GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2025

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

RE: License #: AS630339657
Investigation #: 2025A0626011
Saginaw Center

Dear Janet 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,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630339657
Investigation #:	2025A0626011
Complaint Receipt Date:	02/10/2025
Investigation Initiation Date:	02/10/2025
Report Due Date:	04/11/2025
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:	02/03/2024
Expiration Date:	02/02/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

ALLEGATION(S)

	Violation Established?
Resident E has a seizure disorder and had a seizure on 02/06/2025. It is alleged direct care staff members rudely told him he was not having a seizure	No
Direct care staff allowed resident who was having a seizure, to lie on the floor without medical attention.	No
There is a direct care staff member living in the home and sleeping on a mattress, on the floor, of the upstairs of the home.	Yes
Additional Findings	Yes

II. METHODOLOGY

02/10/2025	Special Investigation Intake 2025A0626011
02/10/2025	APS Referral An APS referral was not sent due to the complaint coming from APS.
02/10/2025	Special Investigation Initiated - Letter Special investigation initiated via sending referral to Office of Recipient Rights.
02/11/2025	Contact - Face to Face Completed unannounced onsite investigation at Saginaw Center. Completed interviews with home manager and Resident A, Resident B, and Resident C.
02/12/2025	Contact - Document Received Received health appraisal, information record, and assessment plan from Shannon Williams for Resident E.
03/18/2025	Contact – Telephone call made Completed phone interviews with direct care staff members, Tantinikka Royal and Nikita Portman.
03/18/2025	Contact – Document Sent An email was sent to Oakland County 911 Dispatch, requesting the call log for the 911 call made on 02/06/2025 at Saginaw Center.

03/19/2025	Contact – Document Received The call log for 02/06/2025 was received from Oakland County 911 Dispatch.
03/24/2025	Contact - Telephone call made. A telephone interview was completed with Relative E1.
03/26/2025	Contact – Document Sent An email was sent to Shannon Patterson, requesting relative and guardian contact information for residents.
03/26/2025	Contact – Document received An email was received from Shannon Patterson, containing relative and guardian contact information for Resident A and Resident B. Ms. Patterson indicated Resident C does not have a guardian or any family still living.
03/26/2025	Contact – Telephone call made Telephone calls were made to Guardian B1 and Guardian A1. Messages were left requesting a return phone call.
03/27/2025	Contact – Telephone call made A telephone interview was completed with Guardian B1.
04/01/2025	Exit Conference I conducted an exit conference with licensee, Janet Patterson, via telephone. The findings were discussed.

ALLEGATION:

Resident E has a seizure disorder and had a seizure on 02/06/2025. It is alleged direct care staff members rudely told him he was not having a seizure and let him lie on the floor with no medical attention.

INVESTIGATION:

On 02/10/2025, I received the complaint, via email, regarding Saginaw Center. The allegations stated there was a staff member living in the home and sleeping on a mattress in a hallway area. The allegations also stated that Resident E, who has a seizure disorder, had a seizure and a direct care staff member told him he wasn't having one, swore at him, and he was left lying on the living room floor.

I initiated the investigation via emailing the complaint to Amanda Clasman, from the Office of Recipient Rights, and we coordinated an unannounced onsite visit to the home.

On 02/11/2025, I completed an unannounced onsite investigation, with Amanda Clasman from the Office of Recipient Rights. I completed a face-to-face interview with home manager, LaPorsha Welch. I requested the resident register, resident information records, and assessment plans for each resident.

Ms. Welch informed me that their new resident, Resident E, has a seizure disorder and that the plan regarding his seizures is to call 911 if he has more than two or more. She stated Resident E had a seizure on 02/06/2025 and was taken to the emergency room and she provided me with the discharge papers from Trinity Health Emergency Center, dated 02/06/2025. She denied anyone yelled at Resident E and stated that the direct care staff members would never yell at a resident.

Ms. Welch provided me with a copy of the incident report regarding Resident E's seizure. The report indicates Tantanikka Royal and Nikita Portman were there for the incident. It was dated 02/06/2025 and the time indicated the incident occurred at 1:55pm. The incident report stated:

> "Resident E appeared to be having a seizure, staff followed proper protocol by placing him on his side, he had another one, so 911 was contacted."

The discharge papers indicate Resident E's reason for the visit was seizures and he was diagnosed with a breakthrough seizure. The report indicates they completed lab tests and a CT head without contrast. The papers were printed at 02/06/2025 at 6:16pm.

On 02/11/2025, I completed a private interview with Resident E. We were talking about his seizure disorder and Resident E stated he had one last week. Resident E stated he was looking at the television, while sitting in a chair, then had a seizure and fell to the floor. He stated staff got him back into the chair and he had another one. He stated direct care staff held him down, in a good way, to help him, they asked him if he was ok and called for help. He denied anyone being mad at him or saying bad words. He stated he likes it here and feels safe. He stated he really likes Ms. Welch and is excited that she will be taking him to his appointments.

On 02/18/2025, I completed a phone interview with direct care staff member, Jalen Booker. Mr. Booker was not working when Resident E had his seizure, but he was there at the home. He stated Resident E started shaking and he put him on his side to protect him. He denied saying anything negative or mean to Resident E and denied swearing at him.

On 03/18/2025, I completed a phone interview with direct care staff member, Tantanikka Royal. Ms. Royal has been employed at Saginaw Center for approximately one year. Ms. Royal was working when Resident E had his seizure. She stated she came into work and saw Resident E lying on the floor. She stated he told her he was not feeling well and then he started seizing, so she called 911. She denied anyone yelling at Resident E or telling him he was not having a seizure.

On 03/18/2025, I completed a phone interview with direct care staff member, Nikita Portman. Mr. Portman is a newer employee at Saginaw Center and was working during the shift when Resident E had his seizure. Mr. Portman stated Resident E was a newer resident and that they had no individual plan of service (IPOS) or health information for him. He stated Resident E was sitting in a chair, watching television and asked him if he could lay on the floor. He told Resident E he was fine with it and Resident E proceeded to lie down. He stated Ms. Royal came on shift and saw Resident E on the floor, then asked, “What is wrong with him?” He then looked and saw that Resident E had gone into what he described as a “tense lock-up mode”. He called 911 and Resident E released. He stated it did not seem like a real seizure to him and Resident E likes attention, like the kind he gets at the hospital. He stated he believes he was putting on a show and denied telling Resident E that, he also denied yelling or swearing at him. He reiterated they had no health information regarding Resident E and his diagnoses.

On 03/18/2025, I requested the 911 call log for 02/06/2025, the day of Resident E’s seizure and received it on 03/19/2025. The log indicates the call was received at 1:54 pm and the ambulance arrived at 2:20 pm. The log indicated a medical call was made for a 54-year-old male who was not breathing (names were redacted). Upon arrival, EMS reported he had abnormal breathing.

On 03/24/2025, I completed a phone interview with Relative E1. Relative E1stated Resident E has a seizure disorder and because of it, she was no longer able to care for him. She stated he was having seizures in public, and she did not feel she was able to keep him safe anymore. She described the seizures as his body becoming contracted, then he will start jerking, or he will have a focal seizure, where he will look like he is looking through you. She stated the seizures can come at any moment and seem to be brought on by stress and other things, like his blood sugar. She stated Resident E’s neurologist refers to them as “episodes”. She stated she was told that he could be faking them sometimes, but she has never suspected it. Relative E1 visits Resident E monthly and denies having any concerns with his care at Saginaw Center, she stated they have been transparent with her and Resident E loves it there.

On 03/27/2025, I completed a telephone interview with Guardian B1. Guardian B1 stated he is considering ending the guardianship. He stated he does not get the whole story about anything from Resident B and the staff at Saginaw Center. He stated he does not know most of the newer staff members, due to their high turnover rate.

APPLICABLE RULE	
R 400.14104	**Licensee and applicant rights.**
	(1) A licensee or an applicant shall have the right to be treated with

	courtesy, dignity, and fairness by the adult foster care licensing division staff of the department and shall not be discriminated against on the basis of race, religion, color, national origin, sex, age, handicap, height, weight, or marital status./
ANALYSIS:	Based upon my investigation and the information gathered, there is not sufficient evidence showing that Resident E was not treated with courtesy, dignity, or fairness. Resident E denied anyone being mean to him or saying bad words, he stated the direct care staff members were helping him and called for help. The direct care staff members who were present for the seizure, all stated they assisted him also denied yelling at Resident E.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based upon my investigation and the information gathered, there is not sufficient evidence showing that Resident E did not obtain needed care immediately. Resident E stated that a direct care staff member assisted him during his seizure and called for help. Home manager, LaPorsha Welch, provided a copy of his discharge papers from the emergency room, indicating he was treated at Trinity Health Emergency Center on 02/06/2025, the day of his seizure. Furthermore, the 911 call log from that day indicates 911 was called around the same time the seizure occurred, per the incident report.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is a direct care staff member living in the home and sleeping on a mattress, on the floor, of the upstairs of the home.

INVESTIGATION:

On 02/11/2025, I completed an unannounced onsite investigation, with Amanda Clasman from the Office of Recipient Rights, at Saginaw Center. We completed an interview with home manager, LaPorsha Welch. Ms. Welch denied that any staff live in the home. She stated that Jalen Booker is employed at Saginaw Center, he last worked over the weekend.

On 02/11/2025, I conducted a private face to face interview with Resident A. Resident A stated there was a direct care staff member living in the home and he identified the staff member as Jalen Booker. Resident A stated that Mr. Booker was sleeping in the landing area on the second level of the home, on a mattress. He stated Mr. Booker had been sleeping in the bedroom of Resident E, until Resident E came to the home. He stated Mr. Booker was living in the home for approximately ten days. He stated the last time Mr. Booker slept on the mattress was the night before last.

On 02/11/2025, I completed a private face to face interview with Resident E. Resident E stated that there is a direct care staff member who sleeps on the landing area. He stated he used to sleep in his room, before he was admitted. He denied that the direct care staff member ever slept in his room after he came to the home. He could not remember the direct care staff member's name.

On 02/11/2025, I completed a private face to face interview with Resident B. He stated that there was a direct care staff member who was sleeping on a mattress on the floor, upstairs, but did not provide a name. He stated he likes where he is and feels they take good care of him.

On 02/11/2025, during the onsite investigation, I viewed the upstairs. The upstairs of the home has open, empty space, approximately the size of a small living room. The resident rooms are up there as well. There is enough room for someone to place a mattress on the floor and not block the stairs or to keep anyone from exiting their bedroom. There was no mattress on the floor at the time of the onsite investigation and I did not see any mattresses that were not on a bed.

On 02/18/2025, I conducted a phone interview with Jalen Booker, the direct care staff member who is alleged to be living in the home. Mr. Booker denied living in the home and stated he only spends the night at the home while he is working and denies sleeping during his shifts, especially on a mattress on the floor.

On 03/18/2025, I conducted a phone interview with direct care staff member, Tantinikka Royal. Ms. Royal denied any direct care staff members sleeping in the home. She stated she only sees Mr. Booker at the home during his scheduled shifts.

On 03/18/2025, I conducted a phone interview with direct care staff member, Nikita Portman. Mr. Portman stated he knew nothing about any direct care staff members living in the home.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	Based on my investigation and evidence gathered, I determined there is evidence to support, that Jalen Booker was sleeping on a mattress on the floor of the upstairs. While Mr. Booker and other direct care staff members have denied it, three of the residents who are able to be interviewed, confirmed having seen Mr. Booker sleeping on a mattress on the floor of the upper level of the home, which is not ordinarily used for sleeping.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/11/2025, during the unannounced onsite investigation, Ms. Welch denied having completed an assessment plan or health care appraisal for Resident E. She did not have documentation of his admission being an emergency. Resident E also did not have a completed assessment plan. Resident E was admitted to the home on 01/31/2025.

On 02/12/2025, I received an email from Shannon Patterson, daughter of Janet Patterson, indicating that Resident E's appointment for the healthcare appraisal was rescheduled to 02/13/2025 due to the weather.

On 02/20/2025, I received the healthcare appraisal, via email, from Ms. Patterson, for Resident E, dated 02/17/2025.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	When I requested the health care appraisal for Resident E, the home manager, LaPorsha Welch, admitted that it had not yet been completed. Resident E was admitted into Saginaw Center on 01/31/2025, there is no documentation indicating it was an emergency admission, and the health care appraisal did not take place until 02/17/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 02/11/2025, during the unannounced onsite investigation, Ms. Welch provided me with resident information records for Resident A, Resident B, and Resident C. She did not have them for Resident D or Resident E. She provided me with assessments for Resident A, Resident B, Resident C, and Resident D. Ms. Welch denied having Resident E's resident information record. Ms. Welch informed me that Resident E had arrived at the home on 01/31/2025 and did not yet have a file. Ms. Welch stated that some of Resident E's paperwork was at the main office and would need to be requested from the licensee.

The resident information record for Resident A was missing a phone number and address for the next of kin/guardian, and burial provisions.

The resident information record for Resident B was missing an address for next of kin/guardian and burial provisions.

The resident information record for Resident C was missing a next of kin/guardian, and burial provisions.

On 02/12/2025, I received an email from Shannon Patterson, daughter of licensee, Janet Patterson, containing requested documents. The resident information record for Resident E was sent and it was found to be missing the contact for a next of kin and burial provisions, it indicated that Resident E is his own guardian. Also included was an individual plan of service (IPOS) for Resident E. In the IPOS for Resident E, his diagnosis for seizure disorders was listed, as well as that they are brought on by low blood sugar, but there are no instructions listed for what to do if he were to have a seizure or what they look like.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.**

	(g) Weight record. **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**
ANALYSIS:	Resident E did not have a resident file at the facility, including a resident information record. When a resident information record for Resident E was provided to me, it was missing required information. Resident A, Resident B, and Resident C had required information missing from their resident information record.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/28/2025, I conducted a search of the Michigan Sex Offender Registry for the address of Saginaw Center and found there are three residents in the home on the registry. Resident C is listed as being non-compliant due to a fee violation.

On 04/01/2025, I conducted an exit conference with licensee, Janet Patterson. The findings were discussed. Ms. Patterson informed me that she has been making sure that the payments were being made for Resident C's fees to make him compliant with the Sex Offender Registry. I requested her to send me documentation showing that they have been paid. She stated she would also contact Michigan State Police to obtain additional documentation. Ms. Patterson agreed to send any available documentation to me by 04/02/2025. As of, 04/04/2025, no documentation has been received.

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:	While checking the Michigan Sex Offender Registry, I found that Resident C is listed on the registry as non-compliant. It is the responsibility of the licensee to assist Resident C with maintaining compliance with the registry, as failure to do so could lead to the arrest of Resident C, which is not attending to his safety and protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

04/15/2025

_____

Sara Shaughnessy Date
Licensing Consultant

Approved By:

For 06/05/2025

_____

Denise Y. Nunn Date
Area Manager