



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 28, 2026

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

RE: License #: AL810086003
Investigation #: 2026A0575036
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.

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 #:	2026A0575036
Complaint Receipt Date:	08/07/2026
Investigation Initiation Date:	08/11/2026
Report Due Date:	09/06/2026
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:	1ST PROVISIONAL
Effective Date:	06/25/2026
Expiration Date:	12/24/2026
Capacity:	16
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed.	No
Resident A is experiencing ongoing emotional neglect.	Yes
Resident A is receiving inappropriate treatment and has unmet hygiene needs.	No
Resident A's airhorn is missing.	Yes

III. METHODOLOGY

08/07/2026	Special Investigation Intake-2026A0575036
08/07/2026	APS Referral received
08/11/2026	Special Investigation Initiated – Telephone-Guardian A1
08/12/2026	Inspection Completed On-site-interviews with (a) Resident A; and (b) Daniel Bogosian, licensee designee
08/12/2026	Inspection Completed-BCAL Sub. Compliance
08/12/2026	Exit Conference with Daniel Bogosian, licensee designee
08/27/2026	Contact- Telephone call made-(a) Dan Bogosian, licensee designee; (b) Traivon Perkins-direct care staff; and (c) Ahmed Abdelmoumene

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

On 8/7/2026, an APS referral was received.

On 8/11/2026, I contacted Guardian A1. She stated that on her visit to Resident A on 8/1/2026, there are 30 people living in the Eisenhower Center East Hall and there were only 1 or 2 staff on duty.

On 8/12/2026, I inspected every room in East Hall, i.e., every resident room, bathroom, clothes closet, laundry room, staff office and mechanical/utility room. All of the residents who were in their rooms stated that they were the only resident residing in the room. There are 16 rooms in the East Hall facility, and I observed 1 resident per resident room, which does not exceed the licensed capacity of 16 residents. Additionally, I did not observe any other residents residing in any other rooms in the East Hall. Furthermore, Daniel Bogosian reviewed the staff schedule and the progress notes for 8/1/2026 which showed 3 staff on duty plus a medical assistant for passing resident medications and a behavior therapist.

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. (b) 12 residents for small group and family homes.
ANALYSIS:	The preponderance of credible evidence is that the licensee has 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. Additionally, the ratio of direct care staff to residents is not less than 1 direct care staff to 15 residents during waking hours.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is experiencing ongoing emotional neglect.

INVESTIGATION:

On 8/11/2026, I asked Guardian A1 to explain to me what she meant by Resident A experiencing ongoing emotional neglect. She stated that she had a recording of a verbal confrontation between a staff member and Resident A. She sent me a copy of the recording.

On 8/11/2026, I listened to the undated audio recording of the staff-Resident A verbal confrontation, which included swearing and other less than cordial comments between the staff and Resident A. I sent it to Daniel Bogosian, licensee designee for his comments. He stated that direct care staff in the audio recording, Rayanne LeBlanc, had her employment terminated by the Eisenhower Center human resources staff on 8/7/2026 because of the audio recording.

On 8/12/2026, I interviewed Resident A. He stated that he had a verbal confrontation with a female staff member, but he did not have any other details/knowledge about an audio recording.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (f) Subject a resident to any of the following: (iii) Derogatory remarks.
ANALYSIS:	The preponderance of credible evidence is that direct care staff, Rayanne LeBlanc, subjected Resident A to derogatory remarks.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A is receiving inappropriate treatment and has unmet hygiene needs.

INVESTIGATION:

On 8/11/2026, Guardian A1 stated that Resident A is receiving inappropriate treatment because the staff wake him up between 5:00am and 6:00am and if he does not want to get up they don't come back to wake him up until noon. She stated that this happens every day. Additionally, she stated that her concerns regarding Resident A's hygiene are that he used the urinal but then spilled it in his bed.

On 8/12/2026, Resident A stated that he likes to get up early but could not specify a time frame to be awakened. He did not object to being awakened at noon. Additionally, he stated that he can use a urinal independently but needs staff assistance with a Hoyer lift because he is wheelchair bound and has to be placed on the toilet or assisted with showering.

On 8/12/2026, I observed Resident A to be clean, have no noticeable body odor and have on clean clothes. I also reviewed Resident A's assessment plan and found it was signed by Guardian A1 on 2/17/2026 and states that Resident A needs staff assistance with bathing and toileting. The document does not differentiate about using a urinal.

On 8/27/2026, I reviewed two incident reports dated 8/25/2026 in which Resident A refused to get up for a shower. Both times, staff made several attempts to get Resident A out of bed at both 7:00am and 8:00am.

On 8/27/2026, I interviewed direct care staffs Traivon Perkins and Ahmed Abdelmoumene. Both stated that normally Resident A is asked to get up about 7:00am, but if he refuses then they get him up when he says he's ready to get up.

On 8/27/2026, Daniel Bogosian stated that the specific times, e.g., 7:00am, when staff are attempting to get Resident A out of bed are based on requests/comments from Guardian A1 and staff are using a whiteboard with Resident A to come up with a mutually agreeable wake up time.

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 doesn't object to getting up at noon, could not specify a timeframe when he wants to awaken by staff and has no apparent unmet hygiene needs, then the preponderance of credible evidence is that the licensee provides supervision, protection, and personal care as specified in Resident A's assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A's air horn is missing.

INVESTIGATION:

On 8/11/2026, Guardian A1 stated that she purchased an air horn for Resident A to use because the call light in his room does not work. She stated that she paid \$30.32 for the air horn, gave it to Resident A on 7/15/26 and when she returned to the facility on 7/22/2026, it was nowhere to be found.

On 8/12/2026, Resident A stated that he remembered having an air horn for a short time, but he does not know what happened to it.

On 8/12/2026, Dan Bogosian stated that none of the call lights work and since they are not a licensing requirement, he will not replace/fix them. He stated that Guardian A1 should submit her receipt to Eisenhower Center for reimbursement for the missing air horn.

On 8/27/2026, Dan Bogosian stated that Resident A's air horn was brought to Resident A by Guardian A1 on 8/1/2026 and was last seen on approximately 8/4/2026. No one knows who took it or what was done with it.

On 8/27/2026, I interviewed direct care staffs Traivon Perkins and Ahmed Abdelmoumene. Both denied ever seeing or hearing about an air horn in Resident A's room.

On 8/12/2026, I conducted an exit conference with Daniel Bogosian, licensee designee. He agreed with my findings and conclusions.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (k) Have reasonable access to and use of personal clothing and belongings.
ANALYSIS:	The preponderance of credible evidence is that Guardian A1 bought and delivered an air horn for Resident A's use at the Eisenhower Center that is now missing. Therefore, the licensee and staff did not respect and safeguard Resident A's right to have reasonable access to and use of his personal belongings.
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: 8/27/2026

Approved By:



Ardra Hunter
Area Manager

Date: 9/28/2026