GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 12, 2021

Janet Patterson
Pathways to Self Determination, LLC
Suite 102
28237 Orchard Lake Rd.
Farmington Hills, MI 48334

RE: License #: AS630339657
Investigation #: 2021A0605038
Saginaw Center

Dear Ms. Patterson:

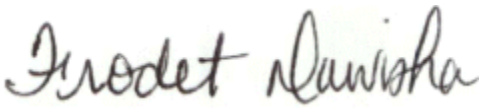
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630339657
Investigation #:	2021A0605038
Complaint Receipt Date:	06/30/2021
Investigation Initiation Date:	06/30/2021
Report Due Date:	08/29/2021
Licensee Name:	Pathways to Self Determination, LLC
Licensee Address:	Suite 102 28237 Orchard Lake Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(248) 723-7152
Administrator/Licensee Designee:	Janet Patterson
Name of Facility:	Saginaw Center
Facility Address:	312 Saginaw Pontiac, MI 48340
Facility Telephone #:	(248) 221-7455
Original Issuance Date:	11/21/2014
License Status:	REGULAR
Effective Date:	02/03/2020
Expiration Date:	02/02/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED/MENTALLY ILL TRAUMATICALLY BRAIN INJURED/AGED

II. ALLEGATION(S)

	Violation Established?
Per an incident report on 6/27/2021, Resident A was smoking a cigarette outside on the porch while staff was making dinner. When staff went to call Resident A inside to eat, Resident A could not be found. A missing person report was filed. Resident A is supposed to be always at eyesight. There is insufficient staff at this home.	Yes

III. METHODOLOGY

06/30/2021	Special Investigation Intake 2021A0605038
06/30/2021	APS Referral Adult Protective Services (APS) denied referral.
06/30/2021	Special Investigation Initiated - Letter I emailed Office of Recipient Rights (ORR) Brittany Navetta regarding the allegations. Ms. Navetta will be investigating the allegations and stated Resident A must be at eyesight according to their individual plan of service (IPOS).
07/01/2021	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed Residents B, C, D, E, and F, the home manager Brandy Nickels and direct care staff (DCS) Harold Roberts. I also reviewed Resident A's individual plan of service completed by Training and Treatment Innovations (TTI) on 04/16/2021 as well as the staff schedule.
08/04/2021	Contact - Telephone call made I contacted ORR worker Brittany Navetta for an update on her case.
08/04/2021	Contact - Telephone call made I interviewed DCS Tonya Greene regarding the allegations.
08/09/2021	Contact - Telephone call made I interviewed Resident A's supports coordinator with TTI, Jessica Dubie.

08/09/2021	Exit Conference I conducted the exit conference with licensee Janet Patterson via telephone with my findings.

ALLEGATION:

Per incident report on 6/27/2021, Resident A was smoking a cigarette outside on the porch while staff was making dinner. When staff went to call Resident A inside to eat, Resident A could not be found. A missing person report was filed. Resident A is supposed to be always at eyesight. There is insufficient staff at this home.

INVESTIGATION:

On 06/30/2021, intake #180480 was assigned for investigation regarding Resident A was supposed to always be at eyesight, but was not; therefore, he eloped from the home.

On 06/30/2021, I made a referral to Office of Recipient Rights (ORR) worker Brittany Navetta. Ms. Navetta reviewed Resident A's Individual Plan of Service (IPOS) completed by Training and Treatment Innovations (TTI) that specifically indicated that Resident A must be at eyesight at all times. Ms. Navetta emailed me Resident A's IPOS. Ms. Navetta stated she will be opening a case regarding these allegations.

On 07/01/2021, I conducted an unannounced on-site investigation. I met with the home manager Brandy Nickels who stated that Resident A was still missing and that a missing persons report was filed with the police. Ms. Nickels has been with this corporation and as the home manager since 10/2020. She usually works the morning and sometimes the afternoon shifts. The allegations were discussed. Ms. Nickels stated that there is only one staff per shift when there should be two staff per shift. She stated this home is short staffed. Ms. Nickels stated that Resident A has eloped several times. The first time was on 06/05/2021, during Ms. Nickels' shift. She was preparing lunch and when she called out to all the residents, everyone responded except for Resident A. Resident A had eloped. Ms. Nickels stated another staff arrived at the home, so she had that staff stay with the residents while she went out looking for Resident A. Ms. Nickels received a call from her friend who stated that Resident A was spotted at a party store. Ms. Nickels went to the party store and was told by the owner that Resident A was there, cashed a check and then left the store. She was unable to locate him. Ms. Nickels stated that Auburn Hills Police Department found Resident A on 06/21/2021 and brought Resident A back to the group home. Ms. Nickels asked Resident A, "Why did you leave?" Resident A replied, "I was just walking and kept walking."

Ms. Nickels stated on 06/26/2021, she caught Resident A eloping from the home when she had arrived for her shift. She immediately jumped into her car and found him walking down the street. Resident A got into her car, and she brought him home. This was in the morning as the staff on shift was making breakfast.

Ms. Nickels stated the next day, on 06/27/2021, DCS Tonya Greene was working the afternoon shift. Ms. Greene was preparing dinner and all the residents including Resident A were outside on the porch. Ms. Greene called out to all the residents including Resident A, but Resident A did not respond nor did Resident A come inside. Ms. Greene checked both the front and back porch and could not locate Resident A. Ms. Greene then called the police and made a report.

Ms. Nickels provided me with a copy of Resident A's IPOS for my review. According to the IPOS dated on 04/16/2021 completed by TTI, "Home staff will provide 3:1 staffing ratio during wake hours and 6:1 staffing during sleep hours to prevent elopement. Home staff will provide "eyes-on" supervision of Resident A at all times due to high elopement risk."

Ms. Nickels provided me with the staff schedule for 06/27/2021 when Resident A eloped. There was only one staff, Tonya Greene who was scheduled for the afternoon shift: 4PM-12AM.

I interviewed Resident B regarding the allegations. Resident B has lived here for five years. Resident B stated that Resident A is not here anymore, but Resident B does not know why. Resident B stated they do not have any information to provide about Resident B.

I interviewed Resident C regarding the allegations. Resident C has lived here for three years. Resident C stated that Resident A left the group home but does not know why. Resident C stated that Resident A has left this home twice. Resident C stated there should be two staff on shift, but there is only one staff.

I interviewed Resident D regarding the allegations. Resident D stated, "Resident A is a murderer that killed me last night." Resident D was unable to provide any details to the allegations.

I interviewed Resident E regarding the allegations. Resident E stated, "I don't know Resident A." Resident E was unable to provide any further information.

I interviewed Resident F regarding the allegations. Resident F stated, "I was inside when Resident A left." No other information was provided.

I interviewed DCS Harold Roberts regarding the allegations. Mr. Roberts stated he works all shifts and has only been working for this corporation for about two years. Mr. Roberts stated there should be two staff per the morning and afternoon shift, but that there is only one staff per those shifts. Mr. Roberts was not working on 06/27/2021 when Resident A eloped but stated that Resident A had eloped more than once from this group home. Mr. Roberts stated that Resident A does not have to be at eyesight when Resident A is outside on the front porch even though according to Resident A's IPOS, Resident A must be always at eyesight. Mr. Roberts stated that Resident A does

not have community access only if there is staff accompanying him. He did not have any other information to provide.

On 08/04/2021, I interviewed via telephone DCS Tonya Greene regarding the allegations. Ms. Greene has worked for this corporation since 10/2020. She works all shifts but usually the afternoon shift. Ms. Greene stated there should be two staff during the morning and afternoon shift, but due to staff shortage, there is only one staff during those shifts. On 06/27/2021, Ms. Greene was working the afternoon shift alone. She was preparing dinner and washing clothes. Resident A was near the washer/dryer as Resident A took their shoes out of the dryer. Ms. Greene passed out medications and Resident A went outside. Ms. Greene finished preparing dinner and when dinner was ready, she called out to all the residents. She did not see Resident A come inside, so she went outside and checked the front and back porch but did not see Resident A. Ms. Greene called the home manager, Ms. Nickels and then called 911 and reported Resident A missing. Ms. Greene stated that Resident A should be always at eyesight, but that is impossible with only one staff on shift. Ms. Greene stated this was the third time that Resident A eloped from this home. The first time Resident A eloped, Ms. Greene was not working, but she was working the second time which was on 06/26/2021, but Ms. Nickels found Resident A and brought Resident A back home. Ms. Greene stated that Resident A was found by police, taken to McLaren Hospital, and discharged back to this group home on 08/03/2021. Ms. Greene stated she asked Resident A “Why did you leave?” Resident A replied, “I don’t like Pontiac.”

On 08/04/2021, I contacted ORR worker Brittany Navetta regarding an update on her case. Ms. Navetta stated she is substantiating her case as neglect three given that this group home did not follow Resident A’s IPOS regarding keeping Resident A at eyesight. Ms. Navetta stated she received a telephone call from Resident A’s supports coordinator Jessica Dubie stating that this group home is short staffed.

On 08/09/2021, I contacted TTI’s supports coordinator Jessica Dubie regarding the allegations. Ms. Dubie stated according to Resident A’s IPOS, there should be two staff per the morning and the afternoon shift due to Resident A’s high risk of elopement. Ms. Dubie is working on getting Resident A into another placement with a higher level of care. Ms. Dubie stated that whenever Resident A eloped from this group home, there was only one staff on shift. Currently, Ms. Dubie has been visiting Resident A weekly given the risk of Resident A’s elopement and that this home is unable to meet Resident A’s IPOS needs regarding keeping Resident A at eyesight always.

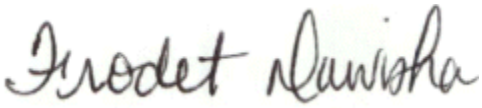
On 08/09/2021, I conducted the exit conference via telephone with licensee Janet Patterson with my findings. Ms. Patterson does not feel that Saginaw Center should be cited because she is not the only licensee having difficulties getting staff. Ms. Patterson was advised that if this group home was unable to meet Resident A’s IPOS regarding sufficient staff and ensuring that Resident A is at eyesight always, then Resident A should not have been admitted into this group home or should have been discharged from his home once Resident A required a higher level of care. Ms. Patterson agreed to submit a corrective action plan regarding the findings.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation and information gathered, there was insufficient staff on 06/05/2021, 06/26/2021, and 06/27/2021 when Resident A eloped from this group home. According to Resident A's IPOS dated 04/16/2021, there should be 3:1 staff during the morning and the afternoon shift. However, there was only one staff during the above dates according to the staff schedule for June 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my review of Resident A's IPOS completed by TTI on 04/16/2021, Resident A was not provided with the proper supervision as specified in their IPOS. Resident A was not at eyesight as stated in their IPOS when Resident A eloped on 06/05/2021, 06/26/2021 and 06/27/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

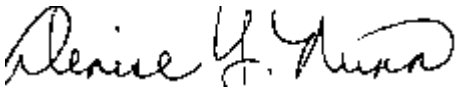
Contingent upon receiving an acceptable corrective action plan, I recommend this special investigation be closed and no change to the status of the license.



08/12/2021

Frodet Dawisha Date
Licensing Consultant

Approved By:



08/12/2021

Denise Y. Nunn Date
Area Manager