STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 23, 2023

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

RE: License #: AL810069928
Investigation #: 2023A0575013
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 #:	2023A0575013
Complaint Receipt Date:	01/03/2023
Investigation Initiation Date:	01/03/2023
Report Due Date:	02/02/2023
Licensee Name:	Moriah Incorporated
Licensee Address:	3200 E Eisenhower Ann Arbor, MI 48108
Licensee Telephone #:	(734) 677-0070
Administrator:	Daniel Bogosian
Licensee Designee:	Daniel Bogosian
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 sustained frostbite on his fingers	Yes

III. METHODOLOGY

01/03/2023	Special Investigation Intake-2023A0575013
01/03/2023	APS Referral
01/03/2023	Referral - Recipient Rights
01/03/2023	Special Investigation Initiated - Telephone
01/03/2023	Contact - Document Received-hospital discharge summary dated 12/27/22
01/09/2023	Contact - Telephone call made-direct care staff-(a) Tiffany Smith; (b) Stephen Richards; (c) nurse Andrea Hatfield; and (d) Resident A's guardian/mother
01/12/2023	Inspection Completed On-site-interviews with (a) Dan Bogosian-licensee designee, and (b) Stephanie Harris-program coordinator
01/12/2023	Contact - Document Received-Resident A's Individual Plan of Service (IPOS)
01/12/2023	Exit Conference with Dan Bogosian, licensee designee

ALLEGATION:

Resident A sustained frostbite on his fingers

INVESTIGATION:

APS and ORR were notified.

Resident A was not interviewed because he was discharged to his guardian, per a 30-day discharge notice, in Genesee County, who's local CMH placed him in another facility in a different county.

On 1/3/2023, I received a copy of Resident A's hospital discharge summary dated 12/27/2022. The attending physicians diagnosed him with frostbite on 2 of his fingers.

On 1/9/2023, I interviewed the direct care staff Tiffany Smith and Stephen Richards. Ms. Smith claimed no knowledge of the incident. Mr. Richards stated his shift starts around 7:00 a.m. and Resident A's routine is to go outside in the facility complex courtyard around 2:00 a.m. and not come back inside until around 7:00 a.m. for breakfast and to get ready for school. (I personally witnessed Resident A outside of his assigned facility on a previous complaint investigation and he had a handful of grass and dirt.) Mr. Richards reported Resident A will not tolerate wearing gloves, he does not have a 1:1 staff, and he is free to roam about the facility complex grounds. Mr. Richards stated even if Resident A had a 1:1 staff, he (Resident A) would be very aggressive if staff attempted to redirect him to something he did not want to do.

On 1/9/2023, I interviewed nurse Andrea Hatfield who stated that Resident A's fingers were evaluated, and he was sent to local hospital ER for evaluation and treatment.

On 1/9/2023, I interviewed Resident A's guardian. She stated that she knew of the frostbite and received the 30-day discharge notice. She stated she could not handle her son. I recommended she contact the local CMH, as did the licensee, and request alternative placement. I also recommended she petition probate court and have a different guardian appointed so that she would not be responsible for Resident A's residential placement.

On 1/12/2023, I received a copy of Resident A's individual plan of service. It states he exhibits self-injurious behaviors and wanders.

On 1/12/2023, I conducted an exit conference with the licensee designee, Dan Bogosian. He stated that Resident A had been placed in another CMH contract special certification facility in Rockwood, MI.

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:	Although Resident A has been appropriately placed in another residential facility, the issue of any resident being allowed to go outside inappropriately dressed, as in this incident, or engaging in any other potentially self-injurious behavior without staff intervention needs to be addressed. This type of incident leads to the conclusion that the resident, here Resident A, was not being provided protection and safety at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the status of the license, pending the submission of an acceptable plan of correction.

Jeffrey J. Bozsik
Licensing Consultant

Date: 1/17/2023

Approved By:

Ardra Hunter
Area Manager

Date: 1/23/2023