GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2022

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

RE: License #: AS630339657
Investigation #: 2022A0465050
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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630339657
Investigation #:	2022A0465050
Complaint Receipt Date:	09/23/2022
Investigation Initiation Date:	09/27/2022
Report Due Date:	11/22/2022
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:	Janet Patterson
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:	02/03/2022
Expiration Date:	02/02/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 9/18/2022, Resident A eloped from the facility. On 10/22/2022, Resident B eloped from the facility.	Yes

III. METHODOLOGY

09/23/2022	Special Investigation Intake 2022A0465050
09/23/2022	APS Referral Adult Protective Services (APS) referral was denied
09/27/2022	Special Investigation Initiated - Letter I communicated with Complainant via email exchange
09/28/2022	Contact – Document sent Email exchange with CMH Office of Recipient Rights Officer, Aaron Winston
10/04/2022	Inspection Completed On-site I conducted a walk-through of the facility, reviewed Resident A and Resident B's records, and interviewed Resident A, Resident B, Resident C, Resident D, Resident E and direct care staff, Aaron Rice
10/14/2022	Contact – Telephone call made I left a voice message for Guardian A1, requesting a return call
10/26/2022	Special Investigation Intake Intake #191305 added to this special investigation
10/26/2022	Contact – Document sent I communicated with Complainant via email exchange
10/26/2022	APS Referral APS Referral pertaining to the complaint for Resident B was assigned to APS Worker, Donna Dennis for investigation
11/02/2022	Contact - Telephone call made I spoke to direct care staff, Harold Roberts, via telephone

11/02/2022	Contact – Document sent Email exchange with APS Worker, Donna Dennis
11/03/2022	Contact - Telephone call made I spoke to direct care staff, Corey Jefferson, via telephone
11/03/2022	Contact – Document received Email exchange with CMH Office of Recipient Rights Officer, Aaron Winston
11/04/2022	Inspection Completed On-Site I conducted a walk-through of the facility and interviewed Resident B and direct care staff, Ronald Bush
11/04/2022	Contact – Telephone call received I received a voice mail from Guardian A1, requesting a call back
11/04/2022	Contact – Telephone call made I spoke to Guardian B1 via telephone
11/04/2022	Contact – Telephone call made I spoke to CMH Case Manager, Margie DeMario, via telephone
11/04/2022	Contact – Telephone call made I received a voice mail from Guardian A1, requesting a return call
11/04/2022	Contact – Telephone call made I called Guardian A1 back, and left a voice mail requesting a return call
11/07/2022	Contact – Telephone call received I left a voice mail for Guardian A1, requesting a return call
11/09/2022	Contact – Telephone call received I spoke to Guardian A1, via telephone
11/09/2022	Exit Conference I conducted an exit conference with licensee designee/ administrator, Janet Patterson, via telephone

ALLEGATION:

- **On 9/18/2022, Resident A eloped from the facility.**
- **On 10/22/2022, Resident B eloped from the facility.**

INVESTIGATION:

On 9/23/2022, a complaint was received, alleging that on 9/18/2022, Resident A eloped from the facility without staff knowledge, due to insufficient staff supervision. The complaint indicated the following: On 9/18/2022, Resident A was observed on the second floor of the home with the exit door open by direct care staff, Aaron Rice. Mr. Rice asked Resident A to go downstairs, which Resident A refused. At approximately 5:30am, Mr. Rice went upstairs to check on Resident A and observed she was gone. Mr. Rice notified management, recipient rights and the police. Resident A returned to the facility on 9/20/2022 and stated that she had been at the hospital.

On 10/26/2022, a complaint was received, alleging that on 10/22/2022, Resident B eloped from the facility without staff knowledge, due to insufficient staff supervision. The complaint indicated the following: On 10/22/2022, at approximately 1:00am, direct care staff, Aaron Rice was unable to locate Resident B in the home. Mr. Rice notified management, recipient rights and law enforcement. Resident B was located at his mother's home by law enforcement and was brought back to the facility on 10/2/2022. The complaint stated that the door alarms in the home have not been working properly, allowing for residents to elope from the home.

On 9/27/2022 and 10/26/2022, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaints are accurate.

On 9/28/2022 and 11/3/2022, I spoke to Recipient Rights Officer, Aaron Winston, via email exchange. Mr. Winston stated that he is in the process of completing his investigation and will not be establishing any rule violations.

On 10/26/2022 and 11/2/2022, I spoke to APS Worker, Donna Dennis, via email exchange. Ms. Dennis stated that she is in the process of completing her investigation and does not believe there is sufficient information to substantiate for neglect.

On 10/4/2022 and 11/4/2022, I conducted onsite investigations at the facility. During the onsite investigations, I conducted a walk-through of the facility, reviewed Resident A and Resident B's records, interviewed Resident A, Resident B, Resident C, Resident D, Resident E and direct care staff, Aaron Rice and Ronald Bush.

During my onsite investigation, I observed that all resident bedrooms are on the second floor. On the second floor, at the end of the hallway, I observed an emergency exit door with a stairway, leading directly outside to the ground level of the home. I observed the exit door to have an adhesive-based door chime installed. Each time I opened the door, the chime made a doorbell ring sound, but immediately stopped once the door was closed shut. I did not observe any other alarm system in place for this exit door. This exit door is on the second floor, and not visible to staff when they are on the main level of the home.

Resident A's *Face Sheet* states that she was admitted to the facility on 2/27/2020 and has a legal guardian, Guardian A1. The *Heath Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia and Bi-Polar Disorder. The *Assessment Plan for AFC Residents* states that Resident A can independently move within the community but is required to notify staff prior to leaving the home, has a history of aggressive behavior, independently completes self-care tasks, and does not require use of assistive devices.

Resident B's *Face Sheet* states that he was admitted to the facility on 3/6/2017 and has a legal guardian, Guardian B1. The *Heath Care Appraisal* listed Resident B's medical diagnosis as Schizophrenia. The *Assessment Plan for AFC Residents* states that Resident B can independently move within the community but is required sign in and out and notify staff prior to leaving the home, has a history of aggressive behavior, requires prompting to complete self-care tasks, and does not require use of assistive devices for mobility.

I reviewed the *Incident/Accident Reports* for Resident A and Resident B, which documented the following elopements:

Resident A:

> 9/18/2022 at 5:15am; Completed by Darryl Pointer: At approximately 5:00am, staff, Aaron Rice, called me while I was on my way to work. Mr. Rice told me that a door was open, but he did not know which one. I informed him to go upstairs and check what is going on. Mr. Rice observed Resident A near the door with door open, stating that she wanted some air. He instructed her to come downstairs so she could be monitored. Resident A refused and returned to her bedroom. When I arrived to the home at 5:45am, I immediately went upstairs to check on the situation. I entered Resident A's bedroom, and she was not in there. I proceeded to check the house and outside premises and Resident A was nowhere to be found. Staff walked around the neighborhood to search for Resident A for 40-45 minutes. We then waited another 40-45 minutes, to see if she would return home on her own, which she did not. I then called the police and upper management to inform them that Resident A was missing. I also called common ground, and surrounding hospitals and emergency rooms to see if Resident A was admitted. Corrective Measure: Staff will report incident to upper management as soon as missing person is discovered, and not wait until after they looked for. Staff will follow correct procedure for missing clients.

Resident B:

> 4/8/2022 at 6:51am; Completed by April McGuire: While staff was cooking breakfast, Resident B asked for a cigarette. Staff gave Resident B a cigarette and then continued to cook breakfast. Staff went to let Resident B know that breakfast was ready and Resident B wasn't on the porch nor in his room. Staff notified police and home manager.

8/2/2022 at 11:50am; Completed by Shavante Hutcherson: Resident B was outside asking strangers for money. I went outside to ask Resident B to stop asking strangers for money. I went back inside to finish making lunch and Resident B walked off. Police were notified.

10/22/2022 at 12:00am; Completed by Aaron Rice: Upon arriving at 12:00am, through shift change, I did a security check and noticed the upstairs door open. Staff drove through the neighborhood for an hour. After not being able to find Resident B, I called the police and made a report and notified the crisis hotline.

I interviewed Resident A, who stated that she is content living at the facility. Resident A stated, “It’s okay living here. Sometimes I want to live on my own, in my own place once day. But I am okay living here for now. I did leave the home in September. I left because I didn’t want to be here. I wanted to be in the community on my own for a while. When I left, I snuck out early in the morning. Staff didn’t know I left because I left from the upstairs exit door. Staff don’t know when we come and go from that door and there is no alarm on the door. When I left the facility, I walked to the hospital, but then I left and met a friend at the bus stop and stayed with that person for the night. I then went and visited other people. I came back to the facility two days after I left. I came back because I was ready to come home. I know I should not have left, and I won’t do it again. I have only left the home that one time and I haven’t don’t it since then.”

I interviewed Resident B, who stated, “I like living here but sometimes I like to go visit my mom. I have left here 4 or five times and when I leave, I do not tell staff where I am going. Whenever I decide to leave, I usually go out the upstairs door, so staff won’t know that I’m leaving. The upstairs door has a doorbell but not an alarm, and sometimes the doorbell isn’t working, and staff don’t hear me leave. Staff are nice to me. I know I am not supposed to leave but sometimes I want to see my mom.”

I interviewed Resident C, who stated, “I do not have any concerns with living here. The staff are good to us. The upstairs exit door is always open, and we can go in and out without staff knowing, but I have never taken off from the home.” Resident C did not vocalize any concerns related to the care and protection provided by direct care staff.

I interviewed Resident D, who stated, “Staff treat us good. There is a door upstairs near our rooms that we can use to leave the home without staff knowing. The door has an alarm that works sometimes but most times it doesn’t work. Staff don’t know when we leave the house when we go out the upstairs door.”

I interviewed Resident E, who stated, “Staff treat us well. I don’t think there are any issues here. There is a door upstairs that is always open, so we can go outside whenever we want, and staff don’t know. The alarm on the door doesn’t work most of the time.”

I interviewed Resident F, who stated, “I don’t have any concerns about living here. I want to move to a less restrictive home one day but other than that, I’m doing okay. A lot of people use to upstairs exit door and staff don’t monitor it.”

I interviewed direct care staff, Aaron Rice, who stated that he has worked at the facility for two months. Mr. Rice stated, “I am familiar with Resident A and Resident B, and I have worked when both eloped from the facility on different days. Upstairs, there is an exit door that leads directly outside and sometimes the residents use that door. There is an alarm on the door, but it sometimes doesn’t work because the residents will take out the batteries or disable it. On 9/18/2022, I heard the upstairs door alarm go off. I went upstairs and Resident A was standing in front of the door, and it was open. Resident A said she was just getting some air. I asked her to come downstairs and she refused and went back to her bedroom. I went back downstairs and decided to go upstairs a short while later to check on Resident A. I went upstairs the second time at 5:00am, and when I went upstairs, I could not find her anywhere. She was gone. Resident A never mentioned she was going to leave. I immediately notified the other staff and management, and staff looked around the neighborhood for her. I called the police and filed a missing person’s report. Two days later, Resident A showed up here at the house. She told me she went to visit friends and family. I am not sure where Resident A really went during the two days that she was gone. Resident A has not eloped since that one time. On 10/22/2022, I was working when Resident B eloped from the facility. Around 12:00am, I did a walk-through of the home and checked on the residents. When I went upstairs, I noticed the upstairs door was open. I notified management and staff came to assist in trying to locate Resident B. Staff drove through the neighborhood several times to try and find Resident B. After not being able to find Resident B, I called the police and made a report and notified the crisis hotline. Resident B has eloped from the home several times. When residents elope from the home, it is usually by using the upstairs exit door. We do not have an alarm on the door, it is more of a doorbell chime that stops when the door is closed.”

On 11/2/2022, I spoke to direct care staff, Harold Roberts, via telephone. Mr. Roberts stated that he has worked at the home for two years. Mr. Roberts stated, “The upstairs exit door is not visible to staff unless we are upstairs at all times. The residents have learned how to disable the door chime. The door does not have a real alarm system installed and the sound it makes is not loud enough for us to hear when we are downstairs because it only beeps for a few seconds. All resident rooms are upstairs, so they use the upstairs door to leave the home whenever they want. Resident A and Resident B have eloped from the facility by using the upstairs door, without staff knowing they have left the home.”

On 11/3/2022, I interviewed direct care staff, Corey Jefferson, via telephone. Mr. Jefferson stated that he has worked at the facility for one year. Mr. Jefferson stated, “I am aware of Resident A and Resident B eloping from the facility, but I was not working on the days they eloped. Resident A and Resident B don’t like feeling restricted and they want to be able to come and go freely. The upstairs exit door has a door chime that goes off when the door is opened but the residents discovered how to disable it so they

can leave the house without staff knowing. We can't lock the upstairs exit door so we can't prevent residents from eloping."

On 11/4/2022, I interviewed direct care staff, Ronald Bush, while onsite at the facility. Mr. Bush stated that he has worked at the facility for one year. Mr. Bush stated, "The upstairs door alarm has been disabled by residents each time they eloped. I don't recall any additional information about the alarm system."

On 11/4/2022, I spoke to CMH Case Manager, Margie DeMario, via telephone. Ms. DeMario stated that she is the case manager for Resident A, Resident B, Resident C, Resident D and Resident F. Ms. DeMario stated that Resident A and Resident B have a history of elopement. Ms. DeMario stated that she does not have any concerns related to the care being provided by staff to the residents.

On 11/4/2022, I spoke to Guardian B1 via telephone. Guardian B1 stated, "Resident B has a history of eloping and does so on a regular basis. He takes off from the home whenever he doesn't get his way or wants to be on his own. I have no concerns with the care the facility is providing. Resident B can be resistant to structure and sometimes does not like to follow rules."

On 11/9/2022, I spoke to Guardian A1, via telephone. Guardian A1 stated, "Resident A has a prior history of elopement, but this is her first time eloping from this home. I am not familiar with the upstairs exit door nor any alarms in place for safety measures. I do not have any concerns related to the supervision and protection being provided by the facility to residents."

On 11/9/2022, I conducted an exit conference with licensee designee/administrator, Janet Patterson, via telephone. Ms. Patterson is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 10/4/2022 and 11/4/2022, I conducted onsite investigations at the facility and observed the upstairs exit door with only a door chime installed. When I opened the door, a chime ringing sound lasted approximately three seconds and then stopped. I did not observe any other alarm system in place for this exit door. This exit door is on the second floor, and not visible to staff when they are on the main level of the home.

	According to the *Incident/Accident Reports*, during the last six months, Resident A has eloped once and Resident B has eloped three times, primarily by accessing the upstairs exit door without staff knowledge. According to Resident A, Resident B, Resident C, Resident D, Resident E and Resident F, the upstairs exit door is commonly used by all residents, during all times of the day, including sleeping hours, without staff knowledge of when residents are entering and exiting the home. According to Mr. Rice, Mr. Roberts, Mr. Jefferson, and Mr. Bush, it is common knowledge that residents enter and exit the home using the upstairs door, which is not monitored by staff and does not contain an adequate, nor properly working, alarm system. Mr. Rice, Mr. Roberts, Mr. Jefferson, and Mr. Bush acknowledged that despite the elopements of residents from the home, there have not been any additional safety measures put in place to prevent future elopements. Based on the information above, the facility has not implemented adequate safety measures to prevent resident elopement, therefore failing to ensure the safety and protection of all residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

Stephanie Gonzalez

11/14/2022

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Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

11/15/2022

_____

Denise Y. Nunn — Date
Area Manager