GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2022

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

RE: License #: AM810015275
Investigation #: 2023A0575009
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 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 #:	2023A0575009
Complaint Receipt Date:	12/04/2022
Investigation Initiation Date:	12/04/2022
Report Due Date:	01/03/2023
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:	05/21/2022
Expiration Date:	05/20/2024
Capacity:	12
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident B's personal hygiene was unattended and Resident C was not supervised adequately.	No
Resident A jumped out of a moving van.	Yes

III. METHODOLOGY

12/04/2022	Special Investigation Intake-2023A0575009
12/04/2022	Special Investigation Initiated - Telephone
12/05/2022	APS Referral-received
12/05/2022	Referral - Recipient Rights
12/06/2022	Inspection Completed On-site-interviews with (a) Dan Bogosian, licensee designee, (b) Ann Pendley, Eisenhower President; (c) Stephanie Harris, program coordinator; (d) Rohman Bounds, education liaison; (e) Doreen Cadreau-Gifford-nurse; (f) Residents A, B, and C
12/06/2022, 12/07/2022, 12/13/2022, 12/15/2022	Contact - Telephone call made-(a) Shaquel Hall-direct care staff; (b) Resident A, B, and C's guardians, (c) Renita Hall-APS, and (d) Rohman Bounds, education liaison
12/06/2022	Inspection Completed-BCAL Sub. Non-Compliance
12/06/2022	Exit Conference with licensee designee, Dan Bogosian

ALLEGATION: **Resident B's personal hygiene was unattended and Resident C was not supervised adequately.**

INVESTIGATION:

On 12/5/2022, APS and ORR referrals were made.

On 12/6/2022, I interviewed Residents B and C. However, both are Developmentally Disabled/Autistic and non-verbal. Resident B was outside on the grounds with a handful of dirt/grass. Resident C was asleep in his room. I visually checked the bruise on his forehead allegedly from when he fell out of bed.

On 12/6/2022 and 12/15/2022, I interviewed Rohman Bounds, education liaison to the Washtenaw Intermediate School District (WISD). He stated he has met with Resident A's schoolteacher, and the school principal to explain that Resident B's autistic behaviors include picking up and playing with handfuls of dirt and grass. Consequently, he almost always has dirty hands and dirt on his shirt and pants. If he smells, it will be the smell of dirt. He stated staff change Resident A's brief, but not necessarily on a set time basis. Additionally, staff pick out clothes for Resident A, but if he has decided which clothes to wear, he will put them on, sometimes backward, and staff will not be able to re-direct him. I also reviewed his AFC assessment dated 1/14/2022. It states he needs prompts for dressing and hygiene but does not address his autistic behaviors.

On 12/6/2022, APS staff Renita Young forwarded a body chart completed by the WISD staff dated 11/28/2022 of Resident B. The body chart noted that Resident B had bad body odor, a soiled brief, and dirty clothes that were on backward.

On 12/6/2022, I met Resident A outside of one of the facilities. He was appropriately dressed, did not have a body odor, but did have a clump of dirt/grass in his hand.

On 12/6/2022, I contacted Resident B's guardian, who acknowledged his behavioral and self-care challenges, but felt that Eisenhower Center has been about the best placement for him to date, since he was previously placed at Hawthorn Center.

Resident C had fallen out of bed on 11/27/22 and sustained a bruise on his forehead. On 12/6/2022, I reviewed Resident C's IPOS which stated his level of supervision is 15-minute bed checks, not 1:1 staffing.

On 12/6/2022, I interviewed staff nurse Doreen Cadreau-Gifford. She stated that Resident C was checked on 11/28/2022, after the bruise on his forehead was discovered by staff. She stated that he was stable, his ADL status was OK, i.e., there was no change in his cognitive status or routine and she felt he did not need to go to the hospital.

On 12/6/2022, 12/7/2022 and 12/13/2022, I called Resident C's guardian/mother. She did not answer and did not return my calls.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Rohman Bounds, education liaison, explained that Resident B's autistic behaviors include picking up and playing with handfuls of dirt and grass. Consequently, he almost always has dirty hands and dirt on his shirt and pants and smells of dirt. Staff change his brief as needed and not on a set schedule. If Resident A has decided which clothes to wear, he will put them on, sometimes backward, and staff will not be able to re-direct him. Resident B's guardian acknowledged his behavioral and self-care challenges, but felt that Eisenhower Center has been about the best placement for him to date Even though Resident B has hygiene challenges, sending a body chart from a week earlier does not provide timely photographic evidence that can be corroborated. Although Resident C fell out of bed and had a bruise on his forehead, his supervision level does not necessitate staff to always check on him. I reviewed Resident C's IPOS which stated his level of supervision is 15-minute bed checks, not 1:1 staffing Therefore, the licensee provided supervision, protection, and personal care as defined in the act and as specified in both resident's written assessment plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: **Resident A jumped out of a moving van.**

INVESTIGATION:

On 12/6/2022, I interviewed Resident A, but he is Autistic and cognitively impaired.

On 12/6/2022, I interviewed Shaquel Hall, Resident A's 1:1 staff. He stated that after he was finished transporting another resident on 12/1/2022, Resident A initially

unlocked his seatbelt and ran into the front windshield and rearview mirror. After he was re-seat belted, he took off his seat belt, opened the van door and jumped out while the van was reportedly going 35 mph. He stated the police and EMS were called and when they arrived Resident A was running through the neighborhood yards. Resident A got in the EMS van unassisted. Although Resident A had a 1:1 staff on the van, here the driver was the 1:1 staff, and he couldn't be both the driver and provide 1:1 supervision for Resident A.

On 12/6/2022, I interviewed Ann Pendley, president, Dan Bogosian, licensee designee, and Stephanie Harris, program coordinator. It was agreed Resident A needs an alternative placement and his guardian was issued a 30-day notice to vacate.

On 12/6/2022, I contacted Resident A's guardian. She stated that generally Eisenhower has done a good job with Resident A.

On 12/6/2022, I conducted exit conference with both Dan Bogosian and Ann Pendley.

APPLICABLE RULE	
R 400.14305	**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:	This is the third substantiated complaint regarding Resident A in the last month. In SIR 2023A0575006, staff took his shoes and put them in the med room. In SIR 2023A0575007, staff confined Resident A to his bedroom. In this complaint, a 1:1 staff doubling as the van driver couldn't provide for Resident A's protection and safety. This lack of adequate staffing directly contributed to Resident A being able to jump out of the moving van.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend modification of the status of the license to provisional.

Jeffrey J. Bozsik
Licensing Consultant

Date: 12/15/2022

Approved By:

Ardra Hunter
Area Manager

Date: 12/15/2022