when MMR brought Resident C back to the home. Residents B, C and D all report that they are left with no staff present at during times at this facility. MMR staff Nicholas Boyd and Sheldon Perrou both report they have been to the AFC home with no staff present.</p> <p>SIR #2025A0623047 dated 10/03/2025 cited violation to the home not having staff when a resident was deceased. Another</p>

	<p>resident had to call 911 to request emergency assistance. The corrective action plan signed by Licensee Mayo dated 10/29/2025, stated she would ensure there would be adequate staffing.</p> <p>Upon completion of this investigation, it has been determined that there is a preponderance of evidence to conclude willful and substantial violation of this rule.</p>
CONCLUSION:	REPEAT VIOLATION ESTABLISHED SIR # 2025A0623047 dated 10/03/2025

ADDITIONAL FINDINGS:

On 02/03/2026, at the time of my onsite investigation, it was determined that DCW Latesha Henley did not have an eligibility letter in her staff file.

INVESTIGATION:

On 02/03/2026, I completed an unannounced investigation at A Place Called Home 2. I reviewed the staff file for DCW Sherman and DCW Henley. The staff files and training records appeared up to date with the exception of the eligibility letter for DCW Sherman and DCW Henley. I called Licensee Mayo after my interviews were completed and asked to her send me the eligibility letters for DCW Sherman and DCW Henley and add them to the staff files. Licensee Mayo informed me that she had DCW Sherman's eligibility letter but there was a problem with DCW Henley's eligibility letter and she was still waiting for it to be approved. I reviewed the Workforce Background Account for A Place Called Home 2 and saw that DCW Henley's eligibility letter was pending and she was not yet approved.

I reviewed the Workforce Background Account for A Place Called Home 2 and observed that DCW Henley's eligibility letter was pending and she was not yet approved. I informed Licensee Mayo that DCW Henley could not supervise the residents alone and a staff member who has an approved eligibility letter would have to be present. Licensee Mayo stated that she would follow up and see why DCW Henley's eligibility letter was pending. On 02/11/2026, Licensee Mayo sent me an email with an approved eligibility letter for DCW Henley. Licensee Mayo stated that she was not sure what the issue was preventing DCW Henley's approved eligibility status.

I informed Licensee Mayo that DCW Henley could not supervise the residents alone without another staff member who has an approved eligibility letter. Licensee Mayo stated that she would follow up and see why DCW Henley's eligibility letter was pending.

On 02/11/2026, Licensee Mayo sent me an email with an approved eligibility letter for DCW Henley.

SIR #2025A0623047 dated 10/03/2025 cited violation to MCL 400.734b(2) and recommended a provisional license be issued, pending the receipt of an appropriate corrective action plan. This violation was due to the facility having no staff listed under the home in the Workforce Background Check Website. The corrective action plan dated 10/29/2026 and signed by Licensee Mayo stated Licensee Mayo had conducted interviews and has hired 3 potential employees that were cleared through milpartnership.org and were waiting for fingerprints. Licensee Mayo will assure there is adequate staff on each shift to accommodate the 1 staff per 6 residents ratio. As of 10/01/2025, Licensee Mayo will verify employees have a complete file for employment before working with residents. The fingerprint process should take approximately 3 to 4 weeks and will be monitored by Licensee Mayo through milpartnership.org.

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

	<p>to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.</p>
<p>ANALYSIS:</p>	<p>On 02/03/2026, at the time of my onsite investigation, it was determined that DCW Latesha Henley did not have an approved eligibility letter in her staff file.</p> <p>I completed a phone interview with Licensee Mayo and she confirmed that DCW Henley did not have an approved eligibility letter and that she was waiting for her eligibility to be approved. Licensee Mayo stated that she was unaware that DCW Henley was unable to work alone and had to work with a staff member who had an eligibility letter.</p> <p>I reviewed the Workforce Background Account and confirmed that DCW Henley’s eligibility letter was pending and not yet approved.</p> <p>On 02/11/2025, Licensee Mayo emailed me DCW Henley’s approved eligibility letter.</p> <p>This licensee was cited for this rule violation on 10/03/2025 ins SIR #2025A0623047, recommending a provisional license. Fatima Mayo submitted a corrective action plan dated 10/29/2025, stating she would ensure there was adequate staff at this home.</p> <p>Upon completion of this investigation, it has been determined that there was a preponderance of evidence to conclude willful and substantial violation of this rule.</p>
<p>CONCLUSION:</p>	<p>REPEAT VIOLATION ESTABLISHED SIR # 2025A0623047 dated 10/03/2025</p>

On 02/18/2026, I completed an exit conference with Licensee Fatima Mayo. I informed Licensee Mayo of the results of my investigation and that I would be citing rule violation due to the infractions discovered during my onsite inspection. I informed Licensee Mayo the recommendation would be revocation of the license. Licensee Mayo did not

have any further questions at that time and she would contact me if she had any questions.

IV. RECOMMENDATION

I recommend revocation of the license of this AFC adult small group home (capacity 3-6).
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Martin Gonzales

02/23/2026

Martin Gonzales Licensing Consultant	Date
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Approved By:

Mary Holton

02/23/2026

Mary E. Holton Area Manager	Date
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