GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 2, 2021

Devin Hutchings
Moriah Incorporated
3200 E Eisenhower
Ann Arbor, MI 48108

RE: License #: AL810069928
Investigation #: 2021A0575033
Eisenhower Center North Hall

Dear Mr. Hutchings:

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 1, 2021, 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. 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 #:	2021A0575033
Complaint Receipt Date:	08/31/2021
Investigation Initiation Date:	08/31/2021
Report Due Date:	09/30/2021
Licensee Name:	Moriah Incorporated
Licensee Address:	3200 E Eisenhower Ann Arbor, MI 48108
Licensee Telephone #:	(734) 677-0070
Administrator:	Devin Hutchings
Licensee Designee:	Devin Hutchings
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?
Staff mistreated Resident A.	Yes

III. METHODOLOGY

08/31/2021	Special Investigation Intake 2021A0575033
08/31/2021	APS referral-made
08/31/2021	Special Investigation Initiated - On Site- (a) Stephanie Harris-program coordinator; (b) Resident A
09/01/2021	Contact - Telephone call made-direct care staff: (a) Gabriel Hawkins; (b) Christian Peterson; (c) TaSheena Hogue
09/01/2021	Inspection Completed-BCAL Sub. Compliance
09/01/2021	Corrective Action Plan Requested and Due on 09/17/2021
09/01/2021	Corrective Action Plan Received
09/01/2021	Corrective Action Plan Approved
09/01/2021	Exit Conference with licensee designee, Devin Hutchins

ALLEGATION: Staff mistreated Resident A.

INVESTIGATION: On 08/31/2021, I interviewed Stephanie Harris, program coordinator, and she stated direct care staff Gabriel Hawkins employment was terminated on 8/27/21, after two other staff reportedly witnessed Mr. Hawkins punch Resident A in the face, causing a laceration between his eyebrows.

On 08/31/2021, I attempted to interview Resident A, but he refused to answer any questions. I was however able to see the laceration between his eyebrows.

On 09/01/2021, I interviewed direct care staff Gabriel Hawkins and he stated he did not punch Resident A. He stated Resident A was quite agitated and was being physically aggressive towards him, biting and kicking him. He stated he called for staff assistance in subduing Resident A.

On 09/01/2021, I interviewed direct care staff Christian Peterson and TaSheena Hogue. They both stated they were called by direct care staff Gabriel Hawkins for assistance because Resident A was biting and kicking him. They stated they witnessed direct care staff Gabriel Hawkins punch Resident A in the face, between the eyebrows causing a laceration and bleeding. They stated the nurse on duty cleaned the wound.

I conducted an exit conference with the licensee designee, Devin Hutchins, who concurred with the findings.

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:	Direct care staff Christian Peterson and TaSheena Hogue both reported witnessing Gabriel Hawkins punch Resident A in the face. Direct acre staff Gabriel Hawkins denied punching Resident A in the face. Resident A refused to be interviewed but I observed a laceration on his face. The preponderance of evidence obtained through this investigation indicates that Gabriel Hawkins punched Resident A in the face. Therefore, a violation of the above cited rule is made.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable plan of correction has been received. I recommend no changes in the status of the license.

Jeffrey J. Bozsik
Licensing Consultant

Date: 09/02/2021

Approved By:

Jerry Hendrick
Area Manager

Date: 09/02/2021