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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 12, 2023

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

RE: License #: AL810015274
Investigation #: 2022A0575032
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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 #:	AL810015274
Investigation #:	2022A0575032
Complaint Receipt Date:	07/21/2022
Investigation Initiation Date:	07/21/2022
Report Due Date:	08/20/2022
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 - 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:	05/21/2021
Expiration Date:	05/20/2023
Capacity:	14
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A's diagnosis of PTSD is a result of his placement in this Eisenhower Center facility.	Yes
Resident A's "open wounds" were untreated/neglected by staff.	Yes
Resident A was administered the wrong dosage of the medication ONFI.	No
Additional Findings	Yes

III. METHODOLOGY

07/21/2022	Special Investigation Initiated - Telephone
01/21/2022, 07/21/2022	APS Referral
01/21/2022, 07/21/2022 02/13/2022, 11/1/2022	Referral - Recipient Rights Contact- Document Received-Resident A's guardian sent emails Contact- Document received- Resident A's guardian sent documents
07/26/2022, 10/27/2022	Contact - Telephone call made- Resident A's psychiatrist office. (a) Rite Aid pharmacy, (b) Resident A's guardian (text)
02/09/2022 07/28/2022 10/27/2022	Contact- Call made- (a) Resident A; (b) Resident A's guardian; and (c) Nurse- Meranda Sawabini Inspection Completed On-site- interviews with (a) Meranda Sawabini-staff nurse; (b) Dan Bogosian-licensee designee Contact-Interview with Meranda Sawabini-Eisenhower nurse
08/11/2022	Inspection Completed-BCAL Sub. Compliance

08/15/2022	Contact - Document Received-Resident A's discharge summary from UM hospital
08/16/2022	Contact - Telephone call received-Resident A's psychiatrist
08/17/2022, 11/02/2022, 01/09/2023	Exit Conference with Dan Bogosian, licensee designee

ALLEGATION:

Resident A's diagnosis of PTSD is a result of his placement in this Eisenhower Center facility.

INVESTIGATION:

On 7/21/2022, Resident A's father sent me a copy of Resident A's psychiatric evaluation dated 3/24/2022.

He writes, "He [Resident A] was recently asked by his (current) school (Resident A resided at Eisenhower Center from 12/21/2021-01/12/2022), to stay away due to increased emotional outbursts, seemingly triggered by experiences there."

He also writes, "It is possible that his recent traumatic experiences, during his residential stay, where he was allegedly exposed to hostility, criticism, and neglect, possibly triggered these responses, as both events seem to be temporally associated. Given the persistence of symptoms for over a month, and significant impairment in functioning, a diagnosis of PTSD is confirmed."

On 8/16/2022, Resident A's psychiatrist returned my call and stated he hasn't seen Resident A since May of 2020. He stated that "although Resident A's developmental disabilities make assessment difficult, he believes that his diagnosis of PTSD is accurate since Resident A has new feelings of anxiety, stress, and a fear of falling to sleep." He stated these behaviors began after Resident A's Eisenhower Center/South Main residential placement.

APPLICABLE RULE	
R 400.15305	**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:	Since Resident A's PTSD diagnosis is believed by his psychiatrist to be a result of what he witnessed/experienced while residing at Eisenhower, the psychiatrist's PTSD diagnosis establishes a preponderance of evidence, then the licensee is violation of this rule. Therefore, Resident A was not treated with dignity and his personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's "open wounds" were untreated/neglected by staff.

INVESTIGATION:

On 2/9/22, I interviewed Resident A who stated that he told the staff he needed assistance with toileting, but they did not assist him.

On 2/9/22, I spoke with Resident A's guardian, who stated he told Nurse- Meranda Sawabini on 1/7/22 that Resident A needed assistance with his personal care, but staff did not attend to Resident A's needs as required in Resident A's behavior plan and he was allowed to walk around the facility in clothes soiled with feces.

On 2/9/22, I spoke with Nurse- Meranda Sawabini, who stated Resident A's personal care skills were assessed and it was determined that Resident A can complete personal care tasks. Therefore, Ms. Sawabini stated staff were to prompt Resident A to use the bathroom every 3 hours and ask if he needed assistance. She stated this would help him to be more independent and attend to his own self care needs. Finally, she stated that when Resident A arrived at the facility it was noted that he had what appeared to be small pimples on his buttocks.

On 2/13/2022, I received 2 emails from Resident A's guardian. They were mainly pictures of lesions/cellulitis on Resident A's thighs/buttocks. There were also pictures of his arms, a head shot, and emails to and from Eisenhower staff. Additionally, there was an email from Resident A's primary care physician who diagnosed the cellulitis and stated it was from poor hygiene.

On 7/28/2022, I interviewed nurse Meranda Sawabini, who provided Resident A's "body and wound chart" from 12/21/2021, Resident A's date of admission to the facility, and from 01/05/2022, five days before he went to the University of Michigan hospital on 1/10/2022. There are no abnormalities noted on either date. She stated he did have several pimples on his buttocks but provided no treatment.

On 8/15/2022, I reviewed a copy of Resident A's discharge summary from UM hospital dated 1/10/2022. The discharge summary is from the University Hospital Emergency Department. Resident A was seen for agitation. There is nothing noted about any wounds in the discharge summary.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
	Previously, in SIR2022A0575011, I substantiated a rule 305(3) violation because Resident A's personal hygiene was not attended to by staff based on his AFC assessment. The cellulitis diagnosis referenced in SIR2022A0575011 was made after he was discharged from the facility and was reportedly from poor hygiene. However, regarding this allegation, since nursing staff Meranda Sawabini admitted to not treating Resident A's "five pimples" on his buttocks, the preponderance of evidence is that staff did not obtain needed care immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was administered the wrong dosage of the medication ONFI.

INVESTIGATION:

On 7/28/2022, I interviewed nurse Meranda Sawabini. She provided Resident A's medication administration record, which showed that Resident A was prescribed one 15 mg tablet of ONFI at 8 pm daily. However, she stated this medication only comes in a 10 mg tablet, not a 15 mg tablet. Therefore, to ensure that Resident A received the prescribed 15 mg, she gave him 1 and ½ tablets daily. She stated the staff documented the medication was given even though the medication administration record reads 1 tablet, not the 1 and ½ tablets needed to equal 15mg/day. Finally, she stated Resident A did not have any seizures while residing at Eisenhower Center.

On 10/26/2022, I did an online search of the medication ONFI, and found that its dosage is 10mg or 20mg scored tablets.

On 10/27/2022, I contacted a Rite Aid pharmacy. The pharmacist on duty stated ONFI medication is dispensed in 10mg (scored) and 20 mg tablets. She stated that if the prescription is for 15 mg, then you cut one of the scored 10 mg tablets and the prescription should read 1 and ½ tablets.

On 10/27/2022, I interviewed Meranda Sawabini. She stated that Resident A's guardian refused to use the pharmacy that Eisenhower Center uses, she never received Resident A's prescriptions she requested from either Resident A's guardian nor from the prescribing physician, and she received the ONFI medication bottles from Resident A's guardian and returned them to him when Resident A left the facility in January 2022.

On 10/27/2022, I emailed Resident A's guardian and requested copies of the original prescriptions and pictures of the bottles.

On 11/1/2022, Resident A's guardian sent copies of Resident A's prescriptions and pictures of the bottles. The prescriptions dated 10/28/2021, state that Resident A is to be given 15 mg (1 and ½ tablets per day of a 10 mg tablet) of the seizure medication ONFI. He also sent the Oakland Co CMH-ORR investigation, which determined that Eisenhower Center nurse Meranda Sawabini incorrectly documented Resident A's ONFI seizure medication but did not conclude that she also administered the wrong dosage (10mg instead of the prescribed 15mg) to Resident A while he was in residence at the Eisenhower Center.

On 1/8/23, I reviewed a copy of the Oakland Co-ORR report dated 5/11/2022. Their findings are consistent with this report's findings that there is a preponderance that Eisenhower Center Nurse Meranda Sawabini incorrectly documented Resident A's ONFI seizure medication, however there is insufficient evidence to conclude that Resident A didn't receive ONFI 15mg as prescribed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	I interviewed Eisenhower Center Nurse Meranda Sawabini who stated that although the medication record documented 1 tablet, Resident A received 1 and ½ tablets of ONFI daily (15 mg) as prescribed and suffered no seizures while residing at Eisenhower Center and I have found her to be credible. A local pharmacist, the prescribing physician's prescriptions for Resident A, and my own research corroborated her statements that the medication did not come in a 15 mg tablet, and she made the correct decision in scoring the tablets to ensure that Resident A received the proper dosage of ONFI medication. Therefore, there is insufficient evidence to establish a preponderance that Resident A was not given ONFI 15mg pursuant to label instructions.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 7/28/2022, I interviewed nurse Meranda Sawabini. She provided Resident A's medication administration record, which showed that Resident A was prescribed one 15 mg tablet of ONFI at 8:00 p.m. daily. However, she stated this medication only comes in a 10 mg tablet, not a 15 mg tablet. Therefore, to ensure that Resident A received the prescribed 15 mg, she gave him 1 and ½ tablets daily. She stated the staff documented the medication was given even though the medication administration record reads 1 tablet, not the 1 and ½ tablets needed to equal 15mg/day. Finally, she stated Resident A did not have any seizures while residing at Eisenhower Center.

On 1/8/23, I reviewed a copy of the Oakland Co-ORR report dated 5/11/2022. Their findings are consistent with this report's findings about improper medication documentation.

I completed exit conferences on 8/17/2022, 11/02/2022, and again on 01/09/2023 with the licensee designee, Dan Bogosian.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(b) Complete an individual medication log that contains all of the following information: **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Nurse Meranda Sawabini admits she did not correctly document Resident A's ONFI medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Jeffrey J. Bozsik
Licensing Consultant
Date: 1/09/2023

Approved By:

Ardra Hunter
Area Manager
Date: 1/12/2023