GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 20, 2023

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

RE: License #: AM810015275
Investigation #: 2023A0575042
Eisenhower Center - Congregate

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 was required. On September 13, 2023, 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. In the event that 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 #:	2023A0575042
Complaint Receipt Date:	09/11/2023
Investigation Initiation Date:	09/11/2023
Report Due Date:	10/11/2023
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 - 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:	06/30/2023
Expiration Date:	06/29/2025
Capacity:	12
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A was mistreated by staff resulting in unexplained bruises on his head and torso.	No
Resident B was given the wrong medication.	Yes

III. METHODOLOGY

09/11/2023	Special Investigation Intake-2023A0575042
09/11/2023	APS Referral
09/11/2023	Referral - Recipient Rights
09/11/2023	Special Investigation Initiated - Telephone
09/11/2023 09/19/2023	Contact - Telephone call made-(a) Resident A's guardian/mother; (b) Dan Bogosian-licensee designee Contact- Telephone call made- direct care staff (a) Mekylla Lewis; (b) Sabrina Dukes; and (c) Travis Gray
09/13/2023	Inspection Completed On-site-(a) reviewed Resident A's AFC Assessment, Behavior Plan, body charts, recent incident reports written by direct care staff Mekylla Lewis, Sabrina Dukes, and Travis Gray with Dan Bogosian, licensee designee; (b) reviewed Resident B medication error incident report and corrective action plan.
09/13/2023	Inspection Completed-BCAL Sub. Compliance
09/13/2023	Exit Conference with licensee designee
09/19/2023	Contact - Telephone call made Direct care staffs Mekylla Lewis, Sabrina Dukes, and Travis Gray

ALLEGATION:

Resident A was mistreated by staff resulting in unexplained bruises on his head and torso.

INVESTIGATION:

On 9/11/2023, APS and ORR referrals made/received.

Resident A was not interviewed because he is non-verbal. He was observed on 9/13/2023.

On 9/11/2023, I interviewed Resident A's guardian/mother. She stated that she is satisfied with his placement and acknowledged that he can be self-abusive resulting in cuts, bruises, and abrasions.

On 9/13/2023, I reviewed Resident A's recent body charts, AFC Assessment dated 4/5/2023, and his behavior plan dated 10/19/2022. His body charts and incident reports were recent examples of and consistent with his history of self-injurious behavior, physical aggression, and head banging. The direct care staff involved in documenting and intervening, which included Mekylla Lewis, Sabrina Dukes, and Travis Gray in the recent weeks all document Resident A's property destruction, physical aggression and self-injurious behaviors and staffs attempts, including a behavior analyst and crisis coordinator when needed, to calm him down which includes using PRN medications.

On 9/13/2023, I conducted an exit conference with the licensee designee, Dan Bogosian. He stated Resident A has an extensive history of self-injurious behavior, physical aggression and property destruction and the recent incident reports document those behaviors.

On 9/19/2023, I interviewed direct care staffs Mekylla Lewis, Sabrina Dukes, and Travis Gray. All three staff stated they did not witness or know of anyone who may have mistreated Resident A.

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:	The preponderance of evidence and Resident A's history of self-injurious behavior leads to the conclusion that his cuts/bruises are self-inflicted, not that he is being mistreated by staff. Therefore, the licensee did not mistreat Resident A and did not permit direct care staff/employees who are under the direction of the licensee or other occupants of the home to mistreat Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B was given the wrong medication.

INVESTIGATION:

On 9/13/2023, I reviewed the incident report dated 8/23/2023, written by staff Laura Caincross explaining/admitting that she gave Resident B the wrong medication. She stated Resident B was sent to St. Joseph's hospital as a precaution and he was returned to the facility the same day.

On 9/13/2023, Dan Bogosian, licensee designee, gave me a copy of the corrective action taken. Staff Laura Caincross was suspended for 2 days and had to retake a medications course.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff admitted to and self-reported this medication error, which was subsequently corrected.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable plan of correction has been received; therefore, I recommend no change in the status of the license.

Jeffrey J. Bozsik
Licensing Consultant

Date: 9/19/2023

Approved By:

Ardra Hunter
Area Manager

Date: 9/20/2023