



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 28, 2026

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

RE: License #: AL810069928
Investigation #: 2026A0122038
Eisenhower Center North Hall

Dear Daniel 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 black ink that reads "Vanita Bouldin". The script is cursive and fluid.

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AL810069928
Investigation #:	2026A0122038
Complaint Receipt Date:	09/04/2026
Investigation Initiation Date:	09/04/2026
Report Due Date:	10/04/2026
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 North Hall
Facility Address:	3200 E Eisenhower Parkway Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	02/09/1996
License Status:	REGULAR
Effective Date:	08/05/2026
Expiration Date:	08/04/2028
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 08/31/2026, Resident A's special diet was not provided to her.	Yes
On 05/28/26 and 08/11/2026, Resident was observed with a black eye, fractured orbital bone, and bruise on her elbow, these injuries were not reported to Guardian A1.	Yes

III. METHODOLOGY

09/04/2026	Special Investigation Intake 2026A0122038
09/04/2026	APS Referral Conducted interview with adult protective services worker, Laveda Hoskins-Smith.
09/04/2026	Special Investigation Initiated - On-site Inspection Conducted interviews with supports coordinator, Ebony Harris, director of residential services, Rohman Bounds, and case manager, Asaria Turnman. Observed Resident A and reviewed her file.
09/10/2026	Contact – Documents received Resident A's file
09/11/2026	Contact – Telephone call made Conducted interview with Guardian A1.
09/16/2026	Contact – Documents received Faxes to Guardian A1
09/18/2026	Contact – Telephone call made Conducted interview with staff member, Zach Seog.
09/28/2026	Conducted interview with staff member, Emily Hook.
09/21/2026	Exit Conference Discussed findings with licensee designee, Dan Bogosian.

ALLEGATION: On 08/31/2026, Resident A's special diet was not provided to her.

INVESTIGATION: On 09/04/2026, I conducted an interview with case manager, Asaria Turnman, who confirmed on 08/31/2026 Resident A was not given her special diet of cut-up meat. Per Ms. Turnman, Resident A was served a cheeseburger that was not cut up and she choked.

On 09/04/2026, I reviewed Resident A's Macomb County Community Mental Health Progress note dated 08/24/2026, which documented that Resident A's diet consisted of "restricted to cut meats (bite size)." Resident A's Health Care Appraisal dated 12/12/2025 documented the same type of diet, "regular with cut up or finger foods." Resident A's mealtime and dietary guidelines dated 08/31/2026 documents that she is to receive a diabetic diet, soft and bite sized, and thin liquids.

On 09/04/2026, I reviewed an incident report dated 08/29/2026 completed by staff member, David Hedrick. Mr. Hedrick documented that Resident A "was eating a burger and may have put ¼ of the burger in her mouth. Staff performed the Heimlich Maneuver on her. The food was cleared..."

On 09/11/2026, I conducted an interview with Guardian A1, who reported that she had been notified of the choking incident Resident A had on 08/29/2026.

On 09/21/2026, I conducted an exit conference with licensee designee, Dan Bogosian, and discussed my findings with him. Mr. Bogosian agreed with my findings and stated he would submit a corrective action plan to address the rule violations found during my investigation.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with case manager, Asaria Turnman, and Guardian A1, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 08/31/2026, Resident A was not given her special diet of cut up meat. Therefore, Resident A was not provided with her prescribed diet on that date.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: On 05/28/26 and 08/11/2026, Resident was observed with a black eye, fractured orbital bone, and bruise on her elbow, these injuries were not reported to Guardian A1.

INVESTIGATION: On 09/04/2026, I conducted interviews with director of residential services, Rohman Bounds, and case manager, Asaria Turnman. Both stated they had reviewed an incident report dated 05/28/2026 completed by staff member, Emily Hook. Ms. Hook reported that she observed Resident A with bruise on her right eye. Mr. Bounds and Ms. Turnman also stated they had reviewed an incident report dated 08/07/2026 completed by staff member, Zachary Seog. Mr. Seog reported that he had observed Resident A with a large bruise on her elbow.

Both incidents were reported to the nursing staff. Per Ms. Turnman, Resident A received medical treatment for the incident on 05/28/2026. Ms. Turnman stated that each incident was reported to Guardian A1.

On 09/04/2026, I reviewed incident reports dated 05/28/2026 and 08/07/2026 completed by staff members, Emily Hook and Zachary Seog respectively. On 05/28/2026, Ms. Hook documented that Resident A was observed with a “bruise on her right eye and it was swollen...” Ms. Hook documented that it was unknown how Resident A sustained injury. On 08/07/2026, Mr. Seog documented that Resident A was observed with “a large bruise on her elbow...nursing team is looking into if resident could potentially be falling without staff witnessing.” Again, it was documented that it was unknown how Resident A sustained injury.

On 09/11/2026, I conducted an interview with Guardian A1, who reported the following, she had not received notification of Resident A’s injuries by anyone affiliated with Eisenhower Center but from a relative who had visited with Resident A. Once Guardian A1 was informed of the injuries, she stated she contacted case manager, Diamond Gardin on 06/03/2026 to receive additional information.

Per Guardian A1, she requested and received incident reports documenting the injuries to Resident A. Guardian A1 confirmed that Resident A received medical treatment for the sustained injury to her eye on 08/25/2026. Guardian A1 stated both documents, incident reports, were received approximately six days after the initial injuries. Guardian A1 submitted Resident A’s After Visit Summary report from Trinity Health Hospital, in Ann Arbor dated 05/28/2026. Guardian A1 stated that Resident A did not receive medical treatment for her bruised elbow observed on 08/07/2026.

On 09/17/2026, I reviewed emails forwarded to Guardian A1 from case managers, Asaria Turman and Diamond Gardin. For the incident of 05/28/2026, Guardian A1 received an email on 06/03/2026 informing her about Resident A’s bruising on her eye. Guardian A1 received notification of the injury to Resident A approximately 5 days after and the injury required medical attention.

Regarding Resident A's injury on 08/07/2026, I reviewed an email sent to Guardian A1 by case manager, Asaria Turman, on 08/10/2026. This injury did not require medical attention.

On 09/18/2026, I conducted an interview with staff member, Zach Seog. Mr. Seog confirmed that he had completed the incident report dated 08/07/2026, in which he observed Resident A had a bruise on her elbow. Mr. Seog confirmed that the injury did not require medical attention but that Resident A was monitored and the minor injury did not cause her any discomfort or distress. Mr. Seog reported he believed the injury could have happened due to Resident A bumping her arm against furniture as she moved independently throughout the facility.

On 09/28/2026, I conducted an interview with staff member, Emily Hook. Ms. Hook reported that she arrived to work on 05/28/2026 and observed that Resident A had an injury to her right eye. Ms. Hook stated that she completed the incident report and reported the injury to the facility nurse. Ms. Hook does not remember anything other than what was reported in the incident report dated 05/25/2026.

On 09/21/2026, I conducted an interview with licensee designee, Dan Bogosian, who reported that Diamond Gardin no longer works for him, therefore I was unable to interview her.

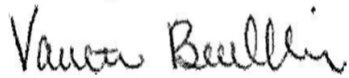
On 09/21/2026, I conducted an exit conference with licensee designee, Dan Bogosian, and discussed my findings with him. Mr. Bogosian agreed with my findings and stated he would submit a corrective action plan to address the rule violations found during my investigation.

APPLICABLE RULE	
R 400.693	Incident notification, incident records.
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: (a) Unexpected or unnatural death of a resident. (b) Unexpected and preventable inpatient hospital admission. (c) Physical hostility, self-inflicted harm, or harm to others resulting in injury that requires outside medical attention or law enforcement involvement. (d) Natural disaster or fire that results in evacuation of residents or discontinuation of services greater than 24 hours. (e) Elopement from the facility if the resident's location is unknown.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with director of residential services, Rohman Bounds, case manager, Asaria Turnman, and Guardian A1, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 05/28/26 Resident A was observed with black eye, fractured orbital bone, and these injuries were not reported to Guardian A. Therefore, Guardian A1 was not notified in the required 48 hours after Resident A received injury that required medical attention.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Vanita C. Bouldin
Licensing Consultant

Date: 09/21/2026

Approved By:



Ardra Hunter
Area Manager

Date: 09/28/2026