GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 5, 2022

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

RE: License #: AL810015274-Eisenhower- South Main
Investigation #: 2023A0575007

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 #:	2023A0575007
Complaint Receipt Date:	11/21/2022
Investigation Initiation Date:	11/21/2022
Report Due Date:	12/21/2022
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 A's shoe was placed in the medication room.	Yes
Resident B did not receive his seizure medication.	Yes

III. METHODOLOGY

11/21/2022	Special Investigation Intake-2023A0575007
11/21/2022 11/22-23/2022	Special Investigation Initiated – Telephone Contact- Telephone call made-Resident A and Resident B's guardians
11/21/2022	APS Referral
11/22/2022 11/23/2022	Referral - Recipient Rights Special Investigation- On site-interviews with nurses David Hedrick and Marrysa Jones.
11/25/2022	Contact - Telephone call received- staff Daniea Jackson
11/28/2022	Contact - Telephone call made-staffs Alayna Burks and Ashley Osborne
11/28/2022	Corrective Action Plan Requested and Due on 12/16/2022
11/23/2022 and 11/28/2022 12/2/2022	Exit Conferences-with licensee designee, Dan Bogosian Contact- document received

ALLEGATION: Resident A's shoe was placed in the medication room.

INVESTIGATION:

APS and ORR referrals were made by facility staff.

On 11/23/2022, my interviews with Residents A and B were not informative due to their cognitive impairments.

On 11/23/2022, I interviewed Resident A's guardian who stated she was not bothered by the shoe incident and is satisfied with the residential services he was receiving at the Eisenhower Center.

On 11/25/2022, I interviewed staff Daniea Jackson, the alleged shoe absconder. She stated another unnamed resident takes Resident A's clothing, including his shoes, so she placed one of Resident A's shoes in the med room to protect it. She stated Resident A likes to play basketball outside and will run outside without notice and sometimes inappropriately dressed. Finally, she stated there was no mention in Resident A's IPOS regarding limiting his access to his clothing.

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: **(e) Withhold clothing.**
ANALYSIS:	Although staff Daniea Jackson admission and explanation for taking Resident A's shoe for his protection and safety is somewhat plausible, taking Resident A's shoe because another unnamed resident may take it is unreasonable. There is no specific language in Resident A's IPOS that speaks of limiting his access to his personal property for whatever reason. Therefore, direct care staff Daneia Jackson, under the direction of the licensee, withheld Resident A's clothing.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B did not receive his seizure medication.

INVESTIGATION:

On 11/22/2022, I interviewed the Resident B's guardian. She sent Resident B's lab results for his seizure medication from UM hospital dated 11/7/2022. The lab results show that his seizure medication was at sub-therapeutic level (less than 2.8 ug/ml, when the therapeutic level is 50-100 ug/ml.) from not receiving his anti-seizure

medication. She stated Resident B was on hospice, so that when Resident B began having seizures, the Eisenhower nursing staff called the hospice nurse, who was 40 miles away. She stated when Resident B was still seizing and the hospice nurse still had not arrived and had to go to the hospital to pick up valium IM, she told staff to call 911 and take Resident B to the hospital. Finally, she did express general satisfaction with Resident B's placement and residential services.

On 11/23/2022, I interviewed nurses David Hendrick and Marrysa Jones. Mr. Hendrick stated he was not at the facility at the time of the incident, but he acknowledged Resident B's anti-seizure medication was not given as prescribed, hence the sub-therapeutic lab levels. He guessed the anti-seizure medication was not given for 2-3 days regardless of what the medication log reads. He presented a plan of correction to prevent the re-occurrence of this medication error. Ms. Jones was on duty, and she said Resident A's hospice protocol is to first call the hospice nurse, not 911. She stated Resident B is a DNR, no CPR, and no de-fib. She stated she was in communication with the guardian and called 911 when she requested same.

On 11/28/2022, I interviewed the two staffs that would have been on shift around the first week of November and passed Resident B his medications. Staff Alayna Burks stated she thought she gave Resident B his seizure medications, but he has difficulty in swallowing pills, so he may not have swallowed them. Staff Ashley Osborne stated she gave Resident B his medications as prescribed.

On 12/2/2022, I reviewed Resident A's electronic medication records and the medication was initialed as being given as prescribed.

I conducted exit conferences on 11/23/2022 and 11/28/2022 with the licensee designee, Dan Bogosian.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	By nursing staff admission and irrefutable hospital labs, Resident B was not given his anti-seizure medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jeffrey J. Bozsik
Licensing Consultant
Date: 12/2/2022

Approved By:

Ardra Hunter
Area Manager
Date: 12/5/2022