GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 14, 2022

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

AS780400203
RE: License #: 2022A0584033
Investigation #: 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 (517) 284-9700.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780400203
Investigation #:	2022A0584033
Complaint Receipt Date:	08/17/2022
Investigation Initiation Date:	08/17/2022
Report Due Date:	10/16/2022
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

II. ALLEGATION(S)

	Violation Established?
On 8/13/2022, direct care staff Andrew Conin verbally abused Resident A and did not provide "line of sight" supervision as written in Resident A Behavior Plan.	Yes

III. METHODOLOGY

08/17/2022	Special Investigation Intake 2022A0584033
08/17/2022	Special Investigation initiated via email to Andrea Andrykovich, Recipient Rights Officer for Shiawassee Health and Wellness. Received denied referral from APS Intake.
09/02/2022	Telephone call received from Andrea Andrykovich, Recipient Rights Officer.
09/12/2022	Face to Face interview with Resident A. Telephone call made to Andrea Andrykovich, Recipient Rights Officer.
10/11/2022	Telephone interview with direct care staff Kylee Burford and message left for direct care staff Imani Johnson.
10/12/2022	Exit Conference via telephone call with Licensee Designee, Bianca Wilson.

ALLEGATIONS:

On 8/13/2022, direct care staff Andrew Conin verbally abused Resident A and did not provide "line of sight" supervision as written in Resident A' Behavior Plan.

INVESTIGATION:

On 08/17/2022, Shiawassee County Adult Protective Services (APS) denied the above allegations for investigation and referred them to the Bureau of Community and Health Systems (BCHS) via the BCHS on-line complaint system.

I conducted a telephone interview with Shiawassee County Health and Wellness Recipient Rights director, Andrea Andrykovich. Ms. Andrykovich stated that she investigated the same allegations and discovered direct care staff Andrew Conin had been relieved of direct care duties at the time of her investigation. Ms. Andrykovich stated that Resident A is diagnosed with Autism Spectrum Disorder, Intellectual Disability, and Intermittent Explosive Disorder. Additionally, Ms. Andrykovich stated that Resident A ambulates on his own and has minimal verbal skills. Ms. Andrykovich stated that she contacted Mr. Conin by telephone for an interview, and Mr. Conin informed her the allegations were not true and told her he resigned from his position. Ms. Andrykovich stated the Shiawassee County Health and Wellness Recipient Rights Office had substantiated the allegations.

On 9/12/2022, I conducted an unannounced onsite investigation and attempted to interview Resident A. Resident A did not participate with interview questions and did not respond verbally. Resident A appeared well groomed and presented no behavior issues at the time of this visit.

I requested and reviewed Resident A's *Shiawassee Health and Wellness Functional Behavior Assessment and Intervention Plan* (Behavior Plan) dated 6/27/2022.

Documentation on Resident A's Behavior Plan indicated:

"BEHAVIOR MODIFYING MEDICATIONS/RESTRICTIONS
Direct Line of Sight Supervision during waking hours.
Staff should complete 30 minute health and safety checks during sleeping hours
Alarms on [Resident A] bedroom windows.
Alarms on windows in common areas of the house where elopement is possible.
Alarms on all doors
Over Door Locks

EVALUATION
1.Staff who work directly with [Resident A] in all settings are responsible for implementing this plan."

I reviewed written statements submitted by direct care staff members Kylee Burford and Imani Johnson, who reported witnessing the incident on 8/13/2022 between Mr. Conin and Resident A.

The written statement from Ms. Burford indicated:

"Consumer woke up around 7am and went into the bathroom. Andrew followed him into the bathroom to give him a shower and began getting frustrated with him. After the shower Andrew came into the dining room and began stating, "it's bullshit that he shit his pants because he knows better and is doing it on purpose so we have to clean him like a baby." He then said, "he wasn't going to put up with his bullshit, and the consumer needed to just sit the fuck down and watch the movie because he

knows he can do that." The consumer then went outside, and Andrew stated to myself and the other staff that "if we left him alone with the consumer for an hour he would rub his nose in it (meaning the feces) like an animal. And make him never have an accident again."

Once the consumer came back inside, he went to his bean bag and took his shoes off. The consumer then tried to stand up to take care of his shoes and Andrew said "sit the fuck down, because he knows the consumer will put them in the toilet and he is not playing those games today."

The written statement from Ms. Johnson indicated:

"Approximately at 7am consumer woke up and went into the bathroom to shower. After the shower Andrew came into the dining room mad that he had to clean consumer from a feces accident. Andrew began to talk about how the consumer did it on purpose and said, "this is bullshit and he's doing it on purpose, so we clean him like a baby." He continued to talk about if the consumer was to have one more mess today then it would be best if Andrew was not here. Consumer was sitting at the activity table in the living room quietly and patiently waiting for breakfast when Andrew told him to "wake the fuck up" because Andrew was not stupid and consumer watches tv so he knows exactly what he was doing. Consumer then went to sit on his bean bag and took his shoes off proceeding to stand up and walk towards the hallway when Andrew told him to "sit the fuck down and watch the movie." Andrew also said, "if you guys (meaning me and the other staff) were to walk away, I shove his face in his own shit like he was an animal and maybe he will learn."

On 10/11/2022, I conducted a telephone interview with Ms. Burford, whose verbal statements were consistent with the written statements she provided. Ms. Burford stated the incident on 08/13/2022 started at approximately 7:30 am and Mr. Conin allowed Resident A to go outside without providing "line of sight" supervision. Ms. Burford stated that while Resident A was outside, Mr. Conin continued to say to both her and Ms. Johnson, "this is bullshit, [Resident A] shit his pants" and "I would rub his nose in it (feces) like an animal". Ms. Burford stated that Mr. Conin lost sight of Resident A during that time, but then Resident A did come back into the house. Ms. Burford said that Mr. Conin then told Resident A directly, "sit the fuck down to watch the movie". Ms. Burford had not witnessed any other type of outburst from Mr. Conin in the past month and when she and Ms. Johnson reported the incident, the facility's home manager Anastasia Birge immediately arrived at the home to relieve Mr. Conin of his duties.

I left a voice message with Ms. Johnson. As of the date of this report, I have not received a call back.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with Shiawassee Health and Wellness Recipient Rights Officer Andrea Andrykovich and facility staff member Kylee Burford, and a review of written statements by Ms. Burford and facility staff member Imani Johnson, as well as a review of other facility documentation relevant to this investigation, it has been established that on 08/13/2022, Andrew Conin verbally abused Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 Shiawassee Health and Wellness Recipient Rights Officer Andrea Andrykovich and facility staff member Kylee Burford, and a review of written statements by Ms. Burford and facility staff member Imani Johnson, as well as a review of other facility documentation relevant to this investigation, it has been established that on 8/13/2022, direct care staff Andrew Conin, who was assigned to provide care and supervision to Resident A that day, did not provide Resident A with “line of sight” supervision per Resident A’s Behavior Plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/12/2022, the findings of this investigation were shared with Licensee Designee Bianca Wilson by telephone.

IV. RECOMMENDATION

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

10/13/2022

Candace Coburn — Date
Licensing Consultant

Approved By:

10/14/2022

Michele Streeter — Date
Area Manager