GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2022

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

RE: License #: AM810015275
Investigation #: 2022A0575016
Eisenhower Center - Congregate

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 May 12, 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
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AM810015275
Investigation #:	2022A0575016
Complaint Receipt Date:	05/03/2022
Investigation Initiation Date:	05/04/2022
Report Due Date:	06/02/2022
Licensee Name:	Moriah Incorporated
Licensee Address:	3200 E Eisenhower Ann Arbor, MI 48108
Licensee Telephone #:	(734) 677-0070
Administrator:	Don Adams, Designee
Licensee Designee:	Don Adams, Designee
Name of Facility:	Eisenhower Center - Congregate
Facility Address:	3200 E Eisenhower Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	08/09/1993
License **Status:**	REGULAR
Effective Date:	05/21/2022
Expiration Date:	05/20/2024
Capacity:	12
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Direct care staff Nash Wadi and Josh Black mistreated Resident A.	Yes

III. METHODOLOGY

05/03/2022	Special Investigation Intake 2022A0575016
05/04/2022 05/04/2022	Special Investigation Initiated – Telephone APS referral- licensee initiated
05/11/2022	Inspection Completed On-site-interviews with Stephanie Harris, program coordinator and Don Adams, licensee designee
05/11/2022	Contact - Telephone calls made-(a) William White- Resident A's guardian; (b) direct care staff-(1) Nash Wadi; (2) complainant; (3) Josh Black; (4) Hunter Combs
05/12/2022	Contact - Document Received-Resident A's body check from 4/23/2022
05/12/2022	Inspection Completed-BCAL Sub. Compliance
05/12/2022	Corrective Action Plan Requested and Due on 05/13/2022
05/12/2022	Corrective Action Plan Received
05/12/2022	Corrective Action Plan Approved
05/12/2022	Exit Conference with Don Adams, licensee designee

ALLEGATION:

Direct care staff Nash Wadi and Josh Black mistreated Resident A.

INVESTIGATION:

An APS referral was made by the licensee.

Resident A was not interviewed due to his cognitive disability.

I interviewed Resident A's guardian, William White, on 5/11/12 and he stated that he is satisfied with the current placement and recognizes that Resident A presents challenging behaviors.

I interviewed the complainant on 5/11/22, and he restated the facts enumerated in his complaint. i.e., that staffs Nash Wadi and Josh Black physically assaulted Resident A, and staff Hunter Combs watched the incident.

I interviewed staffs Nash Wadi, Josh Black, and Hunter Combs on 5/11/12. Staffs Nash and Josh denied mistreating Resident A and staff Hunter stated when he arrived at the scene, he didn't witness anything.

I received a copy of Resident A's body chart from 4/23/2022, the date of the alleged assault. It documented bruises, abrasions, and scratches consistent with the complainant's statement.

I conducted an exit conference with Don Adams, licensee designee. He stated staffs Nash Wadi and Josh Black's employment was terminated after their internal investigation.

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:	Although the staff involved denied mistreating Resident A, the body chart provided the necessary corroborating evidence to substantiate the allegation. Therefore, there is sufficient evidence the direct care staff mistreated Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

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Jeffrey J. Bozsik Date: 5/12/22
Licensing Consultant

Approved By:

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Ardra Hunter Date: 5/17/22
Area Manager