GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 28, 2022

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

RE: License #: AL810069928
Investigation #: 2023A0575006
Eisenhower Center North Hall

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 #:	AL810069928
Investigation #:	2023A0575006
Complaint Receipt Date:	11/09/2022
Investigation Initiation Date:	11/09/2022
Report Due Date:	12/09/2022
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 North Hall
Facility Address:	3200 E Eisenhower Parkway Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	02/09/1996
License **Status:**	REGULAR
Effective Date:	05/15/2021
Expiration Date:	05/14/2023
Capacity:	15
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A was left unsupervised by 1:1 staff.	Yes
Resident B was confined in his bedroom with door shut.	Yes
Resident C was given wrong medication.	Yes

III. METHODOLOGY

11/09/2022	Special Investigation Intake-2023A0575006
11/09/2022	Special Investigation Initiated - Telephone
11/09/2022	APS Referral
11/09/2022	Referral - Recipient Rights
11/17/2022	Inspection Completed On-site-interviews with: (a) complainant #1; (b) staff Stephen Richards; (c) complainant #2; (d) Residents A, B, and C.
11/17/2022	Contact - Document Received-IPOS and behavior plans for Residents A and C
11/17/2022	Contact - Telephone call made-Interviews with guardians for Residents A, B and C; (b) staff Lindsay Wallace; (c) staff Jaquan Griggs
11/17/2022	Exit Conference with Dan Bogosian, licensee designee

ALLEGATION:

Resident A was left unsupervised by 1:1 staff.

INVESTIGATION:

On 11/9/2022, APS and ORR referrals were made.

On 11/17/2022, Resident A was unable to be interviewed due to his developmental disability.

On 11/17/2022, I interviewed complainant #1. She stated that when she walked into the area of the facility where Resident A resides on 11/1/2022 in the late afternoon, she found him unsupervised. She stated he has a 1:1 staff who was not on site.

On 11/17/2022, I interviewed Resident A's assigned 1:1 staff, Stephen Richards. He stated that he was Resident A's 1:1 staff in the late afternoon of 11/1/2022. He stated that the facility was short staffed and so he was covering 2 residents, not just Resident A. He stated the Eisenhower management knew about the staff shortage.

On 11/17/2022, I reviewed Resident A's IPOS, dated 8/9/2022 and his assessment plan. It states his living arrangement is 24 hours direct or 1:1 staffing 24 hours/day.

On 11/17/2022, I interviewed Resident A's guardian who stated that she was aware of the situation but was still satisfied with the placement.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Staff acknowledged and admitted that Resident A wasn't provided the level of supervision established at his IPOS/assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B was confined in his bedroom with door shut.

INVESTIGATION:

On 11/17/2022, Resident B was communicative, but couldn't provide any meaningful input about this allegation.

On 11/17/2022, I interviewed complainant #2. She stated that on 11/15/2022, she witnessed staff Jaquan Griggs holding the door shut to Resident B's bedroom. She stated that when he recognized she was watching him, he let go of the door handle, Resident B opened the door and exited his bedroom.

On 11/17/2022, I interviewed Jaquan Griggs. He stated Resident B had a bowel movement in his pants, took off his pants and was going to exit the facility “as naturel.” He stated Resident B wasn’t listening to him when he told Resident B, he had to clean himself and put on pants before he could leave his room. Finally, he stated he did not remember holding the door shut to Resident B’s bedroom.

On 11/17/2022, I reviewed Resident B’s behavior plan dated 9/1/2022. There is nothing in the plan that allows staff to confine a resident to a room where egress is prevented.

On 11/17/2022, I interviewed Resident B’s guardian. She stated she was not aware of the incident but was satisfied with the placement, given Resident B’s challenging behaviors.

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: **(d) Confine a resident in an area, such as a room, where egress is prevented.**
ANALYSIS:	I found the complainant to be credible and found Jaquan Griggs statement that he did not remember holding Resident B’s bedroom door shut to be lacking in truthfulness. Therefore, direct care staff, Jaquan Griggs, did confine Resident B to his bedroom and prevented his egress.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident C was given wrong medication.

INVESTIGATION:

On 11/17/2022, I attempted to interview Resident C. He was communicative but was unable to provide any meaningful input regarding the allegation. He did know he was hospitalized for a few days but did not know why and stated he felt good.

On 11/17/2022, I interviewed staffs Stephen Richards and Lindsay Wallace. Stephen Richards stated that on 11/13/2022, he mistakenly administered Resident C another resident's medications. He stated that the medications were set up by another staff, Lindsay Wallace. He stated his communication with Lindsay Wallace led him to believe that the set-up medications were for Resident C. They were for another resident. Lindsay Wallace admitted she set-up the medications and took responsibility for the miscommunication with Stephen Richards that led to Resident C being given another resident's medications.

On 11/17/2022, I interviewed Resident C's guardian. She stated that she was satisfied with the services Resident C is receiving and is satisfied with his residential placement.

On 11/17/2022, I conducted an exit conference with the licensee designee and president of Eisenhower Center discussing these findings and future possible steps.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staffs Stephen Richards and Lindsay Wallace admit Resident C was given the wrong medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the submission of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

Jeffrey J. Bozsik
Licensing Consultant
Date: 11/17/2022

Approved By:

Ardra Hunter
Area Manager
Date: 11/28/2022