



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 #: 2025A0575016
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,

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 #:	2025A0575016
Complaint Receipt Date:	02/06/2025
Investigation Initiation Date:	02/06/2025
Report Due Date:	03/08/2025
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 eloped from the facility.	Yes

III. METHODOLOGY

02/06/2025	Special Investigation Intake-2025A0575016
02/06/2025	APS Referral
02/06/2025	Special Investigation Initiated - Telephone
02/11/2025	Inspection Completed On-site-interview with licensee designee Daniel Bogosian; review of Resident A's Individual plan of service (IPOS), and the related incident report.
02/11/2025	Contact - Telephone call made-(a) Resident A's guardian; (b) direct care staff Shalanda Hurt, Ratiba Bouchatra, and Daria King
02/12/2025	Contact- Telephone call made- direct care staff Shalanda Hurt
02/11/2025	Exit Conference with Dan Bogosian

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

Resident A was not interviewed as she is currently hospitalized as a consequence of this elopement and her reported reasons, i.e., stepping in front of an automobile to hurt herself.

An APS referral was received and the APS worker noted that on 2/1/2025 Resident A left her room and ran into the road (around 1:00am).

On 2/11/2025, I interviewed Resident A's guardian. She stated that she is very pleased with Resident A's placement at the Eisenhower Center and has no intention

of moving her to another placement. She stated that Resident A will look for times when the staff are preoccupied with other tasks to attempt to elope from the facility.

On 2/11/2025, I interviewed Daniel Bogosian and we reviewed Resident A's IPOS and the incident report dated 2/2/2025, written by direct care staff Shatonla Hurt. He stated that Resident A does not have a behavior plan since she does not attempt to elope on any consistent basis. Also, he said that Resident A has a 1:1 staff from 7:30am-11:30pm, with 15 minute checks, but Resident A does not have a 1:1 staff from 11:30pm-7:30am. On the incident report, dated 2/2/2025 @ 1:00am, direct care staff Shatonla Hurt described that while she was assisting another resident, Resident A left the building unsupervised. She estimated that Resident A returned to the facility about 10 minutes later. She stated that Resident A told her she left the building because she was hearing voices and wanted to hurt herself by getting hit by a car. Shatonla Hurt stated that she did not witness Resident A's elopement or fall, but that Resident A stated that after she fell, she got up and came back to the facility. Finally, Shatonla Hurt stated that the other staff member working was Daria King.

On 2/11/2025 and 2/12/2025, I telephoned Shatonla Hurt but she did not return my calls.

On 2/11/2025, I interviewed staff Daria King. She stated that she did not witness Resident A's elopement or fall, but did transport her to the emergency room because she tried to kill herself and she fell outside and had lacerations on her knees and head.

On 2/11/2025, I telephoned Ratiba Bouchatra. She could not be contacted because her phone does not work.

On 2/11/2025, I conducted an exit conference with Daniel Bogosian.

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 does not have a 1:1 staff during the overnight shift nor timely checks to monitor her whereabouts, she was able to elope from the facility unnoticed by staff and not found until she returned injured from a fall. Therefore, Resident A was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Jeffrey J. Bozsik
Licensing Consultant

Date: 2/12/2025

Approved By:



Ardra Hunter
Area Manager

Date: 2/13/2025