GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2026

Sara Fredricks
3806 Studor Rd.
Saginaw, MI 48601

RE: License #:	AS730379879
Investigation #:	2026A0123038
	Sara M. Fredricks

Dear Sara Fredricks:

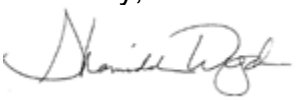
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730379879
Investigation #:	2026A0123038
Complaint Receipt Date:	06/17/2026
Investigation Initiation Date:	06/22/2026
Report Due Date:	08/16/2026
Licensee Name:	Sara Fredricks
Licensee Address:	3806 Studor Rd. Saginaw, MI 48601
Licensee Telephone #:	(989) 332-2291
Administrator:	Sara Fredricks
Licensee:	Sara Fredricks
Name of Facility:	Sara M. Fredricks
Facility Address:	3806 Studor Saginaw, MI 48601
Facility Telephone #:	(989) 332-2291
Original Issuance Date:	07/08/2016
Status:	REGULAR
Effective Date:	01/08/2025
Expiration Date:	01/07/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was in the hospital on 06/15/2026. Resident A needed a ride home. No one was at the hospital with Resident A, and no one was able to pick Resident A up. There is concern that the AFC home did not assist Resident A.	No
There is concern that the facility is not meeting Resident A's medical needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/17/2026	Special Investigation Intake 2026A0123038
06/17/2026	APS Referral Information received regarding APS referral.
06/22/2026	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
07/10/2026	Contact- Telephone call made I left a voicemail requesting a return call from staff Tamara McDaniels.
07/20/2026	Inspection Completed On-site I conducted an unannounced follow-up at the facility.
07/28/2026	Exit Conference I spoke with LD Sara Fredricks.

ALLEGATION:

- **Resident A was in the hospital on 06/15/2026. Resident A needed a ride home. No one was at the hospital with Resident A, and no one was able to pick Resident A up. There is concern that the AFC home did not assist Resident A.**
- **There is concern that the facility is not meeting Resident A's medical needs.**

INVESTIGATION: On 06/16/2026, The Bureau of Community and Health Systems received a complaint regarding the allegations noted above. The complaint also noted that Resident A has an unknown mental illness, cognitive impairment, and

seizure disorder. Resident A was dropped off at the hospital via ambulance. There is concern that the AFC home did not assist Resident A, and that they possibly are not meeting his medical needs. There is concern that no one has reviewed his medication and seen what has been causing him dizziness and feeling like he is going to pass out.

On 06/22/2026, I conducted an unannounced on-site at the facility. I interviewed licensee designee Sara Fredericks. She stated Resident A went to the hospital on 06/15/2026 due to vertigo. Resident A was experiencing dizziness. She stated that staff called 911, and an ambulance arrived and took Resident A to the hospital. LD Fredricks stated that she was out of town at the time, and there was one staff on shift who did not have a work vehicle to load all five other residents up to pick Resident A up from the hospital. She stated that the hospital had agreed to get Resident A a cab or an ambulance ride back to the facility, but Relative 1 picked Resident A up. She stated that Resident A has a primary physician who he sees regularly, and that Resident A gets blood drawn monthly. LD Fredricks stated that she cannot review Resident A's medications because she is not a physician. She stated that staff Tamara McDaniels was the staff on shift on 06/15/2026 when Resident A went to the hospital.

During this on-site, I interviewed Resident A. Resident A stated that he went to the hospital. On 06/15/2026, Resident A stated he woke up about 1:00 pm, feeling like he was going to pass out and was nauseated. Resident A stated he made the decision to go to the hospital. Resident A reported going to the hospital via ambulance. Resident A denied remembering what he was diagnosed with. Resident A stated that Individual 1, Relative 1's neighbor picked him up from the hospital. Resident A stated that someone usually picks him up from the hospital. Resident A stated that he can be out in the community without staff supervision. Resident A stated that the last time he had this issue, it happened two years ago, and the hospital could not figure out what was going on. Resident A stated he likes living in the facility. Resident A denied having any issues with his medications, and that staff makes sure Resident A takes his medication daily. Resident A stated that he called around to get a ride home, because he did not have his cell phone that had contact information for the public transportation company he uses (i.e. Safe Ride Health). Resident A stated that the hospital did offer an ambulance ride back to the facility. Resident A stated that LD Fredricks was not available that day, and the facility does not have a van. Resident A stated he has been doing good.

During this on-site, I reviewed Resident A's resident file. There were no physician appointment notes, or list of physician visits notes observed in the file. A copy of a 06/15/2026 Covenant Health Care *After Visit Summary* was obtained. It notes that Resident A was seen at the hospital due to vertigo. The *reason for visit* is listed as dizziness, and the diagnosis was vertiginous syndrome. It notes that Resident A was to start taking meclizine (Antivert), and the instructions were to pick the medication up at Genoa Healthcare, and Resident A was to follow up with Toby C.J. Long, MD and Covenant Emergency Care Center- Emergency Medicine.

During this on-site, I took photos of Resident A's medication administration records for June 2026 and observed Resident A's medications in the medication cart. After reviewing the medication administration records for June 2026, I noted that Meclizine (Antivert) was not listed. Prescriptions for Dexamethasone (2 mg; *take 1 tablet by mouth daily for 7 days*), Ketorolac (10 mg; *take 1 tablet by mouth every six hours for 4 days*), and Mobic (15 mg; *take 1 tablet by mouth daily for 30 days*) were on the medication administration record and there were no staff initials noting the medication was passed, and there was no discontinued date noted for the medications either.

During this on-site, I took photos of Resident A's *Assessment Plan for AFC Residents*. The assessment plan notes that Resident A can move independently in the community, can communicate needs, is alert to surroundings, reads and writes, and follows instructions. Per the assessment plan, Resident A does not require assistance with personal care. Grooming is the only item checked yes as needing assistance. Resident A requires supervision of taking medication. For medical or dental follow-ups needed, it states "*Regular appointments with Great Lakes Bay Health*." Resident A's *Resident Care Agreement* dated 02/17/2023, does not have any transportation fees, or any specific transportation services noted.

On 07/20/2026, I conducted a follow-up unannounced on-site at the facility. I spoke with LD Sara Fredricks and staff Tamara McDaniels. I inquired about Resident A's medications (i.e. Meclizine (Antivert), Mobic, Ketorolac, and Dexamethasone.) The Meclizine (Antivert) was not on the current July 2026 medication administration record sheet. LD Fredericks stated that the hospital is supposed to send the prescription to Genoa Pharmacy. She stated that she would have to call the pharmacy to see what happened. She stated that she was aware Resident A was supposed to receive a PRN script for vertigo. LD Fredricks checked the medication cart, and the medication was not in the cart. LD Fredricks stated that the script for Mobic was for 30 days, it was an old script and needed to be taken off the MAR. During this visit, LD Fredricks contacted the pharmacy. The pharmacist during this call confirmed the discontinuation dates for Ketorolac (discontinued 05/18/2026), Dexamethasone (discontinued 05/12/2026), and Mobic (discontinued 06/10/2025).

Staff McDaniels stated that Resident A goes out into the community without staff supervision and has transportation services that Resident A's insurance covers. Staff McDaniels stated that Resident A was transported to the hospital by ambulance. LD Fredericks stated that she arranged a plan with the hospital to have Resident A transported back to the facility. LD Fredericks stated that Resident A's Relative 1 must have been on their way to pick Resident A up while LD Fredericks was on the phone with the hospital, or prior to the call with the hospital. Relative 1 called LD Fredericks saying they were headed to the facility with Resident A, but they had gotten lost. Per Staff McDaniels and LD Fredericks, Resident A handles his own medical appointments and keeps track of them himself. Staff McDaniels stated that she does not think that any of Resident A's medications cause Resident A to become dizzy, and that when he was feeling dizzy on 06/15/2026, it was not around med passing time. Staff McDaniels stated that they cannot review his medications, only

Resident A's physician can do that, and that Resident A just recently had a medication review. They reported that Resident A uses his phone and keeps appointment cards in his wallet to keep track of physician appointments.

On 07/28/2026, I conducted an exit conference with LD Sara Fredricks. I informed LD Fredricks of the findings and conclusions. She stated that she has contacted the resident's physicians and requested copies of discontinuation and med change orders so she can start tracking physician orders/instructions.

APPLICABLE RULE	
R 400.697	**Resident transportation.**
	(1) A licensee shall ensure the availability of transportation services as provided for in a resident care agreement. A licensee shall provide or arrange transportation for residents in a certified facility.
ANALYSIS:	On 06/22/2026, I conducted an unannounced on-site at the facility. I interviewed licensee designee Sara Fredericks. She stated that Resident A went to the hospital via ambulance on 06/15/2026, and the hospital agreed to provide Resident A with a cab to be transported back to the facility after discharge, but Relative 1 picked Resident A up. During this on-site, I interviewed Resident A. Resident A confirmed riding by ambulance to the hospital and being picked up from the hospital by Relative 1's friend. Resident A stated that he can be out in the community without staff supervision. Resident A stated that he called around to get a ride home, because he did not have his cell phone that had contact information for the public transportation company he uses. Resident A stated that the hospital did offer an ambulance ride back to the facility. During the course of the investigation, I reviewed Resident A's assessment plan which notes that Resident A can move independently in the community, can communicate needs, is alert to surroundings, reads and writes, and follows instructions. Resident A's *Resident Care Agreement* dated 02/17/2023, does not have any transportation fees, or any specific transportation services noted. On 07/20/2026, I interviewed staff Tamara McDaniels. Staff McDaniels stated that Resident A goes out into the community without staff supervision and has transportation services that Resident A's insurance covers.

	There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident care.**
	(11) A licensee shall contact a resident's health care professional for instructions as to the care of the resident if the resident requires the care of a health care professional. The licensee shall record in the resident's record any instructions for the care of the resident.
ANALYSIS:	On 06/22/2026, I conducted an unannounced on-site at the facility. I interviewed licensee designee Sara Fredericks. She stated that Resident A has a primary physician who he is seen regularly, and that Resident A gets blood drawn monthly. During the course of the investigation, I reviewed Resident A's file. There were no physician appointment notes, nor list of physician visit notes/orders observed in the file. On 07/20/2026, I conducted a follow-up unannounced on-site at the facility. I inquired about Resident A's medications (i.e. Meclizine (Antivert), Mobic, Ketorolac, and Dexamethasone as there was no record in Resident A's file about the medications being discontinued. A call to confirm the discontinuation dates was conducted during this on-site by LD Fredricks. On 07/20/2026, I interviewed staff Tamara McDaniels and LD Fredricks. They reported that Resident A uses his phone and keeps appointment cards in his wallet to keep track of physician appointments. There is a preponderance of evidence to substantiate a rule violation as there was no record of instructions for the care of Resident A in Resident A's case file.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/22/2026, I conducted an unannounced on-site at the facility. During this on-site, I reviewed Resident A's resident file. A copy of a

06/15/2026 Covenant Health Care *After Visit Summary* was obtained. It notes that Resident A was seen at the hospital due to vertigo. The *reason for visit* is listed as dizziness, and the diagnosis was vertiginous syndrome. It notes that Resident A was to start taking meclizine (Antivert), and the instructions were to pick the medication up at Genoa Healthcare, and Resident A was to follow up with Toby C.J. Long, MD and Covenant Emergency Care Center- Emergency Medicine. The discharge paperwork did not give any details as to the dosage of the medication.

On 07/20/2026, I conducted a follow-up unannounced on-site at the facility. I spoke with LD Sara Fredricks regarding Resident A's Meclizine/Antivert script that was prescribed on 06/15/2026 during Resident A's visit at Covenant Health Care. The script was not noted on Resident A's medication administration record, and the medication was not on site at the facility. LD Fredericks stated that she would have to contact the pharmacy to follow up about the medication.

On 07/28/2026, I conducted an exit conference with LD Sara Fredricks. I informed LD Fredricks of the findings and conclusions.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	On 06/22/2026, I obtained a copy of Resident A's hospital discharge paperwork that noted Resident A was prescribed medication after a 06/15/2026 visit to Covenant Health Care. The medication was not added to the June 2026 MAR. On 07/20/2026, I conducted a follow-up on-site at the facility. The prescription was not listed on Resident A's July 2026 MAR, and the medication was not available in the medication cart. There is a preponderance of evidence to substantiate a rule violation as there was no follow-through to obtain the medication prescribed by Resident A's physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/22/2026, I conducted an unannounced on-site at the facility. I requested a copy of Resident A's *Health Care Appraisal*. Licensee Fredricks reported the paperwork for Resident A is not up to date. The health care appraisal on file at the facility was dated 02/23/2023. A photo of the documentation was taken.

On 07/20/2026, I conducted a follow-up unannounced on-site at the facility. LD Fredricks reported she had the health care appraisal updated. Resident A's *Health Care Appraisal* was updated on 06/26/2026. A copy of the updated health care appraisal was observed in Resident A's file.

On 07/28/2026, I conducted an exit conference with LD Sara Fredricks. I informed LD Fredricks of the findings and conclusions.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.
ANALYSIS:	On 06/22/2026, I conducted an unannounced on-site at the facility. Resident A's most current health care appraisal was dated 02/23/2023. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/22/2026, I conducted an unannounced on-site at the facility. I requested a copy of Resident A's *Assessment Plan for AFC Residents*. LD Fredricks reported the paperwork for Resident A is not up to date. The assessment plan on file at the facility was dated 02/17/2023. Photos were taken of the documentation.

On 07/20/2026, I conducted a follow-up unannounced on-site at the facility. LD Fredricks reported she updated the assessment plan. An updated copy of Resident A's *Assessment Plan for AFC Residents* was observed in Resident A's file. It was dated 06/24/2026.

On 07/28/2026, I conducted an exit conference with LD Sara Fredricks. I informed LD Fredricks of the findings and conclusions.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	On 06/22/2026, I conducted an unannounced on-site at the facility. I reviewed Resident A's *Assessment Plan for AFC Residents* which was last dated 02/17/2023. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/22/2026, I conducted an unannounced on-site at the facility. I requested a copy of Resident A's *AFC- Resident Care Agreement*. Licensee Fredericks reported the paperwork for Resident A is not up to date. The health care appraisal on file at the facility was dated 02/17/2023, and there was no documentation noting the care agreement had been reviewed annually.

On 07/20/2026, I conducted a follow-up unannounced on-site at the facility. LD Fredricks reported she updated the *Resident Care Agreement*. An updated copy of Resident A's care agreement was observed in Resident A's file. It was dated 06/26/2026.

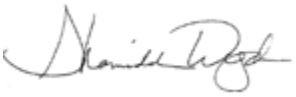
On 07/28/2026, I conducted an exit conference with LD Sara Fredricks. I informed LD Fredricks of the findings and conclusions.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident, resident's designated representative, or responsible agency at least annually or more often if necessary. Any changes to the resident care

	agreement must be re-signed by all applicable parties. If the annual review results in no changes to the resident care agreement the resident care agreement does not need to be re-signed but the licensee shall document that all applicable parties were contacted and agreed that no changes were necessary.
ANALYSIS:	On 06/22/2206, I conducted an unannounced on-site at the facility. I reviewed Resident A's resident care agreement that was observed to be last updated on 02/17/2023. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



07/28/2026

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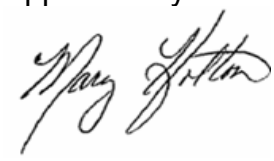
Shamidah Wyden Date
Licensing Consultant

Approved By:



07/28/2026

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Mary E. Holton Date
Area Manager