GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 28, 2026

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

RE: License #: AM810015275
Investigation #: 2026A0575009
Eisenhower Center - Congregate

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 #:	AM810015275
Investigation #:	2026A0575009
Complaint Receipt Date:	01/05/2026
Investigation Initiation Date:	01/05/2026
Report Due Date:	02/04/2026
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 - Congregate
Facility Address:	3200 E Eisenhower Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	08/09/1993
License **Status:**	REGULAR
Effective Date:	06/30/2025
Expiration Date:	06/29/2027
Capacity:	12
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A repeatedly unsupervised without mandated 1:1 staffing possibly leading to a head injury.	Yes

III. METHODOLOGY

01/05/2026	Special Investigation Intake-2026A0575009
01/05/2026	APS Referral
01/05/2026	Special Investigation-Initiated-ORR
01/05/2026	Referral - Recipient Rights
01/07/2026	Inspection Completed On-site-interview with (a) Resident A; (b) Daniel Bogosian, licensee designee
01/07/2026	Contact - Telephone call made-(1) direct care staff: (a) Bianca Gamble; (b) Patricia Bukasa; (2) Guardian A1
01/07/2026	Inspection Completed-BCAL Sub. Compliance
01/07/2026	Exit Conference with Daniel Bogosian, licensee designee

ALLEGATION:

Resident A repeatedly unsupervised without mandated 1:1 staffing possibly leading to a head injury.

INVESTIGATION:

On 1/5/2026 APS and ORR referrals were received.

On 1/7/2026, I attempted to interview Resident A, but he is non-verbal and hearing impaired.

On 1/7/2026, I interviewed Guardian A1. I reviewed the information regarding the three different episodes of a lack of required supervision for Resident A.

First, on the evening of December 20, 2025 Resident A was taken to the hospital because he banged his head on the floor causing an injury that required stitches. It's alleged that the injury would not have happened if Resident A had 1:1 staff present.

Second, during a visit on December 21, 2025, Guardian A1 stated that Resident A's 1:1 staff was absent from the bedroom and there was no 1:1 staff for 11 minutes.

Third, during a visit on December 25, 2025, Guardian A1 stated that although there was a staff in Resident A's room, there was not a 1:1 staff assigned to Resident A.

On 1/7/2026, I interviewed Daniel Bogosian, licensee designee. He acknowledged that Resident A has 1:1 staff 24/7 which I reviewed in his IPOS dated 9/10/2025. He provided a copy of the 12/20/2025 incident report regarding Resident A's emergency room visit and a copy of Resident A's daily residential progress note for 12/25/2025.

On 1/7/2025, I reviewed the 12/20/2025 incident report. The reporting staff, Mawusi Crawford wrote that when Resident A was informed he could not go for a car ride, he began to have behaviors, which included hitting his head on the floor. Mawusi Crawford wrote that he used head blocks and hitting pads to prevent Resident A from injuring himself. During the incident, Resident A cut his hand. He was transported to University of Michigan hospital for treatment.

On 1/7/2025, I interviewed direct care staff, Bianca Gamble, regarding the 12/21/2025 allegation of Resident A not being provided 1:1 staffing. She stated that they were short staffed on 12/21/2025 due to staff using their sick time, and that another resident was having a behavioral incident so she admitted that she left Resident A unattended to assist the other staff member.

On 1/7/2025, I interviewed direct care staff, Patricia Bukasa, regarding the 12/25/2025 allegation of Resident A not being provided 1:1 staffing. She stated that she worked the 8:00 p.m.-overnight shift. She stated that she was on duty when Resident A returned from his family visit/leave of absence, and there was not a 1:1 staff assigned to Resident A.

On 1/7/2025, I conducted an exit conference with Daniel Bogosian. We also reviewed the staffing schedule for the holiday week and although Resident A had a 1:1 staff scheduled, he stated that staff that have accrued sick leave and can call off the same day for shift leaving the shift short staffed.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan.
ANALYSIS:	Since Resident A is supposed to have 1:1 staffing 24/7 and since the staff admit to not providing 1:1 staffing due to staffing shortages, the licensee did not provide supervision, protection, and personal care as specified in a resident's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

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Jeffrey J. Bozsik Date: 1/14/2026
Licensing Consultant

Approved By:

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Ardra Hunter Date: 1/28/2026
Area Manager