GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2026

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

RE: License #:	AS730396181
Investigation #:	2026A1039020
	A Place Called Home

Dear Ms. Mayo:

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.

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.

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 #:	AS730396181
Investigation #:	2026A1039020
Complaint Receipt Date:	02/02/2026
Investigation Initiation Date:	02/02/2026
Report Due Date:	04/03/2026
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
Facility Address:	440 S. 10th Street Saginaw, MI 48601
Facility Telephone #:	(989) 482-8989
Original Issuance Date:	07/09/2019
License Status:	REGULAR
Effective Date:	01/09/2026
Expiration Date:	01/08/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
On 01/29/2026, Mobile Medical Response (MMR) came to A Place Called Home as Resident A was experiencing breathing distress and there were no staff present at the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/02/2026	Special Investigation Intake 2026A1039020
02/02/2026	APS Referral APS denied complaint.
02/02/2026	Special Investigation Initiated - Letter Emailed Saginaw ORR regarding complaint. They did not receive the complaint and have no contract with the home.
02/03/2026	Inspection Completed On-site Interviewed Licensee Fatima Mayo, Resident A, Resident B, Resident C and Resident D.
02/03/2026	Contact - Document Received Saginaw ORR Patterson informed me that they do not have a contract with the home and did not receive a complaint in regards to Resident A.
03/18/2026	Contact - Telephone call made Phone interview with MMR Supervisor Sheldon Perrou.
03/18/2026	Contact - Telephone call made Attempted phone call with MMR staff Sabrina Ross. No answer left message.
03/19/2026	Contact - Telephone call received Phone interview with MMR staff Sabrina Ross.
03/19/2026	Contact - Telephone call made Phone interview with DCW Shamina Bennett.
03/20/2026	Contact - Document Received

	Saginaw CMH Case Manager Tabatha Anderson.
03/23/2026	Contact - Telephone call made Phone call completed with Fatima Mayo.
03/25/2026	Exit Conference Completed with Fatima Mayo. Update on outcome of investigation. Informed her that a provisional license would be recommended.
03/25/2026	Inspection Completed-BCAL Sub. Non-Compliance
03/25/2026	Recommend Provisional License

ALLEGATION:

On 01/29/2026, Mobile Medical Response (MMR) came to A Place Called Home as Resident A was experiencing breathing distress and there were no staff present at the home.

INVESTIGATION:

On 02/02/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It was alleged that On 01/29/2026, Mobile Medical Response (MMR) came to A Place Called Home as Resident A experienced breathing distress and there were no staff present at the home.

On 02/02/2026, a referral was made to Adult Protective Services regarding this complaint. The Department of Health and Human Services Centralized Intake denied the complaint for investigation.

On 02/03/2026, I completed an unannounced investigation at A Place Called Home 1 and interviewed the following people: Licensee Fatima Mayo, Resident A, Resident B, Resident C and Resident D.

On 02/03/2026, I completed an interview with Licensee Fatima Mayo concerning the allegations. Licensee Mayo stated that she was familiar with MMR coming to the home to check on Resident A health, but she was not aware of the allegations that there was no staff in the home when they arrived. Licensee Mayo stated that she was under the impression that staff was working at the time of the incident. Licensee Mayo stated that Direct Care Worker (DCW) Shamena Bennett was working the day that MMR came to the home to service Resident A. Licensee Mayo stated that they have not had any past issues concerning staffing in this home and that DCW Bennett has been working in the home since December 2025 with no issues to report. Licensee Mayo stated that it is currently just herself and DCW Bennett working at the home but she is looking for more

staff to hire. Licensee Mayo stated that they currently have four residents in the home. Licensee Mayo stated that all of the residents are able to move independently in the community.

I reviewed Covenant Emergency Room discharge paperwork dated 01/29/2026. The paperwork noted that Resident A had a chest x-ray and EKG completed and was discharged the same day. The diagnosis was Dyspnea. The physician listed is Dr. Tim Brown.

On 02/03/2026, I completed an interview with Resident A. Resident A was in his room at the time of the interview. Resident A appeared neat and clean and was able to communicate. Resident A stated that he is his own guardian but that he has a case manager through Saginaw County Community Mental Health. Resident A stated that he is aware of the allegations and they are true. Resident A stated that he was having some issues breathing and that there was no staff in the home to call 911 for him. Resident A stated that Resident B called 911. Resident A stated that DCW Bennett showed up to the home before he was taken to the hospital by MMR. Resident A stated that he went to the emergency room at Covenant Hospital but came back the same day. Resident A stated that staff usually leave at night and the residents take care of each other. Resident A stated that he does not like it at the home and wants to move. Resident A stated that the staff are nice to him and treat him pretty good when they are there, he just doesn't like it there. Resident A stated that Licensee Mayo and DCW Bennett are the two staff that work at the home.

Resident A is 57 years old. Resident A is fully ambulatory and is able to move independently in the community. Resident A attend Friends for Recovery day program in Saginaw, MI, approximately 3 to 4 times a week.

On 02/03/2026, I completed an interview with Resident B. Resident B was laying in her bed at the time of the interview. Resident B stated that she was tired and did not want to get up. Resident B appeared neat and clean and was able to communicate. Resident B stated that she was aware of the allegations and they were true. Resident B stated that she called 911 for Resident A because he wasn't breathing too good and there was no staff around. Resident B stated that she doesn't remember what time she called 911 but that it was dark outside when she called. Resident B stated that she called DCW Bennett to let her know she called 911 for Resident A and she came back to the house after that. Resident B stated that staff is not usually at the house after it gets dark outside. Resident B stated that she has lived in the home for about six years and she gets her food and medication daily and likes it at the home. Resident B stated that since she has been at the home she has never had to call 911, this was the first time she had to do anything like that.

On 02/03/2026, I completed an interview with Resident C. Resident C was sitting in his bed at the time of the interview. Resident C appeared neat and clean and was able to communicate. Resident C stated that he was not aware of the allegations but sometimes the staff are not in the home at night. Resident C stated that he does not

remember Resident A having to go to the hospital for anything. Resident C stated that he minds his own business and stays in his room with his roommate Resident D. Resident C stated that he gets his food and medication on time and that he has been in the home for two years and he likes it here.

On 02/03/2026, I attempted to complete an interview with Resident D concerning the allegations. Resident D was laying in his bed at the time that I interacted with him. Resident D stated that he did not want to talk to me and asked me to leave him alone. Resident D refused to acknowledge any questions when I attempted to engage him. Resident D appeared neat and clean at the time I saw him. Resident C and Resident D are roommates. Resident C stated that Resident D doesn't like to talk to anyone so I shouldn't be offended that he doesn't want to talk.

On 03/18/2026, I completed a phone interview with Mobile Medical Response (MMR) Supervisor Sheldon Perrou concerning the allegations. Supervisor Perrou stated that he was aware of the allegations and they were true. Supervisor Perrou stated that he did not go out on the call but that he remembers the incident and that it was reported to him that there was no staff at the home when MMR Emergency Medical Technician (EMT) when out to service Resident A. Supervisor Perrou stated that they have had past issues with no staff being in the home when they respond to a call. Supervisor Perrou stated that he would give me the contact information for MMR (EMT) Sabrina Ross who went out on the call. Supervisor Perrou stated that he has had to call Licensee Fatima Mayo to ask her where staff is and if they can send someone to the home as his EMT's are there servicing someone.

On 03/19/2026, I completed a phone interview with Mobile Medical Response (MMR) Emergency Medical Technician (EMT) Sabrina Ross concerning the allegations. EMT Ross stated that she is familiar with the allegations and they are true. EMT Ross stated that she went out on the call at approximately 8 pm on 01/29/2026, to A Place Called Home 1 and there were no staff in the home when she got there. EMT Ross stated that a resident let her in the home to check on Resident A. EMT Ross stated that a resident called a staff member and EMT Ross talked to them and they informed her that they stepped out for a minute to go get something down the road and would be back shortly. EMT Ross stated that she waited approximately 20 – 30 minutes before a staff member arrived. EMT Ross stated that they took Resident A to Covenant Emergency Room for treatment. EMT Ross stated that they have had past issues with no staff being in the home but she could not remember the exact dates or times.

On 03/19/2026, I completed a phone interview with Direct Care Worker (DCW) Shamena Bennett concerning the allegations. DCW Bennett stated that she was not aware of the allegations but is not sure if they are true. DCW Bennett stated that when she showed up to A Place Called Home 1 that MMR was already there servicing Resident A. DCW Bennett stated that she does not remember if there was another staff there working before she got there or not. DCW Bennett stated that she did not know why MMR was there until she got into the home and spoke with the MMR staff. DCW Bennett stated that MMR took Resident A to address his medical needs. DCW Bennett

stated that she is not aware of any times that there has not been staff in the home to care for the residents. DCW Bennett stated that she works at the home full time and that Licensee Mayo also works there. DCW Bennett stated that she does not remember any more details from that night because it was a while ago.

On 03/20/2026, I received an email from Saginaw County Community Mental Health Case Manager (CM) Tabatha Anderson concerning the allegations. CM Anderson stated that she was familiar with the allegations and believed that they were true. CM Anderson stated that Resident A moved out of A Place Called Home 1 on 02/10/2026, because there were a lot of issues. CM Anderson stated that Resident A informed her that staff would not be there and leave with their boyfriend at night. CM Anderson stated that Resident A got into a heated argument with staff over this and it ultimately got him a 30 day discharge notice. CM Anderson stated Resident A stated that the staff would come in smelling like Marijuana all the time. CM Anderson stated that Resident A is in a new home and receives great care and he will be moving into his own apartment through Saginaw Housing Commission.

Renewal Licensing Study Report dated 12/26/2023 cited violation to R 400.14206 (1) – Staffing Requirements. At the time of the renewal inspection, it was determined that Licensee Fatima Mayo did not have appropriate staffing as she was the only listed staff member for A Place Called Home 1. A Corrective Action Plan (CAP) was completed and signed by Licensee Mayo on 01/08/2024. The CAP indicated that the licensing requirement would be met by hiring a staff member within four months. The CAP will be maintained by retaining staff or hiring another if there is a need to replace staff.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**

ANALYSIS:	It was alleged that On 01/29/2026, Mobile Medical Response (MMR) came to A Place Called Home as Resident A experienced breathing distress and there were no staff present at the home. I completed interviews with the Licensee and Direct Care Worker and they are unsure if the allegations are true. I completed interview with Resident A, Resident B, Resident C, MMR Supervisor, MMR EMT, and Resident A's case manager and this confirmed the allegations are true. On 1/29/2026, Resident A was experiencing a medical emergency and Resident B had to call 911. Resident A stated that he was having some issues breathing and that there were no staff in the home to call 911 for him. Resident B stated that she called 911 for Resident A because he wasn't breathing too good and there was no staff around. EMT Ross reported going out on the call at approximately 8 pm on 01/29/2026, to A Place Called Home, and there were no staff in the home when she got there. It took 20 to 30 minutes for staff to arrive at the facility. MMR Supervisor Perrou and EMT Ross stated that they have had past issues with no staff being in the home when they respond to a call. The licensee was previously cited for inadequate staffing during the Renewal Licensing Study Report dated December 26, 2023. The licensee submitted a corrective action plan stating she would ensure there is adequate staffing. The licensee failed to follow her CAP as demonstrated in this investigation. There is willful and substantial violation of this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal LSR dated December 26, 2023.**

ADDITIONAL FINDINGS:

On 02/03/2026, at the time of my onsite inspection, it was determined that there was no staff schedule completed for January 2026.

INVESTIGATION:

On 02/02/2026, I completed an unannounced investigation at A Place Called Home 1 and interviewed Licensee Fatima Mayo. During my interview I requested to view the staff schedule for January 2026. Licensee Mayo informed me that she did not have a staff schedule completed for January 2026.

I informed Licensee Mayo that she is required to maintain a staff schedule at the home. Licensee Mayo stated that she would make sure that they are completed moving forward. Licensee Mayo stated that she would complete one immediately and ensure that are done moving forward.

APPLICABLE RULE	
R 400.639	**Staff records.**
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: **(a) Names of staff on duty.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Scheduling changes when made.**
ANALYSIS:	On 02/03/2026, at the time of my onsite inspection, it was determined that there was no staff schedule completed for January 2026. I completed an interview with Licensee Fatima Mayo and requested to view the staff schedule for January 2026. Licensee Mayo stated that she did not have one made. I informed Licensee Mayo that a staff schedule is required by policy. Licensee Mayo stated that she would complete one immediately and ensure that are done moving forward. Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/25/2026, I completed an exit conference with Licensee Fatima Mayo. I informed Licensee Mayo of the results of my investigation. Licensee Mayo did not have any follow up questions.

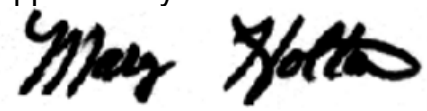
IV. RECOMMENDATION

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.

03/25/2026

Martin Gonzales Licensing Consultant	Date

Approved By:



03/25/2026

Mary E. Holton Area Manager	Date