



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 13, 2025

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

RE: License #: AL810069928
Investigation #: 2025A0575015
Eisenhower Center North 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.

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,

A handwritten signature in blue ink that reads "Jeffrey J. Bozsik".

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 #:	AL810069928
Investigation #:	2025A0575015
Complaint Receipt Date:	02/04/2025
Investigation Initiation Date:	02/04/2025
Report Due Date:	03/06/2025
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:	Eisenhower Center North Hall
Facility Address:	3200 E Eisenhower Parkway Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	02/09/1996
License Status:	REGULAR
Effective Date:	05/15/2023
Expiration Date:	05/14/2025
Capacity:	15
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A's seizure medications were not given as prescribed.	Yes

III. METHODOLOGY

02/04/2025	Special Investigation Intake-2025A0575015
02/04/2025	Special Investigation Initiated - Telephone
02/04/2025	APS Referral
02/04/2025	Inspection Completed On-site-interviews with Resident A and licensee designee, Dan Bogosian
02/04/2025	Contact - Telephone call made-(a) Resident A's guardian; (b) Kelsey Marion, RN; (c) Elizabeth Bower, RN; (d) direct care staff Jennifer Calixto
02/04/2025	Inspection Completed-BCAL Sub. Compliance
02/04/2025	Exit Conference with license designee, Dan Bogosian
02/04/2025	Corrective Action Plan Requested
02/05/2025	Contact- Document received

ALLEGATION: Resident A's seizure medications were not given as prescribed

INVESTIGATION:

An APS referral was made by the complainant.

On 2/4/2025, I interviewed Resident A. She stated that she likes living at Eisenhower Center but has no knowledge of not receiving her prescribed medications.

On 2/4/2025, I interviewed Resident A's guardian. He stated that he is very satisfied with Resident A's placement, but he feels that the Eisenhower Center staff waited too long to refill Resident A's seizure medications, which resulted in her having to go to the hospital actively seizing.

On 2/4/2025, I interviewed the Eisenhower Center nurse on call, Kelsey Marion. She stated that Resident A had missed two doses of her seizure medication on one day due to Eisenhower Center nursing staff having difficulty obtaining the seizure medication refill from Resident A's primary care physician (PCP). She stated that Resident A's assigned nurse would have more accurate details about her situation.

On 2/4/2025, I interviewed Resident A's assigned nurse, Elizabeth Bower, RN. She stated that Resident A missed 3 doses over 1.5 days of her seizure medication due to changing PCPs which led to the lapse in prescription being refilled in a timely manner. She stated that she made several phone calls to try to refill the seizure medication, but that the new PCP would not fill the prescription without seeing Resident A and now Resident A is being switched to a neurologist. She also stated that Resident A was being administered an antibiotic which lowers her threshold for seizure activity and that contributed to her uncontrolled seizure activity and hospitalization.

On 2/4/2025, I interviewed direct care staff Jennifer Calixto. She stated that Resident A had missed medications.

On 2/4/2025, I conducted an exit conference with licensee designee Daniel Bogosian.

On 2/5/2025, I received and reviewed Resident A's medication administration record (MAR). It showed that she had missed her seizure medications over 2 days.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Although there were understandable extenuating circumstances that contributed to the nursing staff not being able to refill Resident A's seizure medication prescription, the evidence illustrates, and was admitted to by the nursing staff, that Resident A's seizure medication was not given as prescribed.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Jeffrey J. Bozsik
Licensing Consultant

Date: 2/6/2025

Approved By:



Ardra Hunter
Area Manager

Date: 2/13/2025