GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2021

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

RE: License #: AM810015275
Investigation #: 2021A0575030
Eisenhower Center - Congregate

Dear Mr. Hutchings:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 #:	AM810015275
Investigation #:	2021A0575030
Complaint Receipt Date:	08/25/2021
Investigation Initiation Date:	08/25/2021
Report Due Date:	09/24/2021
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 - 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:	05/21/2020
Expiration Date:	05/20/2022
Capacity:	12
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Staff mistreated Resident A.	No

III. METHODOLOGY

08/25/2021	Special Investigation Intake 2021A0575030
08/25/2021	Special Investigation Initiated - Telephone
08/25/2021	APS Referral received
08/25/2021	Contact - Telephone call made-complainant
08/31/2021	Inspection Completed On-site-(a) Resident A; (b) direct care staff: (1) Darren Vaughn and (2) Anthony Wimberly
08/31/2021	Exit Conference with Devin Hutchins, licensee designee
08/31/2021	Contact - Telephone call made-complainant

ALLEGATION: Staff mistreated Resident A.

INVESTIGATION: I interviewed the complainant on 8/25/21 at which time she stated that she did not save a recording of the FaceTime video she had with Resident A during which she claims direct care staff Darren Vaughn slapped Resident A in the back of the head when Resident A was trying to remove his protective helmet.

I interviewed Resident A on 8/31/21 but due to his developmental disability he was uncommunicative and was unable to provide any information.

I interviewed Darren Vaughn on 8/31/21 and he stated he followed Resident A's behavior plan when he attempted to remove his protective helmet (it looks like a hockey helmet). He stated when Resident A began to remove his helmet, he verbally redirected him and when that wasn't successful, he physically interrupted Resident A from removing his helmet with his hands and secured the strap that holds it on. He denied slapping Resident A in the head.

I interviewed Anthony Wimberly, direct care staff on 8/31/21 and he stated he witnessed the interaction between Resident A and Darren Vaughn. Mr. Wimberly stated Darren Vaughn followed Resident A's behavior plan and he corroborated

Darren Vaughn's version of the interaction, i.e., Darren Vaughn did not slap Resident A in the head.

I reviewed Resident A's behavior plan and the behavioral intervention is as Darren Vaughn described, i.e., staff are to verbally redirect Resident A if he begins to loosen the strap on his helmet and if Resident A continues to attempt to remove his helmet, staff are to physically intervene and prevent him from removing his helmet.

I conducted an exit conference with Devin Hutchins on 8/31/21 and he agreed with the findings.

I telephoned the complainant at her request to inform her of my findings. She stated she understood that there was no evidence to corroborate her complaint.

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 complainant reported she observed staff Darren Vaughn slap Resident A in the back of his head. Darren Vaughn denied slapping Resident A in the back of his head and explained that all he did was redirect Resident A and physically stop him from removing his helmet. Staff Anthony Wimberly stated he observed the interaction between Resident A and staff Darren Vaughn and denied that Mr. Vaughn slapped Resident A in the back of his head. Resident A's treatment plan states staff are to verbally redirect Resident A if he begins to loosen the strap on his helmet and if Resident A continues to attempt to remove his helmet, staff are to physically intervene and prevent him from removing his helmet. Based upon the information summarized above, a violation is not substantiated.

CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend no changes in the status of the license.

Jeffrey J. Bozsik
Licensing Consultant
Date: 09/04/2021

Approved By:

Jerry Hendrick
Area Manager
Date: 09/07/2021