GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 7, 2022

Daniel Bogosian
Moriah Incorporated
3200 E Eisenhower
Ann Arbor, MI 48108

RE: License #: AL810015274
Investigation #: 2023A0575004
Eisenhower Center - South Main

Dear Mr. Bogosian:

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. 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 #:	AL810015274
Investigation #:	2023A0575004
Complaint Receipt Date:	10/28/2022
Investigation Initiation Date:	10/28/2022
Report Due Date:	11/27/2022
Licensee Name:	Moriah Incorporated
Licensee Address:	3200 E Eisenhower Ann Arbor, MI 48108
Licensee Telephone #:	(734) 677-0070
Administrator:	Daniel Bogosian, Designee
Licensee Designee:	Daniel Bogosian, Designee
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 B sprayed with water by staff Warleen Foster	No
Resident A was verbally abused by staff Dion Lewis.	Yes

III. METHODOLOGY

10/28/2022	Special Investigation Intake-2023A0575004
10/28/2022	APS Referral
10/28/2022	Referral - Recipient Rights
10/28/2022	Special Investigation Initiated – Telephone-Stephanie Harris, program coordinator
11/02/2022	Inspection Completed On-site-interviews with (a) Resident A, (b) Resident B and (c) residential supervisor, Kristin O'Brien
11/02/2022	Contact - Telephone calls made-(a) Resident A's guardian; (b) staff Dion Lewis; (c) Resident B's guardian; (d) staff Warleen Foster; and (e) staff D'Angelo Green
11/02/2022	Corrective Action Plan Requested and Due on 11/17/2022
11/02/2022	Exit Conference with licensee designee, Dan Bogosian

ALLEGATION:

Resident B sprayed with water by staff Warleen Foster

INVESTIGATION:

APS and ORR referrals were made.

On 11/2/2022, I interviewed Resident B. She was non-communicative and does not appear to have the cognitive capacity to understand the question. The residential supervisor for her unit, Kristin O'Brien stated she did not witness anything and was

informed by staff D'Angelo Green that Resident B was sprayed with water by staff Warleen Foster to get her to go back into her bedroom.

On 11/2/2022, I telephone interviewed Warleen Foster. She stated she had no idea what I was referring to, did not understand why anyone would do such a thing, and had no recall of anyone spraying Resident B with water.

On 11/2/2022, I telephone interviewed D'Angelo Green. He stated he did not say that staff Warleen Foster sprayed Resident B with water. He stated water was spritzed into the air, not at anyone, and for no apparent reason.

On 11/3/2022, I telephoned Resident B's guardian. She stated that she is satisfied with the placement and the services Resident B is receiving.

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:	There is no discernible evidence that Resident B was mistreated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was verbally abused by staff Dion Lewis.

INVESTIGATION:

On 11/2/2022, I interviewed Resident A. He stated that staff Dion Lewis had verbally abused him with an assortment of colorful and not so nice vulgarities. He stated as he was being dressed down by Dion Lewis, he was also speaking to his guardian/mother, who recorded the telephone call.

On 11/2/2022, I telephoned Dion Lewis for his version of the interaction, but he did not pick up or return my calls.

On 11/2/2022, I telephoned Resident A's guardian/mother. She replayed the recorded conversation between Dion Lewis and Resident A. She expressed satisfaction in Resident A's current placement, and we discussed possible placement options in Genesee County, since I had previously worked there.

On 11/2/2022, I conducted an exit conference with Dan Bogosian, licensee designee.

APPLICABLE RULE	
R 400.15308	**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:	The preponderance of credible evidence is that Resident A was verbally abused by direct care staff Dion Lewis.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan within 15 days, I recommend no change in the status of the license.

Jeffrey J. Bozsik
Licensing Consultant
Date: 11/3/2022

Approved By:

Ardra Hunter
Area Manager
Date: 11/7/2022