STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

August 2, 2022

Bianca Wilson
Umbrellex Behavioral Health Services, LLC
Suite 255
13854 Lakeside Circle
Sterling Heights, MI 48313

RE: License #: AS780400203
Investigation #: 2022A0584023
Umbrellex 1

Dear Ms. Wilson:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS780400203
Investigation #:	2022A0584023
Complaint Receipt Date:	06/03/2022
Investigation Initiation Date:	06/03/2022
Report Due Date:	08/02/2022
Licensee Name:	Umbrellex Behavioral Health Services, LLC
Licensee Address:	Suite 255 13854 Lakeside Circle Sterling Heights, MI 48313
Licensee Telephone #:	(586) 765-4342
Administrator:	Bianca Wilson
Licensee Designee:	Bianca Wilson
Name of Facility:	Umbrellex 1
Facility Address:	1207 Devonshire CT Owosso, MI 48667
Facility Telephone #:	(586) 765-4342
Original Issuance Date:	10/07/2019
License Status:	REGULAR
Effective Date:	04/07/2022
Expiration Date:	04/06/2024
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

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II. ALLEGATION(S)

	Violation Established?
Facility staff members did not provide Resident A with supervision and protection as indicated in his Community Mental Health Person Centered Plan.	Yes

III. METHODOLOGY

06/03/2022	Special Investigation Intake 2022A0584023
06/03/2022	Special Investigation Initiated – Email to Shiawassee Health and Wellness Recipient Rights Specialist Ardis Bates.
06/07/2022	Contact - Document Received Ardis Bates Shiawassee Health and Wellness
06/13/2022	Contact - Face to Face interviews with facility staff members Brandon Caldwell, Shante Gatewood, Julian Green, Linda Podolan, Kylee Burford, Jay Von Wontergham, Judy Sailor, Ashley Adamczak, Danielle Riley, Brandy Foster and Anastasia Birge.
07/25/2022	Contact - Face to Face with Resident A Contact- Email to facility staff member Anastasia Birge.
07/26/2022	Exit Conference via telephone with Bianca Wilson, licensee designee

ALLEGATION:

Facility staff members did not provide Resident A with supervision and protection as indicated in his Community Mental Health Person Centered Plan.

INVESTIGATION:

On 6/03/2022, the Bureau of Community and Health Systems (BCHS) received the above allegation via the BCHS online complaint system. The written complaint indicated facility staff members are required to provide Resident A with “line of sight” supervision.

I notified Shiawassee Health and Wellness Recipient Rights Specialist Ardis Bates, via email that I received the above allegation.

6/7/2022, Ms. Bates informed me, via email, she scheduled interviews on 6/13/2022 with the following facility staff members, to be held at Shiawassee Health and Wellness; direct care staff members Brandon Caldwell, Shante Gatewood, Julian Green, Aleen Trumbo, Linda Podolan, Kylee Burford, Jay Von Wontergham, Judy Sailor, Ashley Adamczak, Danielle Riley, home manager Brandy Foster, and area manager Anastasia Birge.

6/13/2022, I meet Ms. Bates at Shiawassee Health and Wellness, and together we reviewed Resident A's Community Mental Health Person Centered Plan (PCP) which requires the necessity for "line of sight supervision". Ms. Bates stated that Resident A requires line of sight supervision due to taking items not belonging to him out of unlocked staff members' cars and constantly stealing items from neighbor's property.

Ms. Bates and I interviewed Mr. Caldwell, Ms. Gatewood, Ms. Green, Ms. Trumbo, Ms. Podolan, Ms. Burford, Mr. Wontergham, Ms. Sailor, and Ms. Riley, who all stated they were trained to provide "line-of-sight supervision" to Resident A, as indicated in his PCP. They all stated that when Resident A is out of his bedroom, a direct care staff member must keep their eyes on him all the time. According to each direct care staff member, on 06/01/2022, Resident A had a vape pen in his possession and it is the facility's policy that no vape materials of any type are to be brought onto the facility's property.

Ms. Bates and I conducted an interview with Ms. Foster who stated that on 05/30/2022, she provided Resident A "line of sight" supervision during the facility's day shift, while at a picnic, until 2:00PM. According to Ms. Foster, she was near the grill cooking with an owner of the Umbrellex homes and Resident A was with her the entire picnic. According to Ms. Foster she did not take her eyes off Resident A, nor did she see him gain access to a vape pen.

During our interview with Mr. Caldwell, he stated that on 5/30/2022 he was responsible for providing Resident A with line-of-sight supervision beginning at 2:00pm. Mr. Caldwell stated he did not lose sight of Resident A nor did he see Resident A obtain access to a vape pen. Mr. Caldwell confirmed Resident A was around the grill near two other employees of Umbrellex Homes during the picnic and went to bed when they returned to the home in the evening.

During our interviews with Mr. Green and Ms. Gatewood, they both stated they worked from 10:00PM on 05/30/2022 to 6:00AM on 05/31/2022. Neither Mr. Green nor Ms. Gatewood noticed anything unusual with Resident A during the 20-minute bed checks done per his *Assessment Plan for AFC Residents.* Both Mr. Green and Ms. Gatewood stated Resident A was sleeping the entire time and did not get out of bed during their shift.

Ms. Bates and I conducted an interview with Ms. Birge, who stated that on 5/31/2022, she was bringing a grocery order to the home and noticed when she parked in the driveway Resident A was standing outside by the backyard fence unsupervised. According to Ms. Birge, she went into the house and asked Ms. Adamczak who was assigned to provide Resident A with line-of-sight supervision. Ms. Birge stated Ms. Adamczak answered, "I am not sure". According to Ms. Birge, Resident A was unsupervised for an undetermined amount of time on 5/31/2022 and from where he was standing outside, there are no windows from which to supervise him.

During our interviews with Ms. Riley and Ms. Buford, they stated they worked at the facility on the morning of 6/1/2022 and tried to wake Resident A up. According to both Ms. Buford and Ms. Riley, Resident A would not wake up and they saw a blue vape pen laying on the top of his bed frame. Ms. Buford and Ms. Riley both stated Resident A would not tell them where he got the vape pen. They notified Ms. Birge who then notified the Shiawassee Health and Wellness Recipient Rights Office, BCHS, and the local police department.

Ms. Birge stated she did an internal investigation and requested Ms. Adamczak sign a disciplinary notice on both 6/2/2022 and 06/11/2022 for not following Resident A's Community Mental Health PCP by providing Resident A with "line of sight supervision" as required. Ms. Birge stated Ms. Adamczak refused to sign the disciplinary notice and voluntarily terminated her employment on 6/11/2022.

Ms. Adamczak did not appear for her scheduled interviewed at Shiawassee Health and Wellness on 06/13/2022. I attempted to leave her a voicemail but was unable to, as her mailbox is full.

On 7/25/2022, I attempted an in-person interview with Resident A at the facility. Resident A refused to answer my questions and excused himself to his bedroom.

While onsite, I conducted an onsite inspection of the facility and confirmed that from where Resident A was standing outside on 5/31/2022 unsupervised, there were no windows from which direct care staff members would be able to see or provide him with "line of sight supervision", as directed in his community mental health PCP.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, Shiawassee Health and Wellness Recipient Rights Specialist Ardis Bates, and a review of

	Resident A's Community Mental Health PCP, there is enough evidence to substantiate the allegation that on 05/31/2022, direct care staff member Ashley Adamczak did not provide Resident A with "line of sight supervision" as indicated in his Community Mental Health PCP.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/26/2022, I conducted an exit conference with licensee designee Bianca Wilson both via email and by telephone and shared with her the findings of this investigation.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of this license.

8/2/2022

Candace Coburn — Date
Licensing Consultant

Approved By:

8/02/2022

Michele Streeter — Date
Section Manager