



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 #: AL810280703
Investigation #: 2026A0575037
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.

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 #:	2026A0575037
Complaint Receipt Date:	08/13/2026
Investigation Initiation Date:	08/13/2026
Report Due Date:	09/12/2026
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?
- Former staff Treyvaughn Pittman and Cameron Hardin produced videos of themselves mistreating Resident A. - Staff Abubakarr Bangura, Jonathon Johnson, and Tiffany Edwards dragged Resident C to his bedroom.	Yes
Staff sat in a chair in front of Resident C's room and prevented Resident C's egress from his room.	Yes
Staff administered Resident C multiple doses of PRN medication.	Yes

III. METHODOLOGY

08/13/2026	Special Investigation Intake-2026A0575037
08/13/2026	APS Referral
08/13/2026	Special Investigation Initiated - APS
08/13/2026	Contact - Telephone call received-Pittsfield Twp Police Dept.
08/13/2026	Contact - Telephone call made-email sent to Ann Arbor Police Department
08/13/2026	Contact - Face to Face-interview with Detective Jamil, Ann Arbor Police Dept.
08/14/2026	Inspection Completed On-site-interview with (a) Daniel Bogosian, licensee designee; (b) Resident A; and (c) Resident B.
08/24/2026	Inspection Completed-BCAL Sub. Compliance
08/24/2026, 08/26/2026	Contact- Telephone call made- (a) Guardian A1, (b) Guardian B1; Guardian C1; (d) former direct care staffs: (1) Treyvaughn Pittman; (2) Cameron Hardin
09/10/2026	Contact -Telephone call made- direct care staffs-(a) Abubakarr Bangura; (b) Dejah Cooper; (c) Ebony Harris; (d) Ashley Bickers; (e) Cherre Williams

09/11/2026	Contact- Telephone call made-direct care staff (a) Tiffany Edwards; (b) Michael Howell; (c) Sabrina Haskett; (d) Noah Talbert; and (e) Brittani Brooks
09/11/2026	Exit Conference with Daniel Bogosian, licensee designee
09/12/2026	Contact - Telephone call made-direct care staff Jonathon Johnson
09/14/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- **Former staff Treyvaughn Pittman and Cameron Hardin produced videos of themselves mistreating Resident A**
- **Staff Abubakarr Bangura, Jonathon Johnson, and Tiffany Edwards dragged Resident C to his bedroom.**

INVESTIGATION:

On 8/13/2026, an APS referral was received.

On 8/13/2026, I was contacted by the Pittsfield Twp police department regarding the videos made by Eisenhower Center direct care staff on 3/31/2026, 6/10/2026, and 7/15/2026. The videos were discovered by the Pittsfield Twp police when Eisenhower Center former staff Cameron Hardin was arrested on an unrelated charge, and his cell phone was confiscated by the police. I watched the videos and viewed former direct care staff Treyvaughn Pittman and Cameron Hardin physically assault Resident A. Although Resident B is seen in the videos, he is not seen being mistreated by any Eisenhower Center staff. The Pittsfield Twp Police stated that the videos and the investigation were being turned over to the Ann Arbor Police Dept. since the Eisenhower Center is in their jurisdiction.

On 8/13/2026, I visited the Ann Arbor Police Dept. and met with detective Nader Jamil. We viewed the 3 videos.

On 8/14/2026, I interviewed Daniel Bogosian, licensee designee. He provided the names and contact information for the resident's guardians and the former direct care staff. I also attempted to interview Resident A and B, but their limited verbal communication and cognitive impairments prevented them from providing any information. I did note that neither resident had any obvious or new bruises that could be directly related to the videos.

On 8/24/2026, I contacted Guardian A1 and Guardian B1. Guardian A1 stated that he was aware of the incident but was generally satisfied with Resident A's placement and services. Guardian B1 stated that she was aware of the incident and that

Resident B had not been mistreated by the former Eisenhower Center staff, but she was dissatisfied with his placement and was looking elsewhere.

On 8/24/2026 and 8/26/2026, I contacted former Eisenhower Center staff Treyvaughn Pittman and Cameron Hardin. Treyvaughn Pittman did not answer the phone or return my calls. Cameron Hardin stated that he did not mistreat any of the residents at the Eisenhower Center.

On 8/26/2026, I contacted Guardian C1 about this separate incident unrelated to the Eisenhower Center staff mistreating Resident A. Resident C was not interviewed because he is cognitively impaired and was hospitalized due to his aggressive behaviors on 8/20/2026. He was placed into another facility on 9/2/2026 and did not return to the Eisenhower Center. Guardian C1 stated that she was informed that during a behavioral incident on 8/20/2026, Resident C was dragged by his hands and feet back to his bedroom. She stated that she is dissatisfied with Resident C's treatment, placement and services at the Eisenhower Center.

On 9/10/2026, I interviewed direct care staffs-(a) Abubakarr Bangura; (b) Dejah Cooper; (c) Ebony Harris; (d) Ashley Bickers; and (e) Cherre Williams, regarding the incident with Resident C on 8/20/2026.

Staff Abubakarr Bangura stated that Resident C was physically aggressive and biting and assaulting staff. He stated that when Resident C sat down on the floor, he held Resident C down on the floor and then two other staff, Tiffany Edwards and Jonathon Johnson, assisted him in standing up Resident C and escorting him back to his room. He stated that staff then blocked Resident C's exit from his room.

Staff Dejah Cooper stated that she witnessed Resident C being escorted back to his room. He was standing up.

Staff Ashley Bickers stated that she was not present during the incident.

Staff Cherre Williams stated that when she was restraining Resident C he kicked her in the chest, so she left the room.

Staff Ebony Harris stated that she witnessed staff Abubakarr Bangura hold down Resident C's head when he was on the floor, and then two other staff, whose names she doesn't know, assisted Abubakarr Bangura by grabbing Resident C by the arms and legs and drag him back to his room.

On 9/11/2026, I interviewed direct care staff (a) Tiffany Edwards and (b) Michael Howell regarding the 8/20/2026 incident with Resident C.

Staff Tiffany Edwards stated that when she assisted Abubakarr Bangura and Jonathon Johnson in taking Resident C to his room, he was carried back to his room, and he was not standing up.

Staff Michael Howell stated that he only watched the incident. He stated that the staff used a “closed door protocol” whereby he explained that all the residents are escorted to their respective rooms and not allowed out until the incident is over.

On 9/11/2026, I interviewed an exit conference with Daniel Bogosian, licensee designee. He stated that he has never heard of, nor is there an approved “closed door protocol” that staff are trained on or allowed to implement. I also stated that I found staff Ebony Harris to be credible and was substantiating all three rule violations. He agreed with my findings.

On 9/12/2026, I interviewed direct care staff Jonathon Johnson. He stated that during the 8/20/2026 incident Resident C was walking back to his room.

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 serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	• The video evidence produced and saved by former staff Cameron Hardin provides the preponderance of evidence that the former staff of this Eisenhower Center facility physically assaulted and mistreated Resident A. • Since I found staff Ebony Harris to be credible and her version of events to be corroborated by staff Tiffany Edwards, then staffs Abubakarr Bangura, Tiffany Edwards, and Jonathon Johnson dragged Resident C to his room and thereby mistreated Resident C.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Staff sat in a chair in front of Resident C’s room and prevented Resident C’s egress from his room.

INVESTIGATION:

During my 9/10/2026 interview with Abubakarr Bangura, he stated that after Resident C was escorted to his room, an unnamed staff then blocked Resident C's exit from his room. Also, during my 9/11/2026 interview with Michael Howell, he stated that all staff used a "closed door protocol" whereby he explained that all the residents are escorted to their respective rooms and not allowed out until the incident was over.

Finally, during my 9/11/2026 exit conference with Daniel Bogosian, licensee designee he stated that he has never heard of, nor is there an approved "closed door protocol" that staff are trained on or allowed to implement.

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: (d) Confine a resident in an area where egress is prevented.
ANALYSIS:	Based on the admission of staff Abubakarr Bangura that staff had held the door shut to prevent Resident C's egress from his room and Michael Howell's admission of using a "closed door" protocol which licensee designee Daniel Bogosian stated is unapproved, then the staff confined Resident C in an area where egress was prevented.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Staff administered Resident C multiple doses of PRN medication.

INVESTIGATION:

On 9/11/2026, I interviewed direct care staff and medication passers Sabrina Haskett, Noah Talbert and Brittani Brooks regarding Resident C's 8/20/2026 PRN medication administration.

Sabrina Haskett stated that she did not administer Resident C's PRN medications.

Noah Talbert stated that he gave Resident C two doses of PRN medication. He stated that Resident C is prescribed one dose of PRN medication, but since the medication cart computer allowed the second PRN medication administration, he administered it.

Brittani Brooks stated that she also administered 1 dose of Resident C's PRN medication as he was prescribed.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based upon the admissions of staffs Noah Talbert and Brittani Brooks that Resident C was given a total of 3 doses of PRN medication instead of the 1 dose he is prescribed, then Resident C's PRN medication was not given as prescribed, ordered, or directed by an appropriately licensed health care professional.
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: 9/15/2026

Approved By:



Ardra Hunter
Area Manager

Date: 09/28/2026