GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 8, 2023

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

RE: License #: AS630339657
Investigation #: 2024A0612004
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,

Johnna Cade, Licensing Consultant
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630339657
Investigation #:	2024A0612004
Complaint Receipt Date:	11/15/2023
Investigation Initiation Date:	11/16/2023
Report Due Date:	01/14/2024
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?
The residents are neglected.	No
Resident A was punched by a staff.	No
The residents are verbally abused.	No
Additional findings	Yes

III. METHODOLOGY

11/15/2023	Special Investigation Intake 2024A0612004
11/16/2023	Special Investigation Initiated - Letter I made a referral to the Office of Recipient Rights via email.
11/16/2023	APS Referral Recipient Rights Specialist, Amanda Clasman made a report to Adult Protective Services (APS) on 11/16/23. APS denied the referral.
11/27/2023	Contact - Telephone call made I conducted telephone interviews with Recipient Rights Specialist Amanda Clasman, home manager Laporches Welch, direct care staff Crystal Morant, and direct care staff Ferman Reeves.
11/29/2023	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed Resident A, Resident B, and Resident C.
12/06/2023	Exit Conference I placed a telephone call to licensee Janet Patterson to conduct an exit conference.
12/07/2023	Contact – Documents Received I received an email from Recipient Rights Specialist, Amanda Clasman regarding additional findings. The email included two videos (evidence).

12/08/2023	Contact – Telephone call made Telephone interview with home manager, Laporches Welch.
12/08/2023	Exit Conference I placed a telephone call to licensee Janet Patterson to conduct a second exit conference.

ALLEGATION:

The residents are neglected.

INVESTIGATION:

On 11/15/23, I received an anonymous complaint that indicated a family member of someone who works in the facility punched a resident. Residents are being neglected and verbally abused. On 11/16/23, I initiated my investigation by making a referral to the Office of Recipient Rights via email. Recipient Rights Specialist, Amanda Clasman indicated that she would be investigating. On 11/27/23, I spoke to Ms. Clasman, and she stated that she has conducted several interviews with staff and residents regarding these allegations. In doing so, she obtained clarifying details regarding the allegation. Ms. Clasman explained that Resident A alleged she was punched by direct care staff, Ferman Reeves. Mr. Reeves is not a family member of someone working at the facility as indicated in the complaint. Ms. Clasman interviewed Resident A's CNS case manager, Deb Danton. Ms. Danton reported that Resident A was psychiatrically hospitalized from 11/04/23-11/13/23. She received an injection of Depakote on 11/01/23. Resident A has been on this medication for a while however, at baseline Resident A is delusional. Ms. Clasman stated on 11/16/23, she made a report to Adult Protective Services (APS) via Centralized Intake. APS denied the referral for investigation.

On 11/27/23, I completed a telephone interview with home manager, Laporches Welch. Ms. Welch stated that she started in her role as the home manager on August 16, 2023. Since then, she has been being sabotaged by an unknown source. Ms. Welch believes this could be because she has made many changes including terminating several staff and cutting staff hours. Ms. Welch denied that any of the residents are being neglected. She indicates that she and all the direct care staff work to ensure that all their needs are met at all times. She has no concerns regarding the care that is provided.

On 11/27/23, I completed a telephone interview with direct care staff, Crystal Morant. Ms. Morant stated she has been working at this home since August 17, 2023. Ms. Morant has not observed any of the staff being neglectful to any of the residents. Ms. Morant denied that she is neglectful to the resident's needs. Ms. Morant has no concerns regarding the quality of care being provided.

On 11/27/23, I completed a telephone interview with direct care staff, Ferman Reeves. Mr. Reeves has worked for this company for 5 – 6 years. Mr. Reeves does not work at the Saginaw Center. He stated that he has never picked up shifts at the Saginaw Center. Mr. Reeves has no information regarding this allegation as he does not work at this facility.

On 11/29/23, I completed an unscheduled onsite investigation. I interviewed Resident A, Resident B, and Resident C. While conducting the onsite investigation, I observed that the residents were appropriately dressed for the weather. The home was clean and odor free. There was an appropriate amount of food in the home.

On 11/29/23, I interviewed Resident A. Resident A stated she receives three meals and snacks daily and her medications are given to her regularly. Resident A said that she sometimes runs out of personal items such as soap. She is upset that it is her responsibility to purchase these items for herself as she feels the home should provide them to her. Resident A denied feeling neglected and stated she feels safe and comfortable in the home.

On 11/29/23, I interviewed Resident B. Resident B stated Ms. Welch goes above and beyond to ensure that all the resident's needs are meet. Resident B remarked, "she cares about us and looks out for us." Resident B stated he has enough food, personal items, and he receives his medications regularly. Resident B stated the staff are very respectful, and he has no issues or concerns.

On 11/29/23, I interviewed Resident C. Resident C denied the allegation. Resident C stated he has enough food to eat, he receives his medications regularly, he has enough clothing, and personal care items. Resident C stated he feels safe living in this home, he has no issues, and he does not want to move.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that the residents are being neglected and/or mistreated. Resident A, Resident B, and Resident C denied the allegation. All three residents stated that they have access to an appropriate amount of food,

	clothing, personal care items and that their medications are administered to them as prescribed. Resident A, Resident B, and Resident C stated that they feel safe in the home, and they have no issues or concerns. During an unscheduled onsite inspection, I observed that the residents were appropriately dressed for the weather. The home was clean and odor free and there was an appropriate amount of food. Home manager Laporches Welch and direct care staff Crystal Morant were interviewed and consistently denied the allegation stating they have no concerns with the quality of care being provided.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A was punched by a staff.

INVESTIGATION:

On 11/27/23, I completed a telephone interview with home manager, Laporches Welch. Ms. Welch stated Resident A has a personality disorder and regularly displays delusional behavior. On Monday, 11/14/23, direct care staff Ferman Reeves came to the Saginaw Center to pick up paperwork from Ms. Welch. Mr. Reeves does not work at the home, and he has never picked up a shift at the home. Ms. Welch estimates Mr. Reeves is approximately 75 years old, very soft spoken, and she describes him as respectful. When Mr. Reeves entered the home, he stood near the front door which is near the kitchen. Ms. Welch was sitting at the end of the kitchen table. Resident A was sitting on the other end of the kitchen table, furthest away from Mr. Reeves. Direct care staff, Crystal Morant was also in the kitchen. All the other residents were outside on the front porch smoking. Ms. Welch asked Ms. Morant to get her payroll cover sheet off the copy machine. Ms. Morant exited the kitchen and went to the copy machine. Ms. Welch remained sitting at the kitchen table with Resident A. Ms. Welch estimates Mr. Reeves was in the home approximately 10 minutes. After she completed her paperwork Mr. Reeves left. Soon after, the Oakland County Sheriffs arrived at the home. Ms. Welch was informed that Resident A alleged Mr. Reeves punched her. Ms. Welch stated at no time did Mr. Reeves punch Resident A on 11/14/23. Ms. Welch stated Resident A and Mr. Reeves did not have any physical contact and they did not engage in any verbal disputes. Ms. Welch stated following this alleged incident, Resident A spoke to Sonia McKeown, Advocates of Self Determinations compliance auditor regarding the allegation. Resident A told Ms. McKeowen that she hallucinated the incident.

On 11/27/23, I completed a telephone interview with direct care staff, Crystal Morant. Ms. Morant stated Monday, 11/14/23, was her first-time meeting Mr. Reeves. Mr. Reeves came to the home to pick up paperwork from Ms. Welch. Ms. Morant stated Mr. Reeves stood in the kitchen doorway near the refrigerator while he waited for Ms. Welch to complete her paperwork. Mr. Reeves was at the home no longer than 10 minutes.

Ms. Welch and Resident A were sitting at the kitchen table. Ms. Welch was sitting at the end of the table closes to the refrigerator. Resident A was sitting at the other end of the table, furthest away from Mr. Reeves. Ms. Morant stated Ms. Welch asked her to go get paperwork off the copy machine. The copy machine is in the office. While at the copy machine her back is to the door and therefore, Resident A and Mr. Reeves were out of her line of vision. Ms. Welch stated she exited the kitchen approximately 2-3 times while Mr. Reeves was at the home. However, Ms. Morant did not hear any commotion coming from the kitchen. Mr. Reeves nor Resident A appeared agitated. Ms. Morant did not witness Mr. Reeves punch Resident A. Ms. Morant stated once Mr. Reeves obtained the paperwork form Ms. Welch, she observed him exit the home, get into his car, and drive away. Shortly after the Oakland County Sheriffs arrived at the home and informed them that Resident A alleged Mr. Reeves punched her.

On 11/27/23, I completed a telephone interview with direct care staff Ferman Reeves. Mr. Reeves has worked for this company for 5-6 years. Mr. Reeves does not work at the Saginaw Center. He works at another home in the providers' network. Mr. Reeves has never picked up shifts at the Saginaw Center. About a week ago, Mr. Reeves went to the Saginaw Center between 9:00 am-10:00 am to pick up paperwork from Ms. Welch. When he arrived at the home, he went inside and greeted all the residents. Mr. Reeves met with Ms. Welch and a female staff whose name he cannot recall. Mr. Reeves stated Ms. Welch was in the kitchen sitting at the table finishing her paperwork. Resident A was also sitting at the kitchen table. Mr. Reeves stated he was in the home approximately 15-20 minutes. While he was inside, he stood in the kitchen doorway. Mr. Reeves, stated that he had no physical contact with Resident A. He spoke to Resident A, she smiled, and there was no further interaction between the two of them. Mr. Reeves stated he is really surprised by this allegation and remarked, "nothing like that ever took place." Mr. Reeves adamantly denied punching Resident A.

On 11/29/23, I completed an unscheduled onsite investigation. I interviewed Resident A, Resident B, and Resident C. While onsite I observed the set up of the home. The kitchen doorway is near the refrigerator and the front door of the home. There is a chair at the head of the kitchen table that is close to the refrigerator. There is another chair at the other end of the kitchen table against the wall. If you were standing in the doorway of the kitchen, you would be unable to reach the chair located against the wall.

On 11/29/23, I interviewed Resident B. Resident B stated on 11/14/23, Mr. Reeves came to the home to pick up paperwork from Ms. Welch. When Mr. Reeves arrived at the home Resident B was outside on the front porch smoking. After he finished smoking, he went inside and sat on the couch in the living room. Resident B observed Mr. Reeves standing in the doorway of the kitchen. Ms. Welch and Resident A were sitting at the kitchen table, Ms. Morant was also in the kitchen. Ms. Welch was in the chair closest to Mr. Reeves, Resident A was at the other end of the table. Resident B stated that he did not observe Mr. Reeves and Resident A interact at all. Resident B remarked, "he never took his hands out of his pockets." Resident B further stated that he thinks Resident A "made up" this allegation.

On 11/29/23, I interviewed Resident C. Resident C stated he does not know who Mr. Reeves is. He was not present at the time of the alleged incident, and he has no information to provide.

On 11/29/23, I interviewed Resident A. Resident A stated she was recently hospitalized however, she cannot recall why. Resident A stated on 11/14/23, Mr. Reeves came to the home to pick up paperwork from Ms. Welch. She was sitting at the kitchen table. Ms. Welch and Ms. Morant were also in the kitchen. Mr. Reeves walked over to the table and started to give her a high five then he patted her on her shoulder and punched her in the face with a closed fist. Resident A remarked, “it was sneaky.” Resident A stated she shoved Mr. Reeves to stop him from hitting her. Mr. Reeves did not say anything while this interaction took place. Resident A stated Mr. Reeves does not work at her home, but she has seen him once before at another home in the providers’ network. Resident A does not know why Mr. Reeves would have punched her. Resident A stated her bottom lip was swollen following the incident. She called 911, the Oakland County Sheriff's came to the home and spoke with her about the incident. Resident A indicated that she is not pressing charges.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude Resident A was punched by direct care staff, Ferman Reeves. Mr. Reeves denied the allegation. Home manager Laporches Welch and direct care staff Crystal Morant were present when the alleged incident occurred. Ms. Welch and Ms. Morant consistently denied the allegation stating while Mr. Reeves was in the home, he was standing in the kitchen doorway. Resident A was siting in a chair at the kitchen table that was furthest away from Mr. Reeves. Ms. Welch and Ms. Morant stated Resident A and Mr. Reeves did not have any physical contact. They denied witnessing Mr. Reeve punch Resident A or use any physical force against her. Resident B who was sitting in the living room at the time of the alleged incident denied the allegation. Resident B said he did not observe Mr. Reeves and Resident A interact at all. Mr.

	Reeves stood in the kitchen doorway and never took his hands out of his pockets. During an unscheduled onsite inspection, I observed that if Mr. Reeves were standing in the kitchen doorway, he would have been unable to make contact with Resident A who was sitting in a chair on the other end of the kitchen table.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The residents are verbally abused.

INVESTIGATION:

On 11/27/23, I completed a telephone interview with home manager, Laporches Welch. Ms. Welch denied verbally abusing residents. Ms. Welch further denied witnessing any other direct care staff being verbally abusive towards any of the residents. Ms. Welch stated since starting in her role as the home manager she has made many changes to ensure that all the residents are safe and cared for. Ms. Welch has no concerns with the care being provided to the residents.

On 11/27/23, I completed a telephone interview with direct care staff, Crystal Morant. Ms. Morant stated since working in the home she has not witnessed any of the residents being verbally abused or spoken to in a derogatory manner. Ms. Morant stated the residents chose to spend their time watching TV in their bedrooms or in the living room. Some residents have community access. There are no verbal disputes, no insults being made, no derogatory remarks, or verbal assault that occurs in the home.

On 11/27/23, I completed a telephone interview with direct care staff Ferman Reeves. Mr. Reeves does not work at the Saginaw Center. He stated that he has never picked up shifts at the Saginaw Center. Mr. Reeves has no information regarding this allegation as he does not work at this facility.

On 11/29/23, I completed an unscheduled onsite investigation. I interviewed Resident A, Resident B, and Resident C.

On 11/29/23, Resident A stated none of the staff are verbally abusive towards her. Noone is mean or disrespectful.

On 11/29/23, Resident B stated he is never talked down to. The staff are very respectful, and he has no issues or concerns. Resident B stated if there are any issues the staff have meetings to make sure things run well.

On 11/29/23, Resident C denied the allegation. Resident C remarked, “that has not happened to me.”

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (ii) Verbal abuse.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that the residents are being verbally abused. Resident A, Resident B, and Resident C denied the allegation. Home manager Laporches Welch and direct care staff Crystal Morant consistently denied the being verbally abusive towards the residents and further denied witnessing any other direct care staff being verbally abusive towards any of the residents. Ms. Welch and Ms. Morant stated that they have no concerns with the care being provided to the residents in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/07/23, I received an email from Recipient Rights Specialist, Amanda Clasman who stated on 12/07/23, she completed an onsite investigation at the Saginaw Center. Upon entering home, Ms. Clasman greeted Resident A then asked if Ms. Welch was at the home. Resident A informed Ms. Clasman that Ms. Welch was asleep. Ms. Clasman entered the home and observed Ms. Welch asleep in a chair and recorded a video. Ms. Clasman went into the staff office and observed packs of medication sitting out on a table. The office door was opened and unlocked. The closet inside of the office was also opened and unlocked. The keys for the closet were hanging in the door handle. Ms. Clasman provided video evidence of the medication left unattended and the unlocked office. Ms. Clasman stated Ms. Welch was the only staff on shift. Resident A, Resident B, Resident C, and Resident D were home.

On 12/07/23, I reviewed the videos provided by Ms. Clasman. I observed Ms. Welch reclined in a chair in the living room, covered up with a blanket, asleep. I further reviewed a video of the staff office. The door was open and unlocked. There is a stack of multiple medication bubble packs sitting on a table. There is a closet inside of the office that is opened and unlocked. The keys for the closet were hanging in the door handle.

On 12/08/23, I completed a telephone interview with home manager, Laporches Welch. Ms. Welch stated on 12/07/23, she fell at home and injured her foot. She went to the urgent care and then came to work. She took pain medication for her injury and called in a staff to relieve her. Ms. Welch stated she completed her checks on the residents, and she knew where everyone was. She had just sat down in the chair when Ms. Clasman arrived at the home. Ms. Welch stated her eyes were closed and she “nodded off,” but she was coherent. Ms. Welch stated the medication bubble packs on the table in the office belong to a resident who was discharged from the home. The resident’s mother was coming to pick up the medication, so they were out. The medication cart was locked and located in the hallway. The medication cart keys were with Ms. Welch. Ms. Welch stated the open closet in the office is a pantry where overflow items and food is stored, not medication. Ms. Welch apologized for what happened and stated it was not intentional. Ms. Welch explained she works two jobs, and she was in pain which is the only reason she sat down while on shift.

On 12/06/23, I placed a telephone call to licensee, Janet Patterson to conduct an exit conference. There was no answer. I left a detailed voicemail regarding my findings.

On 12/08/23, I placed a second telephone call to Ms. Patterson to conduct an exit conference. Ms. Patterson acknowledged my findings and voiced her understanding that a corrective action plan will be requested. Ms. Patterson stated Ms. Welch is a good worker and she believes that she is deserving of a second chance. Ms. Patterson acknowledged the seriousness of this incident and stated this was an unfortunate issue that will be addressed.

APPLICABLE RULE	
R 400. 15305	**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:	Based on the information gathered through my investigation there is sufficient information to conclude that home manager Laporches Welch was unable to attend to the residents’

	personal needs, including protection and safety while asleep on shift. Recipient Rights Specialist, Amanda Clasman was able to enter the home, speak to the residents, and record videos without Ms. Welch's knowledge. Although Ms. Welch stated that she was coherent she admitted that her eyes were closed and she "nodded off."
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report 2023A0612036; CAP dated 10/25/2023.**

APPLICABLE RULE	
R 400. 15312	**Resident medication**
	(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 S333.1101 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:	Based on the information gathered through my investigation there is sufficient information to conclude that on 12/07/23, there was medication that was not locked in a cabinet or drawer. In the video provided by Ms. Clasman, I observed a stack of multiple medication bubble packs sitting on a table in the office. The office door was opened and unlocked. Resident A, Resident B, Resident C and Resident D were home and the staff on shift, Ms. Welch was asleep in another room. Ms. Welch admitted that the medication bubble packs on the table in the office belong to a resident who was discharged from the home. The resident's mother was coming to pick up the medication, so they were left out and not locked up.
CONCLUSION:	**VIOLATION ESTABLISHED**

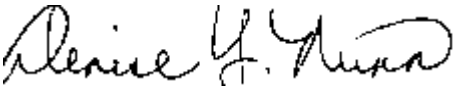
IV. RECOMMENDATION

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

12/08/2023

Johnna Cade — Date
Licensing Consultant

Approved By:



12/08/2023

Denise Y. Nunn — Date
Area Manager