



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2026

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

RE: License #: AL810015274
Investigation #: 2026A0575012
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,

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 #:	AL810015274
Investigation #:	2026A0575012
Complaint Receipt Date:	02/05/2026
Investigation Initiation Date:	02/05/2026
Report Due Date:	03/07/2026
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 - 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 A provided with insufficient staffing.	Yes
Resident B (a) possibly has an untreated UTI, (b) had an untreated knee injury at school on 2/9/2026, (c) engaged in head banging at school which resulted in a cut forehead, and (d) has an untreated ingrown toenail from 2/9/2026.	No
Resident B's bathing/hygiene neglected by staff which included not being bathed, greasy hair, a foul body odor and not wearing her socks and bra on 2/17/2026 and 2/18/2026.	No
Resident B's clothes are not clean.	No

III. METHODOLOGY

02/05/2026	Special Investigation Intake-2026A0575012
02/05/2026	APS Referral
02/05/2026	Special Investigation Initiated - On Site
02/05/2026	Referral - Recipient Rights
02/26/2026	APS Referral
03/03/2026	Inspection Completed On-site-interview with (a) Daniel Bogosian, licensee designee; and observations of (b) Residents A and B.
03/04/2026	Contact - Telephone call made-(a) Guardian A1; (b) Guardian B1; (c) Charity Grady, direct care staff; (d) Timothy Stephens, South Main on site manager; (e) Albert Hudson, direct care staff; (f) Leslie Murray, RN on South Main; (g) Debra Bryant, Oakland Co CMH case manager
03/05/2026	Contact - Telephone call made-(a) Alisha Smith, direct care staff; (b) Noah Talbert, direct care staff; (c) Kim Jennings, direct care staff; (d) Laveda Smith, APS worker

03/06/2026	Inspection Completed-BCAL Sub Compliance
03/06/2026	Exit Conference with Daniel Bogosian, licensee designee
03/16/2026	Contact- Telephone call made-direct care staff: (a) Jace Johnson, (b) Kamari Gregory

ALLEGATION:

Resident A provided with insufficient staffing

INVESTIGATION:

APS referral was received on 2/5/2026. The APS staff alleged that there was insufficient staff on duty on 2/3/2026 about 3:30pm when she witnessed 1 staff and several residents.

On 3/4/2026, Resident A was not interviewed due to being non-verbal. He does not require 1:1 supervision per his IPOS.

On 3/4/2026, I interviewed Guardian A1. She stated that she was aware of the complaint and was satisfied with Resident A's placement and supervision.

On 3/4/2026, I interviewed Daniel Bogosian, licensee designee. He stated that on 2/3/2026 at 3:30pm, there were 12 residents in South Main. He stated that there were 3 residents who required 1:1 staffing and the remaining 9 residents who did not require 1:1 supervision. He stated that there were 5 direct care staff on duty, three assigned to South Main during the 12:30pm-8pm shift, and two other direct care staff reassigned from two of the other licensed facilities at Eisenhower Center and the residential supervisor of South Main during the 12:30-8pm shift. Additionally, he provided the timecards of the 5 direct care staffs and the residential supervisor assigned to South Main on 2/3/2026 at 3:30pm.

On 3/4/2026, I interviewed direct care staff Charity Grady. She stated that she vaguely remembered working at South Main on 2/3/2026 but does not remember if she was assigned to a 1:1 resident. Her timecard showed she called off sick for the day.

On 3/4/2026, I interviewed Tim Stephens, residential supervisor. He stated that he was on duty at South Main on 2/3/2026 doing administrative tasks.

On 3/4/2026, I telephoned Albert Hudson. He did not return my calls, but his timecard showed he did not work on 2/3/2026.

On 3/5/2026, I telephoned direct care staff, Noah Talbert. He stated that he worked at South Main on 2/3/2026 but does not remember if he was assigned to a 1:1 resident.

On 3/5/2026, I interviewed direct care staff Alisha Smith. She stated that she remembered working on 2/3/2026 there were three direct care staff on duty.

On 3/5/2026, I interviewed Kim Jennings. She did not return my calls, but her timecard showed that she was working on 2/3/2026.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.
ANALYSIS:	I gave greater weight to the direct care staff timecards than they may have remembered on 2/3/2026. Since I concluded that there were 3 direct care staff working with the 3 residents who require 1:1 supervision and the residential supervisor was doing administrative tasks, there wasn't one additional staff to work with the remaining 9 residents. Therefore, the licensee did not always have sufficient direct care staff on duty for the supervision, personal care, and protection of Resident A and the other 8 residents and to provide the services specified in Resident A's assessment plan and IPOS.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident B (a) possibly has an untreated UTI, (b) had an untreated knee injury at school on 2/9/2026, (c) engaged in head banging at school which resulted in a cut forehead, and (d) has an untreated ingrown toenail from 2/9/2026.

INVESTIGATION:

On 2/26/2026, an APS referral was received that alleged that Resident B (a) possibly has an untreated UTI, (b) had an untreated knee injury at school on 2/9/2026, (c) engaged in head banging at school which resulted in a cut forehead, and (d) has an untreated ingrown toenail from 2/9/2026.

On 3/3/2026, Resident B was not interviewed because she is non-verbal. However, I did observe her and found her forehead to be clean, clear and without any evidence of a red mark, bruise or abrasion.

On 3/4/2026, I interviewed Guardian B1. She stated that she was aware of the complaint and was satisfied with the residential services that Eisenhower Center staff provide Resident B. Specifically, she stated that when Resident B becomes upset, she will bang her head on the floor.

On 3/4/2026, I interviewed Debra Bryant, Oakland Co CMH case manager. She stated that Resident B has a history of head banging when she becomes upset.

On 3/4/2026, I interviewed Leslie Murray, RN at Eisenhower Center. She stated that she had no knowledge and was never informed of Resident B possibly having a UTI on 2/26/2026. She also stated that she had no knowledge or was ever informed of Resident B having an untreated knee injury at school. She asked why the school staff didn't seek medical care if the alleged injury happened at school. Furthermore, she stated that Resident B's head cut/abrasion was checked when she returned from school. Finally, she stated that Resident B's ingrown toenail on 2/9/2026 was treated with an antibiotic since she would not tolerate soaking it.

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. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Since I found Leslie Murray, RN to be credible as to Resident B's medical concerns/treatments and I observed no bruises/abrasions on Resident B when I observed her, the licensee provided supervision, protection, and personal care as specified in Resident B's assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B's bathing/hygiene neglected by staff which included not being bathed regularly, having a soiled brief, greasy hair, a foul body odor and not wearing her socks and bra on 2/17/26 and 2/18/2026.

INVESTIGATION:

On 3/3/2026, I reviewed Resident B's IPOS bathing schedule with Daniel Bogosian, licensee designee. I reviewed Resident B's daily personal care log and found that she is bathed every day per her IPOS goal to bathe every day with a 75% completion rate. As for Resident B possibly having soiled briefs and not wearing her socks and bra, Daniel Bogosian stated that Resident B probably soiled herself on the bus going to school and she may have decided to remove her socks and bra if she was uncomfortable.

On 3/3/2026, I found Resident B to be clean, her hair to be clean and to have no foul odor.

On 3/4/2026, I interviewed Guardian B1. She stated that she was aware of the hygiene concerns related to Resident B but was satisfied that they had been addressed and remedied.

On 3/16/2026, I interviewed both direct care staffs Jace Johnson and Kamari Gregory. Jace Johnson was the staff member assigned to Resident B on the morning of 2/17/2026. The daily residential progress dated 2/17/2026 was documented by Jace Johnson. He stated that he could not specifically remember 2/17/2026, but he documented that Resident B was showered, dressed properly, was not incontinent and was on time at the time of boarding the school bus. Kamari Gregory was the staff member assigned to Resident B on 2/18/2026. She also documented and remembered that Resident B was showered, dressed properly, was not incontinent and was on time at the time of boarding the school bus.

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(2) A licensee shall ensure the resident receives or has access to all of the following: (a) Bathing at least weekly.
ANALYSIS:	The preponderance of evidence is that the licensee ensured Resident B receives or has access to bathing at least weekly.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B's clothes are not clean.

INVESTIGATION:

On 3/3/2026, I reviewed Resident B's laundry schedule with Daniel Bogosian. I found that her laundry is washed weekly. I observed Resident B's clothes to be clean and in good repair.

On 3/6/2026 I conducted an exit conference with Daniel Bogosian. He agreed with all of my findings. He stated that there are no specific staff assigned to complete a specific resident's laundry.

On 3/4/2026, I interviewed Guardian B1. She stated that she was aware of Resident B's clean clothes related to Resident B but was satisfied that they had been addressed and remedied.

On 3/16/2026, I interviewed both direct care staff Jace Johnson and Kamari Gregory. They both stated that laundry is completed for all of the residents on a weekly basis with no specific staff assigned, but that they have previously completed Resident B's laundry, and had no knowledge of concerns regarding Resident B's clothing.

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(3) A licensee shall assist the resident in obtaining clothing that fits, is clean, and is seasonally appropriate.

ANALYSIS:	The preponderance of evidence is that Resident B's clothes are washed weekly as I found her clothing to be clean. Therefore, the licensee assisted Resident B in obtaining clothing that fits, is clean, and is seasonally appropriate.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION



Jeffrey J. Bozsik
Licensing Consultant

Date: 3/17/2026

Approved By:



Ardra Hunter
Area Manager

Date: 3/19/2026