GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2021

Don Adams
Moriah Incorporated
3200 E Eisenhower
Ann Arbor, MI 48108

RE: License #: AL810280703
Investigation #: 2022A0575003
Moriah Hall

Dear Mr. Adams:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On October 27, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AL810280703
Investigation #:	2022A0575003
Complaint Receipt Date:	10/21/2021
Investigation Initiation Date:	10/21/2021
Report Due Date:	11/20/2021
Licensee Name:	Moriah Incorporated
Licensee Address:	3200 E Eisenhower Ann Arbor, MI 48108
Licensee Telephone #:	(734) 677-0070
Administrator:	Don Adams
Licensee Designee:	Don Adams
Name of Facility:	Moriah Hall
Facility Address:	3200 E. Eisenhower Pkwy Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	03/19/2008
License **Status:**	REGULAR
Effective Date:	09/26/2020
Expiration Date:	09/25/2022
Capacity:	16
Program Type:	DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A's protection and safety was not attended to by the licensee's staff.	Yes

III. METHODOLOGY

10/21/2021	Special Investigation Intake 2022A0575003
10/21/2021	Special Investigation Initiated – Telephone- Stephanie Harris, program coordinator
10/21/2021	APS Referral-received
10/21/2021	Contact - Telephone call made-Tracy Hunt, Resident A's guardian
10/27/2021 10/27/2021	Inspection Completed On-site-interviews with: (a) Residents A and B. (b) Eisenhower Center program coordinators- Candace Nash, Faith Hinson, and Stephanie Harris. (c) Eisenhower Center licensee designee, Don Adams Inspection Completed-BCAL Sub. Compliance
10/27/2021	Corrective Action Plan Requested and Due on 11/04/2021
10/27/2021	Corrective Action Plan Received
10/27/2021	Corrective Action Plan Approved
10/27/2021	Contact - Telephone call made-Eisenhower Center direct care staff-(a) Drew Doubleday and (b) J'Tan Jackson
10/27/2021	Exit Conference with Doon Adams, licensee designee

ALLEGATION:

Resident A's protection and safety was not attended to by the licensee's staff.

INVESTIGATION:

On 10/21/21, an APS referral was received. Resident A is not a CMH special cert client.

On 10/21/21, I interviewed Resident A's guardian, Tracy Hunt. She stated she was notified by Eisenhower Center program coordinator Candace Nash on 7/18/21 that Resident A had been physically assaulted by Resident B. She stated Candace Nash told her Resident A would be moved to another facility in the Eisenhower Center complex to protect her from being harmed. She stated when she was notified about this most recent assault on 10/17/21 and subsequent hospitalization and surgery, Resident A had still not been moved to another facility. Finally, she stated Resident A was moved to the Eisenhower Center-East Hall (AL810086003) facility upon her return from the hospital on 10/21/21 and that she is satisfied both with the services Resident A is receiving from Eisenhower Center and Resident A's placement there.

On 10/27/21, I interviewed both Residents A and B. Neither resident was able to effectively communicate due to their respective disabilities. Resident A was the victim of an assault that resulted in her needed hospitalization and surgery. I reviewed Resident B's behavior plan which stated he engages in physical aggression which includes hitting and scratching. His supervision level was direct 1:1, which is arm's length, from 6/22/21-10/07/21, after which his supervision level was reduced to every 5 minutes.

On 10/27/21, I interviewed Candace Nash, Faith Hinson, Stephanie Harris, and Don Adams. Candace Nash stated other placement options at Eisenhower Center were discussed with Resident A's guardian after the 7/18/21 incident, but other residents needed to be relocated before Resident A could be moved. She stated although Resident B has a behavior plan, there was no written plan to specifically address Resident B assaulting Resident A. She stated when Resident B exhibits physical aggression, staff are to move the other resident to another area. Faith Hinson stated she was informed by the direct care staff on duty, J'Tan Jackson, and Drew Doubleday, that no one witnessed Resident B assault Resident A, and that the two staff responded by dressing the wound and then calling EMS to transport Resident A to the hospital. Finally, I conducted an exit conference with Stephanie Harris and licensee designee, Don Adams.

On 10/27/21, I interviewed Drew Doubleday who stated she did not witness Resident B assault Resident A. She stated she heard Resident A crying in the facility multipurpose room and witnessed Resident B exiting that room, literally with blood on his hands.

On 10/28/21, I interviewed J'Tan Jackson. She stated she did not witness Resident B assault Resident A. She stated she heard Resident A crying and provided her with first aid before Drew Doubleday called EMS.

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:	Although there are extenuating circumstances that explain why Resident A was not moved after 7/18/21 when she was assaulted by Resident B, even though his supervision level was 1:1 at the time, the fact that Resident A was physically assaulted by Resident B again on 10/17/21, this time Resident B's supervision level was less restrictive, which resulted in Resident A's hospitalization, leads to the conclusion the licensee did not always attend to Resident A's protection and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable plan of correction was received; therefore, I recommend no changes to the status of the license.

Jeffrey J. Bozsik
Licensing Consultant

Date: 10/28/21

Approved By:

Ardra Hunter
Area Manager

Date: 11/2/21