STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 12, 2022

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

RE: License #: AS630339657
Investigation #: 2022A0605010
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
Cadillac Place, Ste 9-100
Detroit, MI 48202
(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 #:	2022A0605010
Complaint Receipt Date:	11/12/2021
Investigation Initiation Date:	11/15/2021
Report Due Date:	01/11/2022
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) 723-7152
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 AGED/TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has been hallucinating for several weeks and is currently experiencing psychosis. Resident A was hospitalized, and urine screen tested positive for fentanyl which is not one of her medications.	No
Staff have been passing medications to residents when staff have not completed their medication administration training.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/12/2021	Special Investigation Intake 2022A0605010
11/15/2021	Special Investigation Initiated - On Site I conducted an unannounced on-site investigation. I interviewed Resident A, Resident B, Resident C, and Resident D. I also interviewed direct care staff Will Cunningham and David Ellis who is the consultant services with Pathways to Self Determination, LLC. I reviewed Resident A's medications and medication logs and the staff schedule.
12/02/2021	Contact - Telephone call received Adult Protective Services (APS) Johnathan Johnson is investigating these allegations.
12/02/2021	APS Referral APS made referral.
12/28/2021	Contact - Telephone call made I interviewed the home manager Ronald Bush II, DCS Harold Robers and Kristen Brown.
01/06/2022	Contact - Telephone call made I interviewed DCS Cheryl Powell regarding the allegations and left a voice mail message for DCS Sateka Hobbs and Correy Jefferson. I also left a message for Office of Recipient Rights (ORR) Brittany Navetta.

01/06/2022	Contact - Document Sent I emailed David Ellis with Pathways of Self Determination requesting the staff schedule from 11/01/2021-11/13/2021.
01/06/2022	Contact - Document Sent I emailed ORR Brittany Navetta advising her I will be conducting another on-site visit on 01/10/2022 to review medication logs and staff schedules.
01/06/2022	Contact - Document Received I received an email from ORR Brittany Navetta that included medication logs for Resident A, B, C, D, E, and F. ORR stated she will meet me at Saginaw Center on 01/10/2022.
01/10/2022	Contact - Face to Face I along with ORR Brittany Navetta conducted an unannounced on-site. I interviewed the home manager Ronald Bush and reviewed residents' medication logs and staff schedules.
01/11/2022	Contact - Telephone call made I reinterviewed DCS Kristen Brown and Harold Roberts regarding the medication logs.
01/11/2021	Exit Conference I conducted the exit conference via telephone with licensee Janet Patterson regarding my findings.

ALLEGATION:

- **Resident A has been hallucinating for several weeks and is currently experiencing psychosis. Resident A was hospitalized, and urine screen tested positive for fentanyl which is not one of her medications.**
- **Staff have been passing medications to residents when staff have not completed their medication administration training.**

INVESTIGATION:

On 11/12/2021, intake #183445 was referred by Adult Protective Services (APS) regarding Resident A was hospitalized and tested positive for fentanyl. Resident A is not prescribed fentanyl. On 11/22/2021, I received additional allegations from Office of Recipient Rights Office (ORR) stating that all the residents at Saginaw Center are being administered medications by staff that are not trained to administer medications. In addition, the medication logs are being falsified.

On 11/15/2021, I conducted an unannounced on-site investigation. I interviewed Resident A, Resident B, Resident C, Resident D and Resident E. I also interviewed direct care staff William Cunningham and David Ellis who is the consultant services with Pathways to Self Determination, LLC. I reviewed Resident A's medications and medication logs and the staff schedule.

On 11/15/2021, I interviewed Resident A regarding the allegations. However, due to Resident A’s mental illness, I was unable to complete a full interview. Resident A stated, “they’re putting pills into my pills. I take pills to sleep. I take pills in the AM and PM. Someone makes the pills.” Resident A was unable to provide any details regarding her medications.

On 11/15/2021, I attempted to interview Resident B, Resident C and Resident D regarding the allegations, but they refused to be interviewed.

On 11/15/2021, I interviewed Resident E regarding the allegations. Resident E stated staff pass medications but he’s not sure they’re names but believes it’s Ron the home manager. Resident E stated he does not know what fentanyl is or if he or any other resident is prescribed with fentanyl. He was unable to provide any further details.

On 11/15/2021, I interviewed direct care staff William Cunningham regarding the allegations. Mr. Cunningham began employment with Pathways to Self Determination last week and works 8AM-4PM. Mr. Cunningham stated there is no resident including Resident A that is prescribed with fentanyl. I requested to review Resident A’s medications and medication logs. The medication closet is located inside the office. The office door was propped open with a small trashcan and the medication closet door was unlocked and opened. Mr. Cunningham stated the office door is usually locked but he did not know the medication door was unlocked.

On 11/15/2021, I reviewed all the residents’ medication baskets and there was no fentanyl prescribed to any resident. I took pictures of Resident A’s medication logs for further review and staff schedule from 11/14/2021-11/30/2021.

During my on-site investigation on 11/15/2021, Mr. Cunningham contacted David Ellis who arrived shortly after at Saginaw Center. I interviewed Mr. Ellis regarding the allegations. Mr. Ellis stated that Resident A was taken to Pontiac General because she was in a psychosis state and staff was unable to redirect her due to her manic behavior. He stated then Resident A was transferred to St. Joe’s Hospital and then to Beaumont Hospital in their psychiatric unit. Mr. Ellis stated Resident A is not prescribed fentanyl and neither are any of the other residents. He stated Resident A must have been administered fentanyl at one of the three hospitals she was at, not at Saginaw Center. Mr. Ellis stated there are no narcotics at Saginaw Center and that Resident A does not have community access as she requires 24-hour supervision; therefore, Resident A must have been administered fentanyl at one of the hospitals.

I advised Mr. Ellis that Mr. Cunningham cannot be left unsupervised with Residents A, B, C, and D as he had not completed any of his training except for recipient rights. Mr. Ellis contacted Mr. Bush via telephone and advised Mr. Bush he needed to return to the home. Mr. Ellis stated he will remain with Mr. Cunningham until Mr. Bush arrives.
I advised Mr. Ellis that the medication door was unlocked when I arrived at Saginaw Center. Mr. Ellis stated the medication door is always locked and he is not sure why it was unlocked since all staff know that the door must be locked.

On 12/02/2021, I received a telephone call from APS Jonathan Johnson regarding the allegations pertaining to Resident A. Mr. Johnson stated Resident A was taken to Pontiac General and then transferred to another hospital before going to Beaumont Hospital where she was positive for fentanyl. He stated Pontiac General, or St. Joe's Hospital may have administered fentanyl prior to Resident A going to Beaumont Hospital. Ms. Johnson stated he too review all the residents' medications and could not locate fentanyl at Saginaw Center.

On 12/28/2021, I interviewed the home manager Ronald Bush II via telephone regarding the allegations. Mr. Bush began employment with Pathways to Self Determination, LLC last summer. He stated he works all three shifts when he is needed. Mr. Bush reported Resident A needed a medication review as she had been decompressing over several days. On 11/09/2021, he contacted Resident A's psychiatrist Dr. David Baker to "keep him (Dr. Baker) informed." That night, Mr. Bush was informed by the midnight staff that Resident A was highly agitated and wanted to go outside. Resident A was pacing back and forth. On 11/10/2021, Mr. Bush arrived at Saginaw Center and observed Resident A's behaviors and Resident A appeared to be in a manic psychosis state. Mr. Bush called David Ellis for direction and Mr. Ellis advised Mr. Bush to take Resident A to the hospital. Mr. Bush transported Resident A to Pontiac General Hospital. Pontiac General completed a preliminary assessment and because the hospital was at capacity, Mr. Bush was informed that Resident A will be moved to another hospital once one becomes available. Mr. Bush stated Resident A was still agitated and tried to elope from the hospital. Mr. Bush then observed one of the nurses at Pontiac General administered a drug, (name unknown) to Resident A to calm her down. Resident A was then transferred to St. Joe's Hospital via ambulance and then he received a call on 11/14/2021 stating that Resident A was at Beaumont Hospital. Mr. Bush stated Resident A must have been administered fentanyl while at one of the hospitals because no resident, including Resident A is prescribed with fentanyl or any other narcotic.

Mr. Bush stated the only staff that administers medications to residents are him and Harold Roberts who have completed medication administration training. Mr. Bush denied that staff who have not completed medication training are passing medications.

On 12/28/2021, I interviewed DCS Harold Roberts regarding the allegations. Mr. Roberts has been employed with Pathways to Self Determination, LLC for two years. He works the midnight shift 4PM-12AM. Mr. Roberts stated there were two staff per shift, but since Resident F has been discharged from Saginaw Center, there is only one

staff per shift. Mr. Roberts has completed all his training including medication administration. Mr. Roberts stated that Resident A went to the hospital for low sodium and that the ambulance transported Resident A to the hospital. Mr. Roberts stated he heard that Resident A was at three different hospitals before returning to Saginaw Center. He stated there is no resident that is prescribed with fentanyl including Resident A. Mr. Roberts believes Resident A was administered with fentanyl while at one of the three hospitals: therefore, testing positive.

Mr. Roberts stated he is the only staff that administers medications during his shift, and he does not if any other staff who are untrained are administering medications. He stated he and the home manager Ronald Bush are the only individuals trained on medication administration. Mr. Roberts stated he always keeps the medication door locked to the medication cabinet and has the key with him always.

On 12/28/2021, I interviewed DCS Kristen Brown regarding the allegations. Ms. Brown has been employed with Pathways to Self Determination, LLC for one year. She has not completed all her trainings as she still needs medication administration and nutrition. Ms. Brown stated she does not pass medications to any resident because she is not trained. Ms. Brown stated she works the midnight shift; therefore, medication has already been passed so she does not have to go into the medication room, but that the door to the medication closet is always locked and the keys are with her. Ms. Brown stated she heard about Resident A tested positive for fentanyl and stated that there are no narcotics at Saginaw Center including fentanyl; therefore, Resident A must have been administered fentanyl when she was at one of the three different hospitals. Ms. Brown stated that Resident A was “acting out,” and the home manager Ronald Bush transported her to the hospital. She stated she has no other information regarding Resident A.

On 01/06/2022, I interviewed DCS Cheryl Powell via telephone regarding the allegations. Ms. Powell stated she was employed with Pathways to Self Determination, LLC until her employment was terminated because of her background check. Ms. Powell stated she does not know anything about Resident A going to the hospital or being positive for fentanyl. Ms. Powell stated she was not passing medication because she never completed medication training. She does not know of any staff passing medications that were not trained in medication administration. She stated the only staff she knew who completed medication administration training were the home manager Ronald Bush and DCS Harold Roberts.

On 01/06/2022 and 01/10/2022, I attempted to contact DCS Sateka Hobbs via telephone. I left a message for Ms. Hobbs on 01/06/2022, but when I called again on 01/10/2022, Ms. Hobbs phone number was disconnected and no longer in service.

On 01/06/2022 and 01/10/2022, I left messages for DCS Corey Jefferson, but he never returned any of my calls.

On 01/10/2022, I along with ORR Brittany Navetta conducted a follow-up on-site investigation at Saginaw Center. The home manager Ronald Bush was present, and I observed Residents A and B. I reviewed January 2022 medication logs for Residents A, B, C, D, and E. The only initials on all the medication logs were “R,” for Ronald Bush and “H,” for Harold Roberts. I took pictures of the staff schedules from October 2021 through January 2022 and according to the staff schedules, Ronald Bush was not working daily during medication administration, but his initials were on the medication logs. Mr. Bush stated he works Monday-Friday from 8AM-4PM and DCS Harold Roberts works Monday-Friday from 4PM-12AM. Mr. Bush stated he passes the 8AM and the 4PM medications and when Mr. Roberts is off the schedule, then Mr. Bush returns to Saginaw Center and passes the 8PM medications. He stated during the weekends, both he and Mr. Roberts take turns in coming out to Saginaw Center and pass medications. I advised Mr. Bush that according to Resident A’s medication log at 8AM on 11/05/2021 and 8PM on 11/06/2021, the initials “SH,” were initialed in the box, but then the letter “R,” for Ronald Bush was written over the initials, “SH.” I advised Mr. Bush that according to the November 2021 staff schedule, DCS Sateka Hobbs was working the midnight shift from 4PM-12AM on 11/05/2021 and Ms. Hobbs worked the morning shift from 8AM-4PM on 11/06/2021. Mr. Bush stated, “I do not see that. It looks like an R to me.” Mr. Bush stated he is not falsifying the medication logs and that if his initial is on the medication log, then it means he is the staff that administered the medications. He was unable to provide an explanation as to why the initials “SH,” were on the log prior to him initialing over the “SH.”

On 01/11/2022, I reviewed the residents’ medication logs along with the staff schedules from October 31, 2021-December 31, 2021.

- Resident A’s October 2021, medication log at 8AM on 11/05/2021 and 8PM on 11/06/2021, the initials “SH,” were initialed in the box, but then the letter “R,” for Ronald Bush was written over the initials, “SH.”
- Resident A’s **Melatonin Tab 5MG**: take one tablet by mouth daily at bedtime was given at 8PM on 10/27/2021, but staff did not initial the medication log.
- Resident B’s October 2021 medication log at 8AM and 2PM from 10/02/2021-10/07/2021 has the initial “B,” in the boxes. However, according to the staff schedules, there is no staff with the name starting with the letter “B,” as their first initial. Also, the initial “R,” was on the medication log at 8PM from 10/23/2021-10/25/2021 when DCS Harold Roberts who has completed medication administration worked 4PM-12AM, not Robert Bush.
- Resident B’s **Metoclopram Tab 5MG**: take one tablet by mouth twice daily before meals was administered at 8PM on 12/11/2021 by DCS Kristen Brown who has not completed medication training as her initials “KB,” were in the box and staff did not initial the medication log at 8PM on 12/12/2021.
- Resident B’s **Novolin 100 Unit/ML**: inject subcutaneously three times daily per sliding scale was administered at 8PM from 12/09/2021-12/12/2021, but staff did not initial the medication log.
- Resident C’s October 2021 medication log at 8AM, 2PM, and 4PM from 10/02/2021-10/07/2021 has the initial “B,” in the boxes. However, according to

the staff schedules, there is no staff with the name starting with the letter “B,” as their first initial.

- Resident C’s **Artificial Tears Soln**: instill one drop into both eyes four times daily was administered at 12PM on 12/03/2021, 4PM on 12/10/2021 and 12/12/2021 but staff did not initial the medication log.
- Resident D’s October 2021 medication log at 8AM, 2PM, and 5PM from 10/02/2021-10/07/2021 has the initial “B,” in the boxes. However, according to the staff schedules, there is no staff with the name starting with the letter “B,” as their first initial.
- Resident D’s **Olanzapine Tab 20MG**: take half tablet (10MG) by mouth twice daily was given at 8PM on 10/26/2021, but staff did not initial the medication log.
- Resident E’s October 2021 medication log at 8AM 10/02/2021-10/07/2021 has the initial “B,” in the boxes. However, according to the staff schedules, there is no staff with the name starting with the letter “B,” as their first initial.
- Resident F’s October 2021 medication log at 8AM 10/02/2021-10/07/2021 has the initial “B,” in the boxes. However, according to the staff schedules, there is no staff with the name starting with the letter “B,” as their first initial.
- Resident F’s November 2021, medication log at 8AM on 11/05/2021 and 8PM on 11/06/2021, the initials “SH,” were initialed in the box, but then the letter “R,” for Ronald Bush was written over the initials, “SH.”

On 01/11/2022, I reinterviewed DCS Kristen Brown regarding the medication logs. Ms. Brown stated she normally works the midnight shift from 12AM-8AM during weekdays, but when she works the weekends, the home manager Ronald Bush comes to the home and passes the medications as she is not trained on medication administration. Ms. Brown stated sometimes DCS Harold Roberts comes whenever Mr. Bush is unable to. Ms. Brown stated she has never passed medication to any resident and does not know any staff’s name that starts with a “B.”

On 01/11/2022, I reinterviewed DCS Harold Roberts regarding the medication logs. Mr. Roberts stated he works the midnight shift 4PM-12AM and is the only person who passes medications at 8PM when he is working. Mr. Roberts stated that Ronald Bush’s initials should not be in the box if Mr. Roberts is scheduled to work because Mr. Roberts has completed medication training. Mr. Roberts stated he does not know why Mr. Bush’s initials are on the medication logs and can only speak regarding himself that whenever he passes medications, he initials the medication log. Mr. Roberts stated he does not know of any staff who is not trained on medication administration that has signed the medication log and Mr. Bush’s initial is written on top of that staff’s initials.

On 01/11/2022, I conducted the exit conference with licensee designee Janet Patterson regarding my findings. Ms. Patterson stated DCS William Cunningham completed his toolbox training, but not his Macomb-Oakland Regional Center (MORC) training yet and why he was left unsupervised. Ms. Patterson was not aware that staff who had not completed medication training were passing medications and the home manager Ronald Bush was overwriting his initial on top of their initials. Ms. Patterson stated

Ronald Bush and Harold Roberts are the only individuals who completed medication administration; therefore, both live nearby and return to Saginaw Center to pass medications. Ms. Patterson sent me a text message stating she spoke with Ronald Bush about the medication logs and Mr. Bush advised Ms. Patterson that sometimes Mr. Bush will assist Mr. Roberts with cooking dinner and Mr. Bush will pass medications in stead of Mr. Roberts; therefore, Mr. Bush initials the medication logs.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	During the on-site investigation on 11/15/2021, I observed the medication door to the medication closet unlocked and open.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Based on my investigation and review of Residents A's and Resident F's medication log at 8PM on 11/05/2021 and at 8AM on 11/06/2021, DCS Sateka Hobbs initialed the medication log stating she administered medication, but she had not completed medication administration training. On 12/10/2021, DCS Kristen Brown initialed Resident B's medication log at 8PM on 12/11/2021 when Ms. Brown had not completed her medication administration training.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on my investigation and review of residents' medication logs, I found the following missing initials from the person who administered medications: • Resident A's October 2021, medication log at 8AM on 11/05/2021 and 8PM on 11/06/2021, the initials "SH," were initialed in the box, but then the letter "R," for Ronald Bush was written over the initials, "SH." • Resident A's **Melatonin Tab 5MG**: take one tablet by mouth daily at bedtime was given at 8PM on 10/27/2021, but staff did not initial the medication log. • Resident B's October 2021 medication log at 8AM and 2PM from 10/02/2021-10/07/2021 has the initial "B," in the boxes. However, according to the staff schedules, there is no staff with the name starting with the letter "B," as their first initial. Also, the initial "R," was on the medication log at 8PM from 10/23/2021-10/25/2021 when DCS Harold Roberts who has completed medication administration worked 4PM-12AM, not Robert Bush. • Resident B's **Metoclopram Tab 5MG**: take one tablet by mouth twice daily before meals was administered at 8PM on 12/11/2021 by DCS Kristen Brown who has not completed medication training as her initials "KB," were in the box and staff did not initial the medication log at 8PM on 12/12/2021. • Resident B's **Novolin 100 Unit/ML**: inject subcutaneously three times daily per sliding scale was administered at 8PM from 12/09/2021-12/12/2021, but staff did not initial the medication log. • Resident C's October 2021 medication log at 8AM, 2PM, and 4PM from 10/02/2021-10/07/2021 has the initial "B," in the boxes. However, according to the staff schedules,

	there is no staff with the name starting with the letter “B,” as their first initial. • Resident C’s **Artificial Tears Soln**: instill one drop into both eyes four times daily was administered at 12PM on 12/03/2021, 4PM on 12/10/2021 and 12/12/2021 but staff did not initial the medication log. • Resident D’s October 2021 medication log at 8AM, 2PM, and 5PM from 10/02/2021-10/07/2021 has the initial “B,” in the boxes. However, according to the staff schedules, there is no staff with the name starting with the letter “B,” as their first initial. • Resident D’s **Olanzapine Tab 20MG**: take half tablet (10MG) by mouth twice daily was given at 8PM on 10/26/2021, but staff did not initial the medication log. • Resident E’s October 2021 medication log at 8AM 10/02/2021-10/07/2021 has the initial “B,” in the boxes. However, according to the staff schedules, there is no staff with the name starting with the letter “B,” as their first initial. • Resident F’s October 2021 medication log at 8AM 10/02/2021-10/07/2021 has the initial “B,” in the boxes. However, according to the staff schedules, there is no staff with the name starting with the letter “B,” as their first initial. • Resident F’s November 2021, medication log at 8AM on 11/05/2021 and 8PM on 11/06/2021, the initials “SH,” were initialed in the box, but then the letter “R,” for Ronald Bush was written over the initials, “SH.”
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation and information gathered, Resident A was administered only medications that were prescribed to Resident A. On 11/10/2021, Resident A was hospitalized for a psychotic episode at Pontiac General Hospital, but then moved to two other different hospitals within three days and then tested

	positive at Beaumont Hospital for fentanyl. Resident A possibly received fentanyl at one of the hospitals where she was hospitalized at. I reviewed all the residents' medications at Saginaw Center and no resident including Resident A is prescribed with fentanyl.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During an on-site investigation on 11/15/2021, Mr. Cunningham was working his morning shift with the home manager Ronald Bush. Mr. Bush stepped out with Resident F to "pick up supplies" leaving Mr. Cunningham unsupervised with the residents. Mr. Cunningham stated he has only completed his recipient rights training and is scheduled for all other training on 11/22/2021.

On 12/28/2021, Mr. Bush was interviewed regarding DCS William Cunningham being left unsupervised with Residents A, B, C, D and E. Mr. Bush stated on 11/15/2021, he was scheduled to work, but needed to go grocery shopping. He stated Mr. Cunningham was in training at the time, so Mr. Bush thought it was ok to leave Mr. Cunningham with the residents. Mr. Bush stated this was an isolated incident and no concerns occurred as Mr. Ellis called Mr. Bush while licensing was at Saginaw Center; therefore, Mr. Bush immediately returned to the home.

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:	During the on-site investigation on 11/15/2021, DCS William Cunningham was left unsupervised with Residents A, B, C, D, and E. Mr. Cunningham stated he only completed his recipient rights training. The licensee designee Janet Patterson stated Mr. Cunningham completed Pathways to Self Determination toolbox training but not his MORC training, which had been scheduled for 11/22/2021.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2021A0605038, dated 06/30/2021, CAP dated 09/13/2021**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.

01/11/2022

Frodet Dawisha — Date
Licensing Consultant

Approved By:

01/12/2022

Denise Y. Nunn — Date
Area Manager