GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 8, 2026

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

RE: License #: AL810086003
Investigation #: 2026A0575028
Eisenhower Center - East 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	AL810086003
Investigation #:	2026A0575028
Complaint Receipt Date:	04/25/2026
Investigation Initiation Date:	04/27/2026
Report Due Date:	05/25/2026
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 - East Hall
Facility Address:	3200 Eisenhower Parkway Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	07/22/1999
License Status:	REGULAR
Effective Date:	04/19/2026
Expiration Date:	04/18/2028
Capacity:	16
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Resident A's medications not dispensed by multiple staff.	Yes
Direct care staff did not notify the supervisory staff regarding medication errors.	Yes

III. METHODOLOGY

04/25/2026	Special Investigation Intake-2026A0575028
04/25/2026	Referral - Recipient Rights
04/27/2026	Special Investigation Initiated – Amber Sultes, Macomb Co CMH Recipient Rights Specialist (MCCMH ORR)
04/27/2026	APS Referral
04/29/2026	Inspection Completed On-site- interviews with 1) direct care staff: (a) Rebecca Robinson; (b) Chinar McGraw; (c) Gisselle Orosio Vasquez; (d) Travion Perkins; (e) Rukaya Zuberu Ali; (f) Deema Saeed. 2) Daniel Bogosian, licensee designee; 3) Amanda Davis, nursing director; 4) review of the March and April 2026 MARs for Resident A.
04/30/2026	Inspection Completed On-site interviews with: (a) Zachary Seog, direct care staff; (b) Brook Gillespie, RN East Hall; (c) review of the February 2026 MAR for Resident A.
04/30/2026	Contact - Telephone call made- Guardian A1
04/30/2026	Inspection Completed-BCAL Sub. Non-Compliance
04/30/2026	Exit Conference with Daniel Bogosian, licensee designee
05/01/2026	Contact- Telephone call received- Guardian A1
05/05/2026	Contact- Telephone call made- direct care staff Shakyra Smith
05/06/2026	Inspection Completed On-Site- interviews with direct care staff- Zaria Warren

05/06/2026	Contact- Telephone call made- direct care staff (a) Shaladra Hurt; (b) Warleen Foster; and (c) Jerzee Cheeks
05/06/2026	Recommend Modify to Provisional

ALLEGATION:

Resident A's medications are not dispensed by multiple staff.

INVESTIGATION:

On 4/25/2026, I received an email complaint from Amber Sultes, Macomb County CMH ORR specialist.

On 4/27/2026, an APS referral was made.

On 4/27/2026, I contacted Amber Sultes, Macomb Co CMH ORR specialist and she emailed her notes from her investigation to date regarding Resident A which follows:

On 4/16/26, ORR staff Amber Sultes determined the following by reviewing March and April 2026 MARs for Resident A and forwarded her findings:

On 3/11/26 and 3/22/26, all evening medications were not passed by Chinar McGraw and Zachary Seog.

On 3/17/26, Eisenhower Center (East Hall) Medical Assistant (MA), Shakyra Smith ("SSM"), documented that she passed morning medications for Resident A, but failed to pass the following medications this day: Divalproex Tab 500mg (8:00 am), Docusate Dos 100mg (7:00 am), Eliquis Tab 5mg (7:00 am).

On 3/19/26 - 3/23/26, 3/25/26 - 3/27/26, 4/6/26 - 4/16/26 the following staff did not administer Risperidone 1mg to Resident A due to "resident refused"+, "out of facility" (unknown if this refers to medication or recipient), or "medication not available in cart": Eisenhower Center staff, Shaladra Hurt, Chinar McGraw (East Hall), Zaria Warren, Warleen Foster (East Hall), Jerzee Cheeks (North Main) and Eisenhower Center MA's, Zachary Seog, Rebecca Robinson, Gisselle Vazquez, and Rukaya Zuberu Ali. It is unknown if any of these staff notified the responsible staff for refilling this prescription once they were made aware that the medication was not in supply.

On 3/20/26, Eisenhower Center - East Hall staff, Chinar McGraw ("CMC"), documented that she passed evening medications for Resident A, but failed to pass the following medications this day: Amoxicillin Tab 875mg (9:00 pm), Metoprol Tab Tar 25mg (9:00 pm).

On 3/21/26, Eisenhower Center staff, Shalandra Hurt ("SHU"), documented that she passed morning medications for Resident A but failed to pass the following medications: Amoxicillin Tab 875mg (9:00 am), Metoprol Tar Tab (Lopressor) 25mg (9:00 am).

On 3/21/26 and 3/24/26, afternoon medication Divalproex Tab 500mg, was not passed by Shaladra Hurt and Travion Perkins.

On 3/23/26, Eisenhower Center staff, Travion Perkins ("TP"), documented that he passed the morning medications for Resident A but failed to pass the following medications: Docusate Sod 100mg Cap (7:00 am), Eliquis Tab 5mg (7:00 am), Amoxicillin Tab 875mg (9:00 am), Metoprol Tar Tab (Lopressor) 25mg (9:00 am).

On 3/24/26, Mr. Perkins documented that he passed the evening medications but failed to pass the following medications: Amoxicillin Tab 875mg (9:00 pm), Metoprol Tar Tab (Lopressor) 25mg (9:00 pm). It was also noted that Mr. Perkins failed to take Resident A's blood pressure these days in order to pass the evening doses of Metoprol Tar Tab (Lopressor) 25 mg.

On 3/24/26, no morning medications were passed by Travion Perkins.

On 3/25/26, Ms. McGraw documented that she passed morning medications but failed to pass the following medications: Amoxicillin Tab 875mg (9:00 am), Metoprol Tar Tab (Lopressor) 25mg (9:00 am).

On 3/25/26, Ms. McGraw documented she passed evening medications but failed to pass the following medications: Amoxicillin Tab 875mg (9:00 pm), Metoprol Tar Tab (Lopressor) 25 mg (9:00 pm).

On 3/27/26, Eisenhower Center MA, Rukaya Zuberu Ali, failed to pass the following medication for Resident A: Metoprol Tar Tab (Lopressor) 25mg (9:00 pm). It is noted that Mr. Ali failed to take Resident A's blood pressure this day in order to pass the evening dose of Metoprol Tar Tab (Lopressor) 25mg.

On multiple dates in March 2026 - April 2026, the following staff failed to take Resident A's blood pressure prior to ensure it was above 90/60 prior to administering a 9:00 pm dose Metoprol Tar Tab (Lopressor) 25 mg: Mr. Ali (3/8/26 and 3/16/26), Ms. Vazquez (3/21/26), Ms. McGraw (3/26/26), Eisenhower Center staff, Deema Saeed ("DS") (4/8/26 and 4/9/26), and Ms. Robinson (4/15/26).

On 4/29/2026, Resident A was not interviewed as she is currently hospitalized in Kalamazoo.

On 4/29/2026, I reviewed the March and April 2026 MARs for Resident A with Daniel Bogosian, licensee designee and Amanda Davis, director of nursing at Eisenhower Center. Daniel Bogosiann provided proof/copies that showed that all of

the direct care staff are medication trained. Amanda Davis verified that there were 47 medication errors in March 2026 and 15 medication errors in April. Due to the large number of medication errors, I reviewed Resident A's medications in the February 2026 MAR. I found and verified with Amanda Davis and Daniel Bogosian that the direct care staff had made 24 medication errors of not dispensing Resident A's medications. Amanda Davis stated that although the electronic medication administration cart is designed to reduce medication errors, the direct care staff can and do bypass the system and administer the resident medications manually which adds to the likelihood of medication administration errors. Additionally, when I reviewed Resident A's MARs with Amanda Davis and Daniel Bogosian, I found that the direct care staff medication errors were scattered across times of the day, e.g., Resident A's 1 mg. Risperidone was given at the 8:00am and 8:00pm times, but not at the 2:00pm or given at the 2:00pm time but not the 8:00am or the 8:00pm times on different days.

On 4/29/2026, I corroborated the above findings of Amber Sultes, MCCMH ORR Specialist with regard to the staff not administering Resident A's medications, as opposed to or in addition to, improper documentation/initialing of the MAR. However, Ms. Sultes allegation that staff were not recording Resident A's blood pressure before failing to administering her blood pressure medication (Lopresser) was only verified on one day, 2/17/2026, because the electronic MAR does not retain blood pressure readings when they are input to the record.

On 4/29/2026, I interviewed direct care staff regarding Resident A's medications for the time frame of March 11, 2026-April 15, 2026 as cited above by Amber Sultes. The staff are: (a) Rebecca Robinson; (b) Chinar McGraw; (c) Gisselle Orosio Vasquez; (d) Travion Perkins; (e) Rukaya Zuberu Ali; and (f) Deema Saeed. Each staff member stated that he/she did not administer Resident A's medications between 2-6 times over the period from March 11,2026-April 15, 2026 because the medications were not/were not seen in the medication cart, the medications were out of the facility, Resident A refused the medication, and/or they could not remember whether they passed Resident A's medications.

On 5/1/2026, I interviewed Guardian A1. She stated that she was satisfied with Resident A's placement but had no idea of the extent of the direct care staff's medication errors with regard to Resident A's medications.

On 5/5/2026, I interviewed medical assistant, Shakyra Smith. She stated that when she discovered Resident A to be out of any medication(s), the protocol was to notify the unit nurse and complete an incident report, which she admitted she failed to complete an incident report.

On 5/6/2026, I interviewed direct care staff, Zaria Warren. She stated that she did not administer Resident A's medications on 3/24/2026 because the medications were not in the medication cart, she did not notify the nurse on call and she did not complete an incident report.

On 5/6/2026, I telephoned direct care staff Shaladra Hurt, Warleen Foster, and Jerzee Cheeks. Warleen Foster stated that if Resident A's medications are not in the cart then she notified the nurse on call and completed an incident report. Jerzee Cheeks stated that she works in a different unit and if a resident's medications are out then it's the responsibility of the medical assistants and nurses to check the medication cart and reorder the medications. Shaladra Hurt did not return my calls.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Since there were multiple instances of staff admitting not administering Resident A's medications as prescribed for a variety of reasons, then Resident A's medications were not given, as prescribed by an appropriately licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff did not notify the supervisory staff regarding medication errors.

INVESTIGATION:

On 4/29/2026, both Daniel Bogosian, licensee designee and Amanda Davis stated that if the direct care staff passing medications finds that a particular medication is out, i.e., there is no medication in the medication cart, they are to notify the unit nurse and complete an incident report. They can also hit the "refill" button on the medication cart to initiate the medication refill process.

On 4/29/2026, 4/30/2026, 5/5/2026 and 5/6/2026, 10 of the 11 direct care staff I interviewed in person or by telephone stated that he/she did not notify the unit nurse/manager and/or did not complete an incident report when they found that Resident A was out of medication(s).

On 4/30/2026, I conducted an exit conference with Daniel Bogosian, licensee designee. I stated I was somewhat surprised by the direct care staffs nonchalant or cavalier attitude toward not only making medication errors but also in their not notifying any management or completing incident reports when out of resident medications. I stated that I feel that the responsibility of who can reorder resident medications is too diffused amongst the staff which results in anybody can reorder

resident medications, but then no one does it. Finally, I stated that I am recommending a provisional license due to the large number of medication errors. He agreed with my findings and conclusions and added that the direct care staff just try to blame the medical assistants (MA) for not ordering resident medications.

On 5/5/2026, I interviewed Shakyra Smith, direct care staff. She stated that she could not remember whether she passed Resident A's medications on 3/17/2026. She stated that if the medications were not in the medication cart then staff are to notify the unit nurse and write an incident report. She admitted that she did not write an incident report on 3/17/2026 for Resident A's missed medications.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(f) Contact the resident's licensed health care professional or the appropriately licensed health care professional who prescribed the medication when a medication error occurs.**
ANALYSIS:	Since the direct care staff readily admit to not contacting a unit nurse or completing incident reports, then the direct care staff did not contact Resident A's licensed health care professional when supervising her taking medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend modification of the current status of the license to provisional.

Jeffrey J. Bozsik
Licensing Consultant
Date: 5/07/2026

Approved By:

Ardra Hunter
Area Manager
Date: 6/8/2026