GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 28, 2024

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

RE: License #: AL810280703
Investigation #: 2024A0575005- Moriah 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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. 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
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 #:	AL810280703
Investigation #:	2024A0575005
Complaint Receipt Date:	11/16/2023
Investigation Initiation Date:	11/16/2023
Report Due Date:	01/15/2024
Licensee Name:	Moriah Incorporated
Licensee Address:	3200 E Eisenhower Ann Arbor, MI 48108
Licensee Telephone #:	(734) 677-0070
Administrator:	Daniel Bogosian
Licensee Designee:	Daniel Bogosian
Name of Facility:	Moriah Hall
Facility Address:	3200 E. Eisenhower Pkwy Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	03/19/2008
License **Status:**	REGULAR
Effective Date:	09/26/2022
Expiration Date:	09/25/2024
Capacity:	16
Program Type:	DD; MI; TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A bit Resident B requiring medical treatment.	Yes

III. METHODOLOGY

11/16/2023	Special Investigation Intake-2024A0575005
11/16/2023	Special Investigation Initiated - Telephone
11/16/2023	Contact - Telephone call made-(1) direct care staffs: (a) Aster Ykelo; (b) Leandra Hardesty; (2) Resident B's guardian.
11/16/2023	APS Referral
11/16/2023	Referral - Recipient Rights
11/16/2023	Contact - Document Received-Incident Report -Resident B treated at hospital.
11/20/2023	Contact - Telephone call made-residential supervisor-Curry Baungart.
11/20/2023	Inspection Completed On-site-interviews with Residents A and B
11/21/2023	Contact - Telephone call received-Resident A's guardian.
01/02/2024	Inspection Completed On-site-licensee designee, Dan Bogosian.
01/02/2024	Exit Conference with licensee designee, Dan Bogosian
01/02/2024	Inspection Completed-BCAL Sub. Non-Compliance
01/05/2024	Contact-Telephone call made-Psychologist/plan author-Brianne Martis.
02/27/2024	Exit Conference with licensee designee, Dan Bogosian
03/07/2024	Contact-Telephone call made-direct care staffs: (a) Leandra Hardesty, and (b) Shannon Garner
03/28/2024	Exit Conference with licensee designee, Dan Bogosian

ALLEGATION:

Resident A bit Resident B requiring medical treatment.

INVESTIGATION:

APS and ORR referrals were made/received.

On 11/16/2023, I interviewed Resident A's 1:1 direct care staff, Aster Ykelo. She stated her shift ended and she had left the building before this incident took place.

On 11/16/2023, I interviewed Resident B's 1:1 direct care staff, Leandra Hardesty. She stated that she was walking behind Resident A to get his PRN medication, since he was upset.

On 11/16/2023, I interviewed Resident B's guardian. She stated she was dissatisfied with his treatment, but she did not have a better placement, and she refused moving him to a different facility within the Eisenhower Center complex.

On 11/20/2023, I interviewed residential supervisor, Curry Baungart. He stated he was Resident A's 1:1 staff since Aster Ykelo had completed her shift and had left the building. He stated he was present at the incident, and he verbally prompted Resident B to leave the area, but he would not go. Curry Baungart stated that he [Curry Baungart] was being physically attacked by Resident A, who hit him in the chest and was trying to bite his hand. He stated that his understanding of Resident A's behavior plan is that it requires the staff to verbally redirect Resident A, block his punches, and move other residents out of the way.

On 11/20/2023, licensee designee, Dan Bogosian, and I attempted interviews with Residents A and B, but neither are verbal. Dan Bogosian, licensee designee, got Resident B to pull down his pants to see where he was bitten on the thigh/knee by Resident A. Dan Bogosian stated Resident B was treated and released at a local hospital on 11/13/2023 after he was bitten by Resident A. Resident B was bitten because he did not move out of the area as requested by staff Curry Baungart. Therefore, Curry Baungart was unable to get between Resident A and the target of his physical assault, Resident B, as required by Resident A's behavior plan.

On 11/21/2023, Resident A's guardian called to expressed concerns regarding the possible placement of Resident A to another facility. I discussed the situation with her and her husband.

On 1/2/2024, I met with Dan Bogosian and requested a copy of Resident A's behavior plan, which he emailed to me. I reviewed Resident A's behavior plan dated 12/15/2022 and found that in the section addressing his physical aggression/property

destruction, step 3 states that staff are to “step in between [Resident A] and other consumers if he is targeting them.” I conducted an exit conference with Dan Bogosian and discussed the possibility of referring Resident A to Washtenaw County CMH for an alternative placement.

On 1/5/2024, I contacted psychologist, Brianne Martis. She authored Resident A’s behavior plan and stated that if the staff followed the behavior plan as written, Resident A would not be able to physically assault/bite other residents.

On 2/27/2024, I conducted an exit conference with Dan Bogosian and discussed my findings and recommendation.

On 3/7/2024, I re-interviewed direct care staff, Leandra Hardesty. She was Resident B’s 1:1 staff at the time of the incident. Leandra Hardesty stated that when she witnessed Resident A starting to go attack Resident B, she tried to get between the two residents and used a pillow to block Resident A’s attack. She stated Resident A veered off in a different direction and was able to assault Resident B, who had not cleared out of the area.

On 3/7/2024, I interviewed direct care staff, Shannon Garner, who was present at the time of the incident. She stated she was there because it took place in a large multi-purpose room and confirmed staff Leandra Hardesty’s interpretation of the events.

On 03/28/2024, I conducted an exit conference with Dan Bogosian and discussed the additional interviews conducted, updated findings, recommendation and specifically what needs to be included in the corrective action plan in order for it to be acceptable.

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:	Present at the time of the incident was Resident A's 1:1 staff, Curry Baungart, Resident B's 1:1 staff, Leandra Hardesty, and direct care staff, Shannon Gardner. Curry Baungart attempted to verbally redirect Resident B to leave the area so he would not be assaulted by Resident A, however, Resident B did not leave the area, resulting in Resident B being bitten by Resident A. Leandra Hardesty, tried to get between Resident A and Resident B by using a pillow to block Resident A's attack, but Resident A maneuvered away in another direction and was able to assault Resident B who had not cleared the area. Shannon Garner witnessed the incident from the multi-purpose room and confirmed Leandra Hardesty's description of events. Dan Bogosian stated Curry Baungart tried but was unable to get between Resident A and Resident B, as required by Resident A's behavior plan. I reviewed Resident A's behavior plan dated 12/15/2022 and found that in the section addressing his physical aggression/property destruction, step 3 states that staff are to "step in between [Resident A] and other consumers if he is targeting them." Psychologist, Brianne Martis, authored Resident A's behavior plan and stated that if the staff followed the behavior plan as written, Resident A would not be able to physically assault/bite other residents. Even though, staff involved attempted to prevent Resident A from assaulting Resident B, utilizing the procedures described in Resident A's behavior plan, they were unsuccessful. This allegation was previously substantiated in SIR# 2023A0575023. Therefore, this is a REPEAT VIOLATION as Resident B 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:	**REPEAT VIOLATION ESTABLISHED** **SIR 2023A0575023 dated 4/6/23 and CAP dated 4/17/23.**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend no changes to the current status of the license.

Jeffrey J. Bozsik
Licensing Consultant

Date: 3/28/2024

Approved By:

Ardra Hunter
Area Manager

Date: 3/28/2024