GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 10, 2025

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

RE: License #: AL810015274
Investigation #: 2025A0122035
Eisenhower Center - South Main

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 #:	AL810015274
Investigation #:	2025A0122035
Complaint Receipt Date:	05/22/2025
Investigation Initiation Date:	05/23/2025
Report Due Date:	06/21/2025
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:	Eisenhower Center - South Main
Facility Address:	3200 E Eisenhower Parkway Ann Arbor, MI 48108
Facility Telephone #:	(734) 677-0070
Original Issuance Date:	08/09/1993
License Status:	REGULAR
Effective Date:	05/21/2025
Expiration Date:	05/20/2027
Capacity:	14
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 05/18/2025, Resident A jumped out of the second story window and sustained injuries.	Yes

III. METHODOLOGY

05/22/2025	Special Investigation Intake 2025A0122035
05/22/2025	APS Referral
05/23/2025	Special Investigation Initiated - On Site Completed interview with licensee designee, Dan Bogosian. Reviewed and requested information from Resident A's file.
05/23/2025	Contact - Telephone call made Completed interviews with staff member, Ahmed Abdelmoumene and Rukaya Suyberu and Guardian A. Staff members, Charity Grady and Katelyn Umbenhowar. Both unavailable – left voice messages requesting contact.
05/23/2025	Contact – Document received Requested information from Resident A’s file.
05/27/2025	Contact – Document received Resident A’s After Visit Summary from University of Michigan Hospital.
05/28/2025	Contact – Telephone call made Completed interview with Resident A’s supports coordinator, Lora Maxson. Contact – Document received Resident A’s behavioral data chart
05/29/2025	Contact – Telephone calls made Completed interviews with staff members, Charity Grady and Katelyn Umbenhowar.
05/30/2025	Exit Conference Discussed findings with licensee designee, Dan Bogosian.

ALLEGATION: On 05/18/2025, Resident A jumped out of the second story window and sustained injuries.

INVESTIGATION: On 05/23/2025, I conducted an interview with licensee designee, Dan Bogosian, who confirmed that he was aware of the incident involving Resident A on 05/18/2025. Mr. Bogosian was not present but stated the following, initially Resident A was assigned 1:1 staffing through Detroit Wayne County Integrated Health Network, however that supervision requirement was being faded out and as of 05/18/2025, Resident A no longer had that supervision requirement. Mr. Bogosian stated the supervision change for Resident A would be listed in his behavior plan.

On 05/23/2025, I conducted separate interviews with staff members, Ahmed Abdelmoumene and Rukaya Zuyberu. Mr. Abedelmoumene reported the following: on 05/18/2025, Resident A's supervision requirement was 1:1 staffing at all times, there was insufficient staffing scheduled to provide Resident A with his supervision requirement, and he jumped out of a window sustaining injury. Mr. Abelmoumene stated he was the lead staff member on duty on 05/18/2025 and per protocol he contacted the staffing department to alert them that there was insufficient staffing to provide Resident A 1:1 supervision and to request additional staffing. Per Mr. Abdelmoumene he contacted the licensee's staffing department at least eleven separate times to inquire about additional staffing, however his request was never honored. Mr. Abdelmoumene provided a screen shot of the individual phone calls made to the staffing department on that date – verifying that he made attempts to obtain staffing to provide Resident A with his required supervision.

Staff member, Rukaya Zuyberu reported the following: on 05/18/2025, she was assigned the task of medication passer for the residents of Eisenhower Center - South Main. She confirmed that Resident A was not assigned 1:1 staffing on 05/18/2025 due to insufficient staff available on the same day. She observed Resident A sitting in the facility living room and then leave that area as if he was going to his bedroom. Per Ms. Zuyberu, approximately 10 minutes later an unknown co-worker informed her that Resident A was found outside on the ground by jumping out of the window.

Ms. Zuyberu stated she went outside, confirmed that it was Resident A, and emergency personnel was called to give aid. Resident A was transported from the facility University of Michigan Hospital to receive medical treatment.

Mr. Abelmoumene stated the following staff members were also assigned to work with him on 05/18/2025, Charity Grady and Kaitland Umbenhowar. On 05/29/2025, I conducted separate interviews with staff members, Charity Grady and Kaitland Umbenhowar. Both described Resident A's supervision need as "direct attention/direct staff," for 24 hours per day. Ms. Umbenhowar described it as Resident A "needing someone with him at all times, even at night, even as he sleeps."

Both confirmed that they were short staffed on 05/18/2025 and Resident A did not have a direct staff member assigned to him. They both reported Resident A was in the common area of the facility, they observed him walk down the hallway – assuming to his bedroom, and approximately 3 minutes later they were being informed that Resident A jumped out of the window.

On 05/23/2025, I conducted an interview with Guardian A1. Guardian A1 confirmed that Resident A's supervision requirement is that he is to receive 1:1 supervision at all times. Guardian A1 also reported that Resident A has a history of jumping out of windows no matter where they are located or the risk/safety factors involved, which was why he had specific supervision requirements. Guardian A1 stated that she was informed of Resident A's accident and injury on 05/18/2025 by both medical personnel and representatives from Eisenhower Center - South Main. Guardian A1 reported that Resident A sustained 6 back fractures and a shin fracture, his injuries are not deliberating, and he will be discharged back to Eisenhower Center - South Main. Guardian A1 stated that Resident A is non-verbal and deaf and therefore unable to participate in an interview. Per Guardian A1 she has met with representatives of Eisenhower Center - South Main and she wants to be assured that Resident A's supervision needs will be met in the future so that an incident like this will not happen again.

On 05/23/2025, I reviewed documents from Resident A's file. Resident A's assessment plan dated 03/21/2025, documents that he is unable to move independently in the community and Resident A is "deaf and receives enhanced supervision."

Resident A's Behavior Treatment Plan (BTP) dated 04/16/2025, documents that he is diagnosed with autism spectrum disorder, intermittent explosive disorder, and bilateral deafness. Resident A's target behaviors are listed as, "self-injurious behaviors, physical aggression, elopement, and property destruction." The plan states that Resident A requires, "1:1 staffing," however the staffing requirement can be decreased if behaviors and elopement incidents decreases. There is a note at the end of the plan, which states, "Last month, based on no behaviors being reported, it was discussed that once this was confirmed, the fading plan could start to be implemented. However, based on updated data, this is not appropriate at this time, and 1:1 should be fully continued due to safety concerns and history of elopement."

Resident A's *After Visit Summary* from University of Michigan Hospital dated 05/18/2025. The *After Visit Summary* documents Resident A was admitted on 05/18/2025 and discharged on 05/27/2025. Per the summary, it states that Resident A has past medical history of "non-verbal, deafness, seizure disorder, autism who presents as a class II trauma following a fall at his living facility. Per EMS he fell 20 feet out of a second story window. He landed on his buttock and did not hit his head or lose consciousness…" Resident A's injuries are fractures of the scrum and several back fractures that will be followed up and treated by the Orthopedic Surgery Clinic of the University of Michigan Hospital.

Resident A's Detroit Wayne Integrated Health Network Recipient Rights Complaint form dated 05/20/2025 states that Resident A was "approved/authorized for 1:1 staffing 24/7…"

On 05/28/2025, I conducted an interview with supports coordinator, Lora Maxon who confirmed that Resident A's supervision requirement on 05/18/2025 was 1:1 staffing, 24 hours per day for 7 days per week.

On 05/28/2025, I reviewed Resident A's behavioral data chart submitted by licensee designee, Dan Brogran, which documents the numbers of behaviors he displayed on a monthly basis. It lists the following behaviors, self-injurious, evasion of supervision, elopement, mental status change, physical aggression, non-cooperation, falls, and other. The chart documents that for the month of May 2025, Resident A displayed one incident with a fall but gives no details of the incident.

It is Mr. Bogosian stance that since Resident A's behaviors had decreased for the month of May then the supervision requirement was no longer 1:1 staffing. However, there was no documentation that the information of the chart had been reviewed by the behavioral therapist nor any documentation that Resident A's supervision requirement had been changed based upon the data presented on the chart.

On 05/30/2025, I completed an exit conference with licensee designee, Dan Bogosian and discussed my findings with him. Mr. Bogosian did not agree with my findings but stated he would submit a corrective action plan to address the rule violations stated in this report if approved by my supervisor.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, Ahmed Abdelmoumene, Rukaya Zuyberu, Charity Grady, and Katelyn Umbenhowar, and licensee designee, Dan Bogosian, and Guardian A1, and a review of pertinent documentation relevant to this investigation there is enough evidence to substantiate the allegation that staff failed to provide the required 1:1 supervision to Resident A on 05/18/2025 so Resident A was allowed to jump out of the second story window and sustained injuries. Therefore, the licensee did not provide Resident A's required supervision as specified in his Behavior Treatment Plan dated 04/16/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, Ahmed Abdelmoumene, Rukaya Zuyberu, Charity Grady, and Katelyn Umbenhowar, and licensee designee, Dan Bogosian, and Guardian A, and a review of pertinent documentation relevant to this investigation there is enough evidence to substantiate the allegation that staff failed to provide the required 1:1 supervision to Resident A on 05/18/2025 so Resident A was allowed to jump out of the second story window and sustained injuries. Therefore, Resident A's protection and safety was not attended to.
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
Licensing Consultant

Date: 05/30/2025

Approved By:

06/10/2025

Dawn Timm
Area Manager

Date