GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2024

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

RE: License #: AS780404958
Investigation #: 2024A0584014
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.

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) 284-9727.

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 #:	AS780404958
Investigation #:	2024A0584014
Complaint Receipt Date:	01/30/2024
Investigation Initiation Date:	01/30/2024
Report Due Date:	03/30/2024
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:	02/21/2023
Expiration Date:	02/20/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff was observed sleeping, which is against the facility's policy.	Yes
Staff pushed an unidentified resident.	No
Additional Findings	Yes

III. METHODOLOGY

01/30/2024	Special Investigation Intake - 2024A0584014.
01/30/2024	Special Investigation Initiated - Email to Ardis Bates, Shiawassee Health and Wellness Recipient Rights.
01/30/2024	APS Referral - Sent via email to Central Intake.
01/31/2024	Contact - Telephone call received from Rebecca Schalow, APS worker.
02/05/2024	Contact - Face to Face interviews with direct care staff Kanari Ross, Antionio Garza, Justin Lawrence, and Team Home Manager Brandy Foster at Shiawassee County Health and Wellness office with Ardis Bates, Recipient Rights Officer.
02/12/2024	Contact – Face to face interviews with direct care staff Justin Green and Jayden Thomas.
02/15/2024	Contact - Document Received via email from Shiawassee Health Department administrator Denise Bennett regarding information received of additional allegations regarding physical plant issues.
02/26/2024	Inspection Completed On-site. Face to face interviews with Resident A, B, C and direct care staff Jayden Thomas.
03/04/2024	Contact – Telephone interview with facilities contractor Robert Wilson.
03/08/2024	Contact – Face to face interviews with direct care staff Judy Sailor, Leeanne Little, Samantha Sawvel, Jasmine Redwine, Area Operations Manager Anastasia Foster, Area Client Services manager, Cierra Tillis.
03/12/2024	Exit Conference via telephone with licensee designee Bianca Wilson.

ALLEGATIONS:

- **Staff was observed sleeping**, **which is against the facility's policy.**

- **Staff pushed an unidentified resident.**

INVESTIGATION:

On 1/30/2024, the Bureau of Community and Health Systems (BCHS) received the above allegations via the online complaint system.

On 2/5/2023, I conducted separate face-to-face interviews with direct care staff Kanari Ross, Antonio Garza, Justin Lawrence, and home manager Brandy Foster at the Shiawassee Health and Wellness office with Recipient Rights Officer Ardis Bates.

Mr. Ross, Mr. Garza, Mr. Lawrence all denied the allegations and stated they have not witnessed any staff members pushing residents or sleeping on duty.

Ms. Foster stated she has not pushed a resident, slept during her shift, and/or witnessed or have been informed by residents or other staff members regarding any incidents when a staff member pushed a resident or slept during their work shift. Ms. Foster stated that she periodically visits the facility to do checks on the third shift staff, and to date, has not witnessed any staff sleeping on their shift.

On 2/12/2024, I conducted face to face interviews with direct care staff Jaden Thomas and Justin Green. Mr. Thomas stated he works first shift hours and denied the allegations. According to Mr. Thomas, he has not witnessed or heard of any staff members pushing a resident or sleeping during their shift.

Mr. Green stated he works the third shift, full time, at the facility. Mr. Green stated that he does not sleep on his shift and denied pushing any resident, as well as denied witnessing other staff members pushing residents or sleeping on their shift.

On 2/26/2024, I conducted an unannounced investigation at the facility and interviewed Residents A, B, C. Residents A, B, and C all denied having any problems interacting with staff or being pushed, nor did Residents A, B, and C ever witness other residents be pushed by any staff members. Resident A and B stated they have witnessed third shift staff sleeping during their shift on multiple occasions.

On 3/8/2024, I conducted a face to face interview with Jasmine Redwine. Ms. Redwine stated she works the third shift at the facility. Ms. Redwine admitted that she has fallen asleep during her shift.

According to the facility's Original Licensing Study Report, dated 8/18/2020, the licensee indicated that direct care staff members were to remain awake during resident sleeping hours.

On 3/18/2024, I requested and reviewed the facility's employee manual, which indicated that sleeping while on duty is an example of employee misconduct.

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(1) A licensee shall have written policies and procedures that include all of the following: **(b) Resident care related prohibited practices.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with residents and staff members, as well as a review of facility documentation relevant to this investigation, there is enough evidence to substantiate the allegation staff was observed sleeping, which is against the facility's policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with residents and staff members, there is no evidence to substantiate the allegation staff pushed any resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 2/27/2024, I conducted an inspection of the facility due to Residents A, B, and C stating there are some areas that required repair. I observed the following items that require repair or replacement:

- The kitchen refrigerator door is not able to stay closed and was found to be open about an inch wide allowing cold air to escape.
- The floor in the doorway from the kitchen to the dining area was cracked and a piece of tile is missing.
- The floor in the doorway from the dining area to the bathroom is sagging and about a quarter inch of subflooring is exposed.
- Broken back support to dining room chair.
- A light covering is missing from the fixture in the bathroom ceiling.
- The bathtub wall paneling has black staining at the horizontal seam above the bathtub rim.
- There is a hole in the drywall in the hallway.
- Residents A, B, and C are sleeping on badly stained mattresses and pillows, and their beds have no sheets, cases, blankets or bedspreads.
- Resident A's bedroom window has broken mini blinds.
- Resident B's bedroom window has a screen missing.
- There are no towels or washcloths available.
- The backyard deck had no railings or steps and was at least 12 inches above ground level.
- The garage was cluttered with broken furniture and extra trash.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair. **(7) All water closet compartments, bathrooms, and kitchen floor surfaces shall be constructed and maintained so as to be reasonably impervious to water and to permit the floor to be easily kept in a clean condition.** **(8) Stairways shall have sturdy and securely fastened handrails. The handrails shall be not less than 30, nor more than 34, inches above the upper surface of the tread. All exterior and interior stairways and ramps shall have handrails on the open sides. All porches and decks that are 8 inches or more above grade shall also have handrails on the open sides.** **(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.**
ANALYSIS:	Based on interviews with Residents A, B, and C, as well as an inspection of the facility, there is evidence the facility must repair or replace the refrigerator, broken flooring, broken dining room chair, back deck steps and railing, bathroom light fixture, hole in the hallway drywall, Resident A's window covering, and Resident B's bedroom window screen, as well as remove clutter and extra trash in and outside of the garage.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a waterbed is not prohibited by this rule.
ANALYSIS:	Based upon interviews with Residents A, B, and C, as well as an inspection of the facility, there is evidence that Residents A, B, and C's mattresses were soiled and worn.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillowcase, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled. **(2) A licensee shall provide at least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident bed.** **(3) A licensee shall provide bath towels and washcloths. Towels and washcloths shall be changed and laundered not less than twice weekly or more often if soiled.**
ANALYSIS:	Based upon interviews with Residents A, B, and C, as well as an inspection of the facility, there is evidence all three residents did not have a clean bed pillow, extra sheets, pillowcases, blankets, bedspreads, and no towels or washcloths.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/12/2024, I conducted an exit conference via telephone with licensee designee Biance Wilson and informed her of the findings of this investigation.

IV. RECOMMENDATION

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

3/15/2024

Candace Coburn — Date
Licensing Consultant

Approved By:

3/19/2024

Michele Streeter — Date
Area Manager