



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 #: AL810280703
Investigation #: 2026A0575018
Moriah 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.

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,

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 #:	AL810280703
Investigation #:	2026A0575018
Complaint Receipt Date:	03/11/2026
Investigation Initiation Date:	03/11/2026
Report Due Date:	04/10/2026
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:	Moriah Hall
Facility Address:	3200 E. Eisenhower Pkwy Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	03/19/2008
License Status:	REGULAR
Effective Date:	09/26/2024
Expiration Date:	09/25/2026
Capacity:	16
Program Type:	DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with the required 1:1 supervision and he was using unsanitary water bottles.	Yes

III. METHODOLOGY

03/11/2026	Special Investigation Intake-2026A0575018
03/11/2026	Special Investigation Initiated - ORR
03/11/2026	APS Referral
03/12/2026	Inspection Completed- On site interviews with: (a) Resident A, and (b) Daniel Bogosian, licensee designee
03/12/2026	Contact - Telephone call made- Debra Bryant, Oakland Co CMH case manager
03/13/2026	Contact - Telephone call made-(a) Guardian A1; (b) direct care staff: (1) Ahmad Abdelmoumeno; (2) Imaya Peterman; (3) Jonathon Johnson
03/16/2026	Contact - Telephone call made- Lydia Bevier, direct care staff
03/17/2026	Contact - Telephone call made- Ashley Noble, medical assistant
03/17/2026	Inspection Completed-BCAL Sub. Compliance
03/17/2026	Exit Conference with Daniel Bogosian, licensee designee

ALLEGATION:

Resident A was not provided with the required 1:1 supervision and he was using unsanitary water bottles.

INVESTIGATION:

On 3/11/2026 an ORR referral was received and an APS referral was made. The ORR referral alleged that on 2/21/2026 Resident A was not provided with 1:1 supervision as specified in his IPOS during which time he was banging his head on the floor and he was using unsanitary water bottles.

On 3/12/2026, I interviewed Daniel Bogosian. He provided a copy of the incident report dated 2/21/2026, we reviewed Resident A's IPOS requirement for 1:1 staffing, and he provided the names and telephone numbers of the staff involved in the incident. He also took me to observe Resident A.

On 3/12/2026, I observed Resident A. I did not interview him because he is non-verbal, uses a wheelchair and is visually impaired. I observed him slapping himself in the face while the direct care staff used a foam mitt to block/minimize his slaps. He did have a red mark on his forehead.

On 3/12/2026, I telephoned Debra Bryant, Resident A's Oakland Co CMH case manager to determine Resident A's 1:1 staffing requirements. She stated that Resident A's 1:1 supervision contract specifies that Resident A be within eyesight when he is asleep and within arm's length during awake hours. She stated that he has a history of punching himself in the face with such force that he has detached both eye retinas.

On 3/13/2026, I interviewed Ahmad Abdelmoueno. He stated that he worked midnight to 8:00 a.m. but had no recollection of what transpired on 2/21/2026.

On 3/13/2026, I interviewed Jonathon Johnson. He stated that his work schedule on 2/21/2026 began at 7:30 p.m., so he was not present when the incident occurred.

On 3/13/2026, I interviewed Imaya Peterman. She stated that she was the 1:1 staff assigned to Resident A on 2/21/2026, but she denied leaving him unsupervised and did not remember what transpired on 2/21/2026.

On 3/13/2026, I interviewed Guardian A1. She stated that Resident A does slap himself in the face and/or engage in head banging many times for communication. She stated that she has visited Eisenhower Center in the past and Resident A's 1:1 staff were not present but she found his personal care to be adequately maintained by the staff. Finally, she stated that she is not very satisfied with Resident A's placement at the Eisenhower Center and wants to move him somewhere else.

On 3/16/2026, I interviewed Lydia Bevier, direct care staff and reviewed the incident report she wrote dated 2/21/2026 at 3:30 p.m. She stated that on 2/21/2026 around 3:00 p.m. she was asked to relieve Imaya Peterman, Resident A's 1:1 staff. She stated that she found dirty reusable water bottles, he was soiled, his bed sheets were soiled, he was hungry and his room was unkept. She stated that she and

another staff, Ashley Noble, cleaned Resident A's water bottles, changed and showered him, changed his bed sheets and fed him. She stated that after Imaya Peterman returned she heard noise from Resident A's room and found Resident A alone in his room hitting his head on the floor while Imaya Peterman was down the hall in another room. She stated that she estimated Resident A to be unattended by any staff for about 10 minutes.

On 3/17/2026, I interviewed Ashley Noble, medical assistant. She corroborated Lydia Bevier's description of the incident, except that she did not witness Resident A alone in his room hitting his head on the floor.

On 3/17/2026, I conducted an exit conference with Daniel Bogosian, licensee designee.

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:	The preponderance of credible evidence is that direct care staff Imaya Peterman left Resident A unsupervised and did not provide supervision and personal care as specified in his assessment plan.
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: 3/18/2026

Approved By:

Ardra Hunter
Area Manager

Date: 3/19/2026