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GOVERNOR

# STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA ACTING DIRECTOR

November 8, 2023

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

> RE: License #: AL810086003 Investigation #: 2024A0575001

> > Eisenhower Center - East Hall

#### 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.

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

Syfrey Jr. Bozaik

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 #:	AL810086003
Investigation #:	2024A0575001
Complaint Receipt Date:	10/25/2023
Investigation Initiation Date:	10/25/2023
mvootigation mitiation bate.	10/20/2020
Report Due Date:	11/24/2023
Licensee Name:	Moriah Incorporated
Licensee Name.	Widtham mediporated
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 - East Hall
Facility Address:	3200 Eisenhower Parkway
r demisy / tadi occi	Ann Arbor, MI 48108
Estilia Talanhara #	(704) 077 0070
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	07/22/1999
License Status:	REGULAR
Effective Date:	04/19/2022
Expiration Date:	04/18/2024
Capacity:	16
Program Type:	PH; DD; MI; TBI

# II. ALLEGATION(S)

Vio	latic	n
Estab	lish	ed?

Resident A mistreated by residential staff.	Yes

#### III. METHODOLOGY

10/25/2023	Special Investigation Intake-2024A0575001
10/25/2023	Special Investigation Initiated - Telephone
10/25/2023	APS Referral
10/25/2023	Referral - Recipient Rights
10/25/2023	Contact - Telephone call made-1) direct care staff: (a) Geremiah Williams; (b) Steanna Wilson; (c) Daniel Bullord; and (d) Matthew Hesceles. 2) Resident A's guardian
10/26/2023	Inspection Completed On-site-interviews with (a) Resident A, (b) Stephanie Harris, Eisenhower Center program coordinator, and (c) Joseph Keller, Eisenhower Center psychologist and CMH liaison.
10/26/2023	Inspection Completed-BCAL Sub. Compliance
10/26/2023	Exit Conference with Dan Bogosian, licensee designee

### **ALLEGATION:**

Resident A mistreated by residential staff.

# **INVESTIGATION:**

APS and ORR referrals received/made.

On 10/25/2023, I interviewed Resident A's guardian. He stated he was aware of the incident and was satisfied with Resident A's placement.

On 10/25/2023 I interviewed the four direct care staff who were involved in/observed the incident with Resident A.

Staff Matthew Hesceles stated he was called to the scene by staff Steanna Wilson. He stated she said she was assaulted by Resident A and she was going to "beat his a\*\*" if he hits her again. Staff Matthew Hesceles stated when he walked into the room where the incident was occurring, he observed staff Geremiah Williams on top of Resident A with his forearm on Resident A's neck. He also reported that he observed staff Daniel Bullord holding down Resident A's arm, in what were not approved behavior management restraints.

The other three staff involved in the incident stated that Resident A had assaulted staff Steanna Wilson

Staff Geremiah Williams stated that when Resident A assaulted staff Steanna Wilson, he tried to re-direct Resident A. He stated that he did not perform an NCI (Nonviolent Crisis Intervention) approved restraint and that he and staff Daniel Bullord held Resident A down on the couch. He stated that when staff Matthew Hescheles witnessed them restraining Resident A they were told to "get off him."

Staff Daniel Bullord stated he was holding Resident A's arm to prevent him from assaulting staff while staff Geremiah Williams was also restraining Resident A.

Staff Steanna Wilson stated that she was assaulted by Resident A and that the other two staff were using NCI restraints.

On 10/26/2025, I interviewed both Stephanie Harris, program coordinator and Joseph Keller, psychologist. They both stated that the three staff involved in the incident with Resident A, not including Matthew Hescheles, did not use an approved behavioral intervention.

On 10/26/2023, I conducted an exit conference with the licensee designee, Dan Bogosian. He stated the three staff involved in the incident had their employment terminated.

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:	By their own admission, the three staff involved in the incident with Resident A did not use approved behavioral intervention(s), thereby resulting in the licensee permitting direct care staff, who are under the direction of the licensee, to mistreat Resident A.
CONCLUSION:	VIOLATION ESTABLISHED

# IV. RECOMMENDATION

Pending an acceptable plan of correction; I recommend no changes in the status of the license.

Date: 10/30/23

Date: 11/8/23

Jeffrey J. Bozsik

Licensing Consultant

Approved By:

Ardra Hunter Area Manager

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