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 #: AM810015275
Investigation #: 2026A0575029
Eisenhower Center - Congregate

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 #:	AM810015275
Investigation #:	2026A0575029
Complaint Receipt Date:	05/22/2026
Investigation Initiation Date:	05/26/2026
Report Due Date:	06/21/2026
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 - Congregate
Facility Address:	3200 E Eisenhower Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	08/09/1993
License **Status:**	REGULAR
Effective Date:	06/30/2025
Expiration Date:	06/29/2027
Capacity:	12
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Complainant reported concerns of possible abuse and neglect of Resident A.	No
Resident A is not provided with proper supervision by 1:1 staff	Yes

III. METHODOLOGY

05/22/2026	Special Investigation Intake-2026A0575029
05/23/2026	APS Referral received
05/26/2026	Special Investigation Initiated - On Site-interviews with: (a) Resident A, (b) Tiaunna Mock, direct care staff; and (c) Daniel Bogosian, licensee designee
05/27/2026	Contact - Telephone call made-(a) Guardian A1; (b) Ahmed Sangere, direct care staff; (c) Sean Hines, special education schoolteacher
05/28/2026	Contact - Telephone call made- Caiden Campbell, direct care staff
05/28/2026	Inspection Completed-BCAL Sub. Compliance
05/28/2026	Exit Conference with Daniel Bogosian, licensee designee

ALLEGATION:

Complainant reported concerns of possible abuse and neglect of Resident A.

INVESTIGATION:

On 5/23/2026, an APS referral was received referencing the 5/20/2026 original complainant who alleged that Resident A's groin area bruising was possible abuse and neglect.

On 5/26/2026, I interviewed Daniel Bogosian and he stated that Resident A's assessment plan requires that he have an assigned 1:1 staff 24/7. He provided an incident report dated 5/21/2026 as a possible explanation for Resident A's injuries.

I reviewed the incident report which stated that Resident A was attacked by another resident on 5/16/2026. The incident report stated that staff intervened and separated the two residents. No injuries to either resident were noted on the incident report, and no medical treatment was provided by staff.

On 5/26/2026, I visited Resident A, who is non-verbal, and witnessed firsthand the bruising in his groin area. I did not request that he remove his brief/diaper, but I easily observed the 1-2 inch wide ring of bruising on his front side that followed the outside contours of his brief/diaper.

On 5/26/2026, I interviewed direct care staff, Tiaunna Mock. She stated that she was Resident A's 1:1 staff on 5/19/2026 from 8:00 a.m.-8:00 p.m. and did not witness any bruising or any incident/altercation that would have caused Resident A's groin area bruising.

On 5/26/2026, I reviewed Resident A's 5/20/2026 hospital discharge summary. The attending UM hospital physician diagnosed that Resident A had traumatic ecchymosis (bruising) of the groin.

On 5/27/2026, I interviewed Guardian A1. She stated that she was informed about Resident A's injuries and requested that he be sent to UM hospital for treatment. She stated that she wasn't satisfied with Resident A's treatment/services at Eisenhower Center and was pursuing an alternative placement.

On 5/27/2026, I interviewed direct care staff, Ahmed Sangere. He works the 8:00 p.m.-midnight shift and stated that he did not witness anything that could have caused Resident A's injuries.

On 5/27/2026, I interviewed special education teacher, Sean Hines. He stated that on 5/20/2026 Resident A was incontinent at school. When he went to change Resident A's brief/diaper, he found the extensive bruising in Resident A's groin area including his penis. He stated that he reported the injury and Resident A was transported to the UM hospital. He stated that he knew of no incident at school that could explain Resident A's injuries.

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:	Since I could not determine the proximate cause of Resident A's injuries, then the preponderance of evidence is that the facility staff did not mistreat Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not provided with proper supervision by 1:1 staff

INVESTIGATION:

On 5/28/2026, I interviewed Caiden Campbell, direct care staff. He is Resident A's assigned 1:1 staff during the midnight to 8:00 a.m shift. This is the time during which Resident A takes a shower every day before going to school. He stated that he did not witness Resident A's bruising even when Resident A undressed and took a shower in the morning and, therefore, did not complete a body chart noting Resident A's injuries. Finally, he stated that he did not see Resident A's groin bruising until 5/24/2026.

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:	As much as the other assigned 1:1 staff reasonably may not have seen Resident A's groin injuries given their respective shift times, I found Caiden Campbell's statements that he did not notice Resident A's groin injuries to lack credibility. Therefore, the licensee did not provide Resident A with supervision, protection, and personal care as specified in a Resident A'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
Licensing Consultant

Date: 5/28/2026

Approved By:

Ardra Hunter
Area Manager

Date: 6/8/2026