GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 18, 2022

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

RE: License #: AL810015274
Investigation #: 2022A0575011
Eisenhower Center - South Main

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 2/15/2022, 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
22 Center Street
Ypsilanti, MI 48198
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AL810015274
Investigation #:	2022A0575011
Complaint Receipt Date:	01/21/2022
Investigation Initiation Date:	01/21/2022
Report Due Date:	02/20/2022
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:	Eisenhower Center - South Main
Facility Address:	3200 E Eisenhower Parkway Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	08/09/1993
License **Status:**	REGULAR
Effective Date:	05/21/2021
Expiration Date:	05/20/2023
Capacity:	14
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A allegedly assaulted by staff Amaya Patton.	No
Resident A was not given his prescribed medications.	No
Resident A's CPAP sleep apnea device filter was not changed, and his personal hygiene was not attended to by staff.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

01/21/2022	Special Investigation Intake 2022A0575011
01/21/2022	APS Referral-received
01/21/2022	Referral - Recipient Rights
01/21/2022	Special Investigation Intake-2022A0575011
01/21/2022	Contact- call made Resident A's guardian
01/21/2022	Special Investigation Initiated-Telephone call
02/02/2022	Inspection Completed On-site-interviews with: (a) Stephanie Harris-program coordinator; (b) direct care staff: 1) Amaya Patton; 2) Corey Mayes; 3) Candace Thompson; (c) Meranda Sawabini-nurse; (d) Joseph Keller- behavior psychologist
02/07/2022	Contact- Call received Ann Arbor police
02/09/2022	Contact- Call made- (a) Resident A; (b) Resident A's guardian; and (c) Nurse- Meranda Sawabini
02/11/2022	Contact- Call received Stephanie Harris- program coordinator
02/11/2022	Contact- Call made

	Joseph Keller- behavioral psychologist
02/11/2022	Contact-Document received Resident A's initial assessments
02/13/2022	Contact- Document received Resident A's guardian sent emails
02/14/2022	Exit Conference Don Adams, licensee designee
02/14/2022	Contact- Document Received Resident A's Assessment for AFC Residents

ALLEGATION:

Resident A allegedly assaulted by staff Amaya Patton.

INVESTIGATION:

On 1/21/22, APS and ORR referrals were received and made.

On 1/21/22, Resident A's guardian alleged that on 1/9/22 staff Amaya Patton physically assaulted Resident A and was removed from the situation by staff Corey Mayes. On 2/13/2022, Resident A's guardian sent pictures which included a picture of Resident A's face. I did not observe any bruises or other redness on his face that would have allowed me to decide that he had been physically abused.

On 2/2/22, I interviewed Staff- Amaya Patton and Corey Patton. Amaya Patton denied assaulting Resident A and stated Resident A walked into the office and was upset because he could not buy coffee. She stated Resident A was about to physically assault her and Corey Mayes intervened to stop the incident and redirect Resident A.

On 2/9/22, I interviewed Resident A. He stated Staff- Amaya (Patton) hit him and Staff- Corey (Mayes) witnessed it and intervened to break up the altercation.

APPLICABLE RULE	
R 400.15308	**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:	On 2/13/2022, I reviewed a picture of Resident A's face. I did not observe any bruises or other redness on his face that would have allowed me to decide that he had been physically abused. On 2/2/22, I interviewed Staff- Amaya Patton and Corey Patton. Both staff deny that Resident A was assaulted by Amaya Patton, stating Resident A was about to assault Amaya Patton and Corey Patton intervened. On 2/9/22, I interviewed Resident A. Resident A stated Staff- Amaya Patton hit him and Staff- Cory Patton intervened. There is insufficient evidence to substantiate the allegation. There is no one else to corroborate Resident A's allegation. I was unable to decide from the picture of Resident A's face that he had been physically abused. Therefore, the licensee did not mistreat or permit Staff- Amaya Patton to mistreat Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not given his prescribed medications.

INVESTIGATION:

On 1/21/22, Resident A's guardian alleged staff did not administer Resident A his "rescue" (his term) medications, Ativan, Xanax, and Clonidine, on 1/10/22 resulting in Resident A having a behavioral outburst and being transported to the University of Michigan hospital.

On 2/2/22, I interviewed Nurse- Meranda Sawabini, who stated Resident A's "rescue" medications are PRN medications. She provided the medication records that documented that Resident A was given Ativan on 1/7, and 1/10.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 2/2/22, I interviewed Nurse- Meranda Sawabini. Nurse-Meranda Sawabini stated Resident A's prescribed Ativan, Xanax, and Clonidine are PRNs. I reviewed Resident A's medication record that documented Resident A was given Ativan on 1/7/2022 and 1/10/2022. Resident A was given his prescribed medications as needed according to the label instructions.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's CPAP sleep apnea device filter was not changed, and his personal hygiene was not attended to by staff.

INVESTIGATION:

On 1/21/22, I interviewed Resident A's guardian. He stated he delivered new CPAP equipment and when Resident A left the facility, the equipment was still in the original box and that the filter had not been changed. Additionally, he stated Resident A had skin breakdown on his buttocks from the staff not assisting him with his ADLs as required in his behavior plan. He stated that this skin breakdown was treated by Resident A's primary care physician, and he was told by the physician that it was a bacterial infection that took 7-14 days to develop, which he believes means that the staff did not attend to Resident A's personal care needs as required by his behavior treatment plan.

On 2/2/22, I interviewed Staff- Candace Thompson and Corey Mayes related to Resident A's CPAP machine. They stated the filter was changed and when Resident A was leaving the facility, they placed it back in the original box to avoid any complaints about its use or condition. They stated there is no documentation of changing the CPAP filter.

On 2/2/22, I interviewed Behavioral Psychologist- Joseph Keller who provided Resident A's Comprehensive Behavior Protocol. There is a section in it addressing Resident A's ADLs. It states staff are supposed to prompt Resident A to use the

bathroom every 3 hours or more. Also, it states Resident A requires assistance from staff to wipe after a bowel movement. Another section addresses Resident A's medical issues, specifically his use of a CPAP device. The plan states staff are to prompt him to use the device.

On 2/2/22, I interviewed Staff- Candace Thompson. She stated staff ask Resident A if he needs assistance wiping himself and respond accordingly to his answer. She stated if Resident A refuses assistance, which he usually did, staff do not aid. She stated there is no documentation staff provide on whether Resident A did or did not need assistance with this personal care issue.

On 2/7/2022, the Ann Arbor police called and asked for a copy of the special investigation report, when it's completed.

On 2/9/22, I interviewed Resident A who stated that he told the staff he needed assistance with toileting, but they did not assist him.

On 2/9/22, I spoke with Resident A's guardian, who stated he told Nurse- Meranda Sawabini on 1/7/22 that Resident A needed assistance with his personal care, but staff did not attend to Resident A's needs as required in Resident A's behavior plan and he was allowed to walk around the facility in clothes soiled with feces.

On 2/9/22, I spoke with Nurse- Meranda Sawabini, who stated Resident A's personal care skills were assessed and it was determined that Resident A can complete personal care tasks. Therefore, Ms. Sawabini stated staff were to prompt Resident A to use the bathroom every 3 hours and ask if he needed assistance. She stated this would help him to be more independent and attend to his own self care needs. Finally, she stated that when Resident A arrived at the facility it was noted that he had what appeared to be small pimples on his buttocks.

On 2/11/2022, I spoke with Program Coordinator- Stephanie Harris who stated that an OT evaluation of Resident A's personal care skills was never completed due to Resident A being in the program for such a short length of time, approximately 3 weeks. Further, she stated that Resident A was not permitted to walk around the facility with his personal care not attended to. Finally, although Resident A resided in this facility for only 3 weeks and therefore did not receive comprehensive OT and PT evaluations, OT and PT screens dated 1/3/22 were completed and faxed to me by Stephanie Harris. The OT screen listed the only ADL need was that Resident A needed assistance with fasteners and noted there was no need for other equipment. The PT screen noted no equipment needed.

On 2/11/2022, I interviewed Behavioral Psychologist- Joseph Keller for clarification on Resident A's behavior plan. He stated that the section of Resident A's behavior plan that addressed his ADLs and use of a CPAP device (which would be on a PRN basis), implicitly acknowledges Resident A's right to refuse staff assistance and using the CPAP device. He stated that incident report(s) would have been written

(none were written) had he been non-compliant with staff assistance or use of the CPAP device.

On 2/13/2022, I received 2 emails from Resident A's guardian. They were mainly pictures of lesions/cellulitis on Resident A's thighs/buttocks. There were also pictures of his arms, a head shot, and emails to and from Eisenhower staff. Additionally, there was an email from Resident A's primary care physician who diagnosed the cellulitis and stated it was from poor hygiene.

On 2/14/22, I contacted Licensee Designee- Don Adams and requested a copy of Resident A's Assessment Plan for AFC Residents. He emailed the Assessment Plan which did not include the signature page. In the section addressing self-care skill assessment, specifically toileting, whomever completed the Assessment Plan wrote, "Needs 3 hour prompt for urinating and needs help cleaning after bowel movement."

On 2/14/2022, I conducted an exit conference with Licensee Designee- Don Adams.

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:	On 2/2/22, I interviewed Staff- Candace Thompson and Corey Mayes regarding Resident A's CPAP machine. They stated the filter was changed and placed back in the original box. I am unable to determine if the CPAP filter was changed and/or just placed back in the original box. On 2/13/2022, I reviewed an email from Resident A's primary care physician who diagnosed cellulitis from poor hygiene. On 2/14/22, I reviewed Resident A's Assessment Plan for AFC Residents. The Assessment Plan documented, "Needs 3 hour prompt for urinating and needs help cleaning after bowel movement." Resident A needed assistance cleaning himself after a bowel movement. The preponderance of evidence is that the Eisenhower staff were negligent in helping clean Resident A after his bowel movements; therefore, Resident A's personal needs, including protection and safety, were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 2/14/2022, Licensee Designee- Don Adams, emailed a copy of Resident A's Assessment Plan for AFC Residents. The Assessment Plan was filled out, but the signature page was missing, so there is no way to know when it was completed or by whom.

On 2/13/2022, I emailed Resident A's guardian to ask if he had a copy of the Assessment Plan. On 2/14/2022, Resident A's guardian said he did not have a copy of the Assessment Plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall

	maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On 2/14/2022, I reviewed Resident A's Assessment Plan for AFC Residents. Since the signature page for Resident A's Assessment Plan was not received and Resident A's guardian reported not receiving a copy, which he would have signed, then a written assessment plan was not completed at admission with the resident or the resident's designated representative as required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable correction action plan was received; therefore, I recommend no change in the license status.

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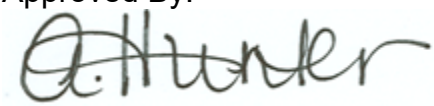
Jeffrey J. Bozsik Date: 2/18/2022
Licensing Consultant

Approved By:



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Ardra Hunter Date: 2/18/2022
Area Manager