GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2024

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

RE: License #: AL810015274
Investigation #: 2025A0575004
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AL810015274
Investigation #:	2025A0575004
Complaint Receipt Date:	10/23/2024
Investigation Initiation Date:	10/23/2024
Report Due Date:	11/22/2024
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, 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:	05/21/2023
Expiration Date:	05/20/2025
Capacity:	14
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A's injuries are inconsistent with behavioral incident report.	Yes

III. METHODOLOGY

10/23/2024	Special Investigation Intake-2025A0575004
10/23/2024	APS Referral
10/23/2024	Special Investigation Initiated – Telephone call to licensee designee, Dan Bogosian
10/23/2024	Contact- Documents received-incident reports
10/23/2024	Contact - Telephone calls made-(a) direct care staff: (1) Davion Priester; (2) Alec Cooper; and (3) Marchia Seuell. (b) Resident A's guardian
10/23/2024	Inspection Completed On-site-interview with (a) Resident A and (b) licensee designee, Dan Bogosian
10/23/2024	Inspection Completed-BCAL Sub. Compliance
10/23/2024	Exit Conference with Dan Bogosian
11/21/2024	Contact- Telephone call made- (a) direct care staff, Davion Priester; and (b) APS investigator Kaitlyn McGill

ALLEGATION:

Resident A's injuries are inconsistent with behavioral incident report.

INVESTIGATION:

An APS referral was received. APS investigator, Kaitlyn McGill called, but did not return my call.

On 11/21/2024, I called APS investigator Kaitlyn McGill and we discussed my findings. She agreed with my findings.

On 10/23/2024, I attempted to interview Resident A. He is verbal but cannot explain what happened. He did voluntarily pull up his shirt to show me his injuries/rug burns.

On 10/23/2024, I received and reviewed the incident reports emailed from the licensee designee, Dan Bogosian related to Resident A's injuries. The incident reports were written by direct care staff Davion Priester and Marchia Seuell.

On 10/23/2024 and on 11/21/2024, I telephoned Davion Priester, but he did not answer the telephone or return my calls. According to the incident report he wrote dated 10/17/2024, he states that Resident A was trying to elope and when he prevented his elopement, Resident A fell to the floor and began head banging. He stated he put his shoe under Resident A's head to prevent Resident A's injury and then Resident A grabbed his leg in an attempt to bite his shoe/leg. He stated that as he started to pull away, he fell and dragged Resident A across the floor resulting in Resident A's injuries/rub burns.

On 10/23/2024, I telephone direct care staff Marchia Seuell. She stated that she did not witness Davion Priester hit or drag Resident A, but according to her incident report dated 10/17/2024, she writes basically the same scenario, with Resident A holding onto Davion Priester's leg and trying to bite his shoe/leg, with Davion Priester pulling away and dragging Resident A across the floor which resulted in injuries/rug burns.

On 10/23/2024, I interviewed direct care staff, Alec Cooper. He stated that he as a witness he felt Davion Priester used excessive force when he tried to prevent Resident A from eloping from the facility and that he dragged Resident A across the floor while trying to escape his hold on his leg.

On 10/23/2024, I interviewed Resident A's guardian. He stated that he was aware of the incident and was satisfied with Resident A's placement.

On 10/23/2024, I interviewed Dan Bogosian. We reviewed Resident A's behavior plan. It does not state any specific strategy for staff to utilize when Resident A is physically aggressive Resident A's elopement attempts are isolated so there is no plan to address those incidents. When Resident A exhibits self-injurious behavior, staff are to block attempts with their forearm or use a pillow or cushion to protect Resident A's head. Finally, I conducted an exit conference. He agreed with my findings and stated that he expected Davion's employment, who has been taken off the staff schedule, to be terminated.

On 11/21/2024, I called Dan Bogosian. He stated that Davion Priester's employment was terminated on 10/24/2024.

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:	The preponderance of evidence is that direct care staff Davion Priester dragged Resident A across the floor while trying to escape his hold on his leg, which resulted in Resident A's injuries/rug burns. Therefore, staff Davion Priester mistreated Resident A by his intentional action and exposed Resident A to physical harm.
	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable action plan, I recommend no changes in the license status.

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Jeffrey J. Bozsik
Licensing Consultant

Date: 11/21/2024

Approved By:

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Ardra Hunter
Area Manager

Date: 12/2/2024