GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 20, 2025

Daniel Bogosian
Moriah Inc. c/o Dan Bogosian
3200 East Eisenhower Pkwy
Ann Arbor, MI 48108

RE: License #: AL810015274
Investigation #: 2025A0575039
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.
- 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 #:	AL810015274
Investigation #:	2025A0575039
Complaint Receipt Date:	08/04/2025
Investigation Initiation Date:	08/04/2025
Report Due Date:	09/03/2025
Licensee Name:	Moriah Inc. c/o Dan Bogosian
Licensee Address:	3200 East Eisenhower Pkwy Ann Arbor, MI 48108
Licensee Telephone #:	(734) 677-0070
Administrator:	Daniel Bogosian
Licensee Designee:	Daniel Bogosian
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:	05/21/2025
Expiration Date:	05/20/2027
Capacity:	14
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident B is not receiving proper care.	No
Resident A's seizure medication was not administered.	Yes
Resident B is not being bathed.	No

III. METHODOLOGY

08/04/2025	Special Investigation Intake-2025A0575039
08/04/2025	APS Referral
08/04/2025	Referral - Recipient Rights
08/04/2025	Special Investigation Initiated - Telephone
08/05/2025	Inspection Completed On-site-interviews with (a) Daniel Bogosian-licensee designee; (b) Rohman Bounds-program coordinator; (c) Kierlynn Lawless-direct care staff
08/05/2025	Inspection Completed-BCAL Sub. Compliance
08/05/2025	Contact - Telephone calls made-(a) Guardian A1; (b) Guardian B1
08/05/2025 08/06/2025 08/19/2025	Exit Conference with Daniel Bogosian, licensee designee Contact- Telephone call made- Jhai'la Grant-medical assistant Contact- Telephone call received- (a) Jhai'la Grant- medical assistant; (b) Rhianna Ortiz- bus attendant

ALLEGATION:

Resident B is not receiving proper care.

INVESTIGATION:

On 8/4/2025, APS and ORR referrals were made/received. The APS worker alleged that when Resident B became sick upon getting on the bus for school, the

Eisenhower staff did not respond to the bus attendants request to assist Resident B, his wheelchair was always dirty and the brakes on the wheelchair did not work properly.

Resident B was not interviewed because he is non-verbal. However, when he arrived at the facility in the afternoon on 8/5/2025, the staff assisting him demonstrated that the wheelchair brakes were fixed and I did observe his wheelchair to be in good repair.

On 8/5/2025, I interviewed Rohman Bounds, program coordinator. He stated that Resident B was getting on the bus wheelchair lift when he began to cough up his breakfast. He stated that when the bus attendant requested staff assistance, the Eisenhower Center staff responded but the bus attendant just stood by and did not provide any assistance. He stated that Resident B was cleaned up and did not need a change of clothes. Lastly, he stated that Resident B's wheelchair brakes were repaired on 7/29/2025 by a company the school contacted.

On 8/5/2025, I interviewed Kierlynn Lawless, direct care staff. She participated in assisting Resident B when he became sick and corroborated Rohman Bound's description of the incident.

On 8/5/2025, I interviewed Resident B's guardian. She stated that she was "satisfied for the most part", with Resident B's placement at the Eisenhower Center and understood the problems with staff turnover.

On 8/19/2025, I interviewed Rhianna Ortiz, bus attendant. She returned my call and stated that on 7/29/2025 when Resident B was loaded on the bus to go to school he became sick and began to choke and vomit. She stated that she notified the bus driver and yelled for assistance from the Eisenhower Center staff. She stated that the staff were slow to respond, but did come out to assist with Resident B. She stated that neither her nor the bus driver assisted/provided any assistance to Resident B before the Eisenhower Center staff arrived because they are not trained and they are not to assist for insurance/liability purposes. Finally, she stated that Resident B did not attend school that day.

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:	The preponderance of credible evidence is that Resident B's personal needs were appropriately attended to by staff and since his wheelchair brakes were repaired on the same day of the filing of this complaint, that renders this part of the allegation moot.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's seizure medication was not administered.

INVESTIGATION:

Resident A was not interviewed because he is non-verbal.

The complainant alleged that Resident A has not been administered his seizure medication on 7/28/2025 and 7/29/2025 resulting in seizures that required his hospital visit.

On 8/5/2025, I interviewed Daniel Bogosian and he verified that Resident A's seizure medication had run out and that the prescription was not refilled so that Resident A was not administered his prescribed seizure medication on 7/28/2025 and 7/29/2025.

On 8/5/2025, I interviewed Guardian A1. He stated that he was aware of the seizure medication error and understood mistakes do happen. He stated he was satisfied with Resident A's placement so far.

On 8/6/2025, I telephoned Jhai'la Grant, medical assistant. Daniel Bogosian stated that she is the staff responsible for reordering Resident A's seizure medication.

On 8/19/2025, Jhai'la Grant returned my telephone call. She stated that she is the medical assistant for the first shift, 7:30am-4:00pm. She stated that she does re-order medications for the unit, but since she doesn't dispense Resident A's seizure medications, she did not know they needed reordering and any of the medical assistants on the other work shifts could have reordered Resident A's seizure medications once they were aware he was running out of medications.

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

ANALYSIS:	Since Resident A's seizure medication prescription was not refilled in a timely manner and apparently no one took responsibility for insuring that his medications were reordered, then his seizure medication was not given as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B is not being bathed.

INVESTIGATION:

The APS referral also alleged that Resident B has an odor and he is not being bathed.

On 8/5/2025, I interviewed Rohman Bounds. He stated that Resident B is bathed daily and he frequently assists staff making certain he is showered before he goes to school.

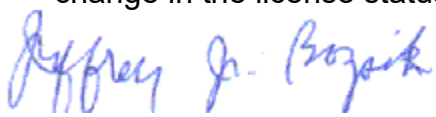
On 8/5/2025, I observed Resident B when he arrived at the facility from school. His clothes were clean and he looked clean and did not have any noticeable odor.

On 8/5/2025, I interviewed Guardian B1. She stated that she was satisfied for the most part with Resident B's care and understood that staff turnover makes the situation much more difficult.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1)A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Since I did not find any noticeable odors emanating from Resident B and I found Rohman Bounds to be credible, the preponderance of credible evidence is that Resident B is being showered daily. Therefore, the licensee did ensure that Resident B bathes at least weekly and more often if necessary.
CONCLUSION:	**VIOLATION NOT 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: 8/19/2025

Approved By:

Ardra Hunter
Area Manager
Date: 8/20/2025