GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

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

RE: License #: AL810280703
Investigation #: 2026A0575030
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,

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 #:	2026A0575030
Complaint Receipt Date:	05/26/2026
Investigation Initiation Date:	05/26/2026
Report Due Date:	06/25/2026
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:	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's injuries are the result of staff abuse or improper restraint.	No
Resident A not provided with proper supervision by staff.	Yes

III. METHODOLOGY

05/26/2026	Special Investigation Intake-2026A0575030
05/26/2026	APS Referral
05/26/2026	Special Investigation Initiated - On Site-interviews with (a) Resident A; (b) Daniel Bogosian, licensee designee
05/27/2026	Contact - Telephone call made- 1) direct care staff-(a) Jessica Hess; (b) Noah Talbert; (c) Tim Stephens; 2) Guardian A1
05/28/2026	Contact - Telephone call made-direct care staff-Jonathon Johnson
05/28/2026	Exit Conference with Daniel Bogosian, licensee designee

ALLEGATION:

Resident A's injuries are the result of staff abuse or improper restraint.

INVESTIGATION:

On 5/26/2026 an APS referral was received. It is alleged that Resident A's injuries were the result of staff abuse or improper restraint by inexperienced staff working on the weekends.

On 5/26/2026, I interviewed Resident A. He is non-verbal so I requested him to show me bruises alleged to be on his right calf, scratches on his neck, arms and behind his ear; and scabs on his knees from rug burns. I witnessed the remains of bruises on his neck, behind his ear, and on his knees.

On 5/26/2026, Daniel Bogosian stated that the direct care staff are fully trained. He stated that Resident A's assessment plan provides for a 1:1 staff for 4 hours/day Sunday-Friday and for 8 hours/day on Saturday. He provided incident reports dated

5/15/2026 and 5/16/2026. Both reports detailed Resident A's agitation and physical aggression toward staff and other residents.

On 5/27/2025, I interviewed Jessica Hess, direct care staff. She wrote the incident report dated 5/15/2026 and stated that she was Resident A's 1:1 staff on 5/15/2026 and had taken Resident A on a car ride. She stated that Resident A was inconsolable and agitated because he missed going bowling. She stated that redirection and de-escalation techniques did not work with Resident A on 5/15/2026 and that his injuries were self-inflicted.

On 5/27/2027, I interviewed Noah Talbert, direct care staff. He wrote the incident report dated 5/16/2026 and stated that when Resident A came back from a car ride on 5/16/2026, he was agitated, self-abusive, hitting his head on the walls, screaming, and physically aggressive towards staff, biting direct care staff, Jonathon Johnson's leg. He stated that he does not know what upset Resident A.

On 5/27/2026, I interviewed direct care staff, Tim Stephens. He stated that he did not witness Resident A's behaviors prior to his becoming agitated. He stated that Resident A was very physically aggressive and it was difficult to calm him down.

On 5/27/2026, I interviewed Guardian A1. She stated that Eisenhower Center management has given her a written 30-day discharge notice to find Resident A different residential placement. Her tone of voice was somber and she asked if I knew of alternative residential placements. I referred her to LARA website for potential residential providers for her ward.

On 5/28/2026, I interviewed direct care staff, Jonathon Johnson. He stated that Resident A was very agitated after a car ride. He stated that Resident A was physically aggressive, bit him on the leg, and de-escalation techniques were of limited success on 5/16/2026.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.

ANALYSIS:	Given the credible staff description of Resident A's agitated state and physically aggressive behaviors possibly originating from not being able to go on a scheduled outing, their appropriate use of verbal redirection and de-escalation techniques leads to the conclusion that the staff did not mistreat Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A not provided with proper supervision by staff

INVESTIGATION:

On 5/27/2026, as part of my interview with direct care staff Jessica Hess, she stated that when she took Resident A for a car ride, she was very uncomfortable being the only staff in the car, i.e., the driver and Resident A's 1:1 staff. She stated that on one of the car rides, Resident A took off his seat belt, and she was fearful of what action he might attempt.

On 5/28/2026, I conducted an exit conference with Daniel Bogosian, licensee designee. I stated my conclusions, especially about 1:1 staff taking volatile residents on car rides or other transportation in the community with no other staff in the car/van. I emphasized that a previous resident had jumped out a moving vehicle several years ago. He was not in total agreement with the need for another staff in addition to the 1:1 staff during transportation/outings.

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:	Given the volatile/agitated/aggressive behaviors that Resident A and/or other residents have exhibited, the practice of having only the 1:1 staff take residents who require 1:1 supervision on outings or transport results in the licensee not providing supervision and protection as specified in Resident A's and/or other resident's 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 — Date: 6/1/2026
Licensing Consultant

Approved By:

Ardra Hunter — Date: 6/11/2026
Area Manager