GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 19, 2025

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

RE: License #: AS810321336
Investigation #: 2025A0122031
The Loft of Manchester

Dear Mr. Bogosian:

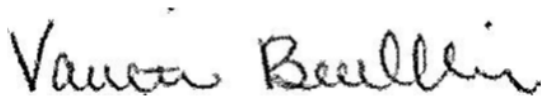
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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,



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 #:	AS810321336
Investigation #:	2025A0122031
Complaint Receipt Date:	05/12/2025
Investigation Initiation Date:	05/14/2025
Report Due Date:	06/11/2025
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:	The Loft of Manchester
Facility Address:	8737 M-52 Manchester, MI 48158
Facility Telephone #:	(734) 428-0369
Original Issuance Date:	11/16/2012
License Status:	REGULAR
Effective Date:	05/24/2024
Expiration Date:	05/23/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The staff of Manchester Loft failed to report Resident A's injury to Guardian A.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/12/2025	Special Investigation Intake 2025A0122031
05/12/2025	APS Referral Recipient Rights Referral
05/14/2025	Special Investigation Initiated – Telephone Left voice message for Guardian A.
05/14/2025	Contact - Telephone call made Contact – Document sent Completed an interview with licensee designee, Dan Bogosian. Left voice message for Dan Bogosian. Requesting him to contact me – I need Resident A's schedule so that a face-to-face meeting can be completed.
05/15/2025	Contact – Telephone call made Contact – Document sent Left voice message and sent email to Dan Bogosian. Left message informing him that I had located Resident A. Requesting that Mr. Bogosian contact me to complete an exit conference.
05/15/2025	Contact – Telephone calls made Completed interviews with Guardian A and Relative A. Completed interviews with teacher, Jeff Brown, and home manager, Hailee Gilbert. Attempted to complete interview with Eisenhower case manager, Samantha Harbison. Called Washtenaw County supports coordinator, Jeanne. Unable to leave a message for Jeanne.
05/15/2025	Contact – Face to face Completed face time video with Resident A.

05/15/2025	Contact – Documents received Resident A's incident reports and Trinity Health Emergency Center report.
05/16/2025	Exit Conference Discussed findings with licensee designee, Dan Bogosian.

ALLEGATION: The staff of Manchester Loft failed to report Resident A's injury to Guardian A.

INVESTIGATION: On 05/14/2025, I completed an interview with licensee designee, Dan Bogosian. Mr. Bogosian had no personal knowledge of Resident A's injury or how it was obtained. Mr. Bogosian stated that an internal investigation would be completed, and he submitted an incident report dated 05/10/2025 documenting a self-injury of Resident A.

On 05/15/2025, I completed interviews with Guardian A and Relative A. Both reported the following: On 05/12/2025, Guardian A received a phone call from teacher, Jeff Brown, informing her that Resident A had an injury on his head. Per Guardian A, Mr. Brown asked Guardian A if she had any knew about the injury and how it was obtained. Guardian A informed Mr. Brown that this was her first time being informed that Resident A had an injury. Mr. Brown sent Guardian A an incident report, documenting Resident A's injury via email. Guardian A picked Resident A up from school at the end of the day, and took him to Trinity Health Emergency Center, where he received medical treatment. Guardian A kept Resident A and did not return him to the facility.

Guardian A contacted home manager, Hailee Gilbert, to obtain information regarding Resident A's injury. Per Guardian A, Ms. Gilbert, reported to her that she did not understand when Resident A's injury occurred but that an internal investigation would be conducted, and she would receive additional information at a later date.

On 05/15/2025, I completed an interview with teacher, Jeff Brown. Mr. Brown reported the following: on 05/12/2025, Resident A arrived at school at approximately 7:45 a.m. and he observed "large abrasion red mark" on Resident A's forehead. Mr. Brown stated he wrote an incident report documenting Resident A's injury and sent a copy to Guardian A and mailed a copy to the Eisenhower center. Guardian A contacted Mr. Brown, stating she had no knowledge of Resident A's injury and that she would pick him up from school at the end of the day. Per Mr. Brown, Resident A's behavior was observed to be normal for the day and Guardian A pick up Resident A from school.

On 05/15/2025, I completed an interview with home manager, Hailee Gilbert. Ms. Gilbert confirmed that Guardian A contacted her first regarding Resident A's injury. Per Ms. Gilbert Resident A's injury happened on Sunday, 5/11/2025, and it should have been reported to on-call personnel, who should have contacted Guardian A. Ms. Gilbert stated this protocol was not followed with Resident A's injury.

On 05/15/2025, I attempted to complete an interview with Eisenhower case manager, Smantha Harbison. I asked Ms. Harbison if she was aware of Resident A's injury that was sustained over the weekend of 05/10/2025, Ms. Harbison responded that she was attempting to obtain more information. I asked Ms. Harbison if Guardian A first notified her of Resident A's injury, I received no response from Ms. Harbison, and the phone call was disconnected. I made two attempts to reconnect my phone call with Ms. Harbison, Ms. Harbison did not pick up my phone calls, and the calls went to her voice message mailbox. I was unable to leave voice messages for Ms. Harbison as her voice message mailbox was full.

On 05/15/2025, I reviewed Resident A's incident reports and Trinity Health Emergency Center report. Resident A's Eisenhower Center Incident Report dated 05/14/2025 documents that he received an inflicted self-injury on 05/10/2025 at 1:00 a.m. due to "2.bangs head, hits wall, and flops on floor." The form states that management was notified on same date and time. Resident A's Washtenaw Intermediate School District Student Incident/Accident Report completed by teacher, Jeff Brown documents Resident A's injury and stating that Manchester Center Staff and Guardian A were notified on 05/12/2025 at 7:45 a.m.

Resident A's Trinity Health Emergency Center After Visit Report dated 05/12/2025 documents that he was diagnosed and treated for injury of the head and abrasion of the forehead. Resident A was discharged on the same day. This document was submitted by Guardian A.

On 05/16/2025, I completed an exit conference with licensee designee, Dan Bogosian, and discussed my findings with him. Mr. Bogosian stated he understood my findings and would submit a corrective action plan to address rule violation found.

APPLICABLE RULE	
R 400.14311	**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 or 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 home if the resident's whereabouts is unknown.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with licensee designee, Dan Bogosian, Guardian A, Relative A, home manager, Hailee Gilbert, teacher, Jeff Brown, and case manager, Samantha Harbison, and review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that the staff of Manchester Loft failed to report Resident A's injury to Guardian A within 48 hours. Resident A was injured on 05/10/2025 and Guardian A contacted case manager, Hailee Gilbert on 05/12/2025 to discuss Resident A's injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 05/15/2025, I reviewed Resident A's incident report form from Eisenhower Center Incident Report dated 05/14/2025, which documents that he received an inflicted self-injury on 05/10/2025 at 1:00 a.m. due to "2.bangs head, hits wall, and flops on floor."

On 05/15/2025, I conducted separate interviews with Guardian A, Relative A, and teacher Jeff Brown; all stated they observed an injury on Resident A. Mr. Brown described Resident A's injury as a "large abrasion red mark," on Resident A's forehead.

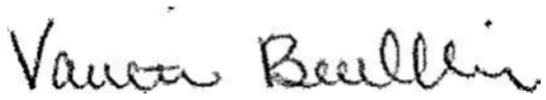
Guardian A took Resident A to the Trinity Health Emergency Center on 05/12/2025, where he was diagnosed and treated for injury of the head and abrasion of the forehead. Guardian A submitted the After Visit report as documentation of the medical care Resident A received on 05/12/2025.

On 05/16/2025, I completed an exit conference with licensee designee, Dan Bogosian, and discussed my findings with him. Mr. Bogosian stated he understood my findings and would submit a corrective action plan to address rule violation found.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with Guardian A, Relative A, and teacher, Jeff Brown, and review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that the staff of Manchester Loft failed to obtain needed care immediately. Resident A got an injury on 05/10/2025 and Guardian A took him to the Trinity Health Emergency care center on 05/12/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan, I recommend no change to the status of the license.



_____

Vanita C. Bouldin Date: 05/16/2025
Licensing Consultant

Approved By:

_____

Ardra Hunter Date: 05/19/2025
Area Manager