GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 7, 2023

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

RE: License #: AS780400203
Investigation #: 2023A0584018
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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) 284-9727.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780400203
Investigation #:	2023A0584018
Complaint Receipt Date:	01/03/2023
Investigation Initiation Date:	01/05/2023
Report Due Date:	03/04/2023
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:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 1/2/2023, direct care staff member Diamond Mayfield did not provide “line of sight” supervision as written in Resident A Community Mental Health Behavior Plan.	Yes

III. METHODOLOGY

01/03/2023	Special Investigation - Intake 2023A0584018
01/05/2023	Special Investigation Initiated – Email to Andrea Andrykovich, Recipient Rights Officer with Shiawassee Health and Wellness.
01/09/2023	Onsite investigation. Face to face interviews with direct care staff members Jay Vanwonterghem, Brandon Caldwell, Diamond Mayfield, home manager Cierra Tillis, and Resident A.
02/23/2023	Exit Conference with licensee designee Bianca Wilson.

ALLEGATION:

On 1/2/2023, direct care staff member Diamond Mayfield did not provide “line of sight” supervision as written in Resident A Community Mental Health Behavior Plan.

INVESTIGATION:

On 1/3/2023, Shiawassee County Adult Protective Services (APS) denied the above allegation for investigation and referred it to the Bureau of Community and Health Systems (BCHS) via the BCHS on-line complaint system.

On 01/05/2023, I informed Shiawassee Health and Wellness Recipient Rights Officer Andrea Andrykovich, via email, I was assigned to investigate this allegation.

On 1/9/2023, I met Ardis Bates, of Shiawassee Health and Wellness Recipient Rights at the facility, and together, we conducted an unannounced investigation. I attempted to interview Resident A. However, Resident A was unwilling to answer my questions. Resident A appeared well groomed and presented no behavioral issues during my investigation.

I 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.

EVALUATION

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

I conducted face to face interviews with Ms. Bates, direct care staff members Jay Vanwonterghem, Brandon Caldwell, and Diamond Mayfield, and home manager Cierra Tillis. Mr. Vanwonterghem, Mr. Caldwell, Ms. Mayfield, and Ms. Tillis all stated that on 01/02/2023, during resident waking hours, Resident A left the home without the knowledge of Ms. Mayfield, who was Resident A's assigned 1:1 direct care staff member. Upon leaving the home, Resident A walked across the street and into a neighbor's yard. Mr. Vanwonterghem and Mr. Caldwell stated they witnessed a neighbor walking Resident A walking back to the facility. Ms. Mayfield stated she was not aware that Resident A had left the home's backyard and admitted to losing line of sight of Resident A briefly between the time he was in the backyard and later walked back to the facility by a neighbor.

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 Ardis Bates and facility direct care staff members Jay Vanwonterghem, Brandon Caldwell, Diamond Mayfield, and home manager Cierra Tillis, as well as a review of facility documentation relevant to this investigation, it has been established that per Resident A's Community Mental Health Behavior Plan, facility staff members were to provide Resident A with "line of sight" supervision during waking hours. There is enough evidence to substantiate the allegation that on 1/2/2023, Ms. Mayfield, who was assigned to provide 1:1 supervision to Resident A that day, lost sight of Resident A, who left the property and walked to a neighboring home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

3/6/2023

Candace Coburn Date
Licensing Consultant

Approved By:

3/07/2023

Michele Streeter Date
Area Manager