GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2022

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

RE: License #: AS780404958
Investigation #: 2022A0584032
Umbrellex 2

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.

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780404958
Investigation #:	2022A0584032
Complaint Receipt Date:	08/08/2022
Investigation Initiation Date:	08/08/2022
Report Due Date:	10/07/2022
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 2
Facility Address:	805 E King St Owosso, MI 48867
Facility Telephone #:	(586) 765-4342
Original Issuance Date:	08/21/2020
License Status:	REGULAR
Effective Date:	02/21/2021
Expiration Date:	02/20/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A does not feel safe at the facility.	No
Staff do not take Resident A to his medical appointments.	No
Additional Findings	Yes

III. METHODOLOGY

08/08/2022	Special Investigation Intake 2022A0584032 Special Investigation Initiated with an email sent to Shiawassee County APS Specialist Jamie Murdock.
10/04/2022	Face to Face interview with Resident A, direct care staff Brandon Bledsoe and Umbrellex Behavioral Health Services area manager Anastasia Birge. Separate Telephone Interviews with home manger Cierra Tillis and Guardian A 1. Exit Conference with licensee designee Bianca Wilson via email.

ALLEGATION:

- **Resident A does not feel safe at the facility.**
- **Staff do not take Resident A to his medical appointments**.

INVESTIGATION:

On 08/08/2022, 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.

Via email I informed APS Specialist Jamie Murdock that I was assigned to investigate these allegations.

On 10/4/2022, I conducted a face-to-face interview with Resident A, who stated he is doing well at the home and had not experienced any verbal or physical harm from facility staff members or other residents. Resident A stated things are good at the home and he gets along with everyone. According to Resident A, last month he missed one doctor's appointment because facility staff members were not able to take him.

I conducted a face-to-face interview with direct care staff Brandon Bledsoe who stated that he has not witnessed any verbal and/or physical abuse of residents by facility staff members, nor any incidents of residents verbally and/or physically abusing other residents.

I conducted a telephone interview with Guardian A 1, who confirmed Resident A relies on facility staff members to provide him with transportation to his medical appointments. However, according to Guardian A 1, Resident A has a history of calling doctor's offices and scheduling medical appointments and then failing to inform facility staff members that he has done so. Guardian A 1 stated that she is only aware of Resident A missing one, possibly two appointments in the last two months due to Resident A failing to notify facility staff members that he scheduled the appointments. Guardian A 1 stated that Resident A has not informed her of any physical or verbal abuse from facility staff member and/or other residents. Guardian A 1 stated that she is well informed by all facility staff members regarding Resident A's care and behaviors. According to Guardian A 1, she has not received any reports from facility staff members regarding Resident A being harmed in any way. Guardian A 1 stated facility staff members provide excellent care to Resident A.

I conducted a telephone interview with the home manager Cierra Tillis. Ms. Tillis confirmed Guardian A 1's statements regarding Resident A making medical appointments and failing to notify facility staff members. Ms. Tillis stated that on 9/12/2022, she was on the way to Jackson when Resident A informed her that he had a medical appointment in Ann Arbor. Ms. Tillis stated she had to tell him she was not able to transport him to the appointment since she was already almost to the city of Jackson and wouldn't be able to get him to Ann Arbor on time. According to Ms. Tillis, Resident A participates in agitating his house mates and says negative comments to them and facility staff members. Ms. Tillis stated that she is not aware of any facility staff members and/or residents verbally and/or physically abusing Resident A.

APPLICABLE RULE	
R330.1805	**Accessibility**
	Common use areas of the facility are accessible to all clients in residence or an individual plan of service addresses the removal of imposed restrictions. The facility shall be capable of meeting the transportation needs of all clients the facility accepts for service.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, Guardian A 1, and multiple facility staff members, it has been established that Resident A relies on facility staff members to provide him with transportation to his medical appointments. However, Resident A has a history of calling

	doctor's offices, scheduling medical appointments and then failing to inform facility staff members that he has done so, resulting in facility staff members being unable to provide Resident A with transportation on short notice. Other than what was indicated in the written complaint, there is no evidence to substantiate the allegation facility staff members failed to transport Resident A to medical appointments they were made aware of in advance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**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 interviews with Resident A, Guardian A 1, and multiple facility staff members, other than what was indicated in the written complaint, there is no evidence to substantiate the allegation that Resident A did not feel safe in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/7/2022, I reviewed Resident A's medication administration records (MARs) for the month of August 2022. As indicated by missing direct care staff workers' initials on Resident A's MARs, it appeared there was an occasion Resident A did not receive his prescribed medications. According to missing direct care staff initials on Resident A's MAR, during the facility's 8:00PM medication pass on 8/24/2022 the following medications were not administered to Resident A; Cyclobenzaprine 500mg, Lorazepam 2mg, Metformin 1000mg, Montelukast 10 mg, Oxcarbazepine 300 mg, Quetiapine 200mg, and Symbicort 160-4.5.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(b)Complete an individual medication log that contains all of the following information: **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Based upon my investigation, missing documentation on Resident A's August 2022 MAR indicated Resident A did not receive several medications during the 8:00PM medication pass on 08/24/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/4/2022, the findings of this investigation were shared with Licensee Designee Bianca Wilson by email.

IV. RECOMMENDATION

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

10/11/2022

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Candace Coburn Date
Licensing Consultant

Approved By:

10/12/2022

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Michele Streeter Date
Section Manager