GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 23, 2024

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

RE: License #: AS780404958
Investigation #: 2024A0584030
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 #:	2024A0584030
Complaint Receipt Date:	07/11/2024
Investigation Initiation Date:	07/11/2024
Report Due Date:	09/09/2024
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?
On 7/7/2024, direct care staff Kermit Craig verbally threatened and physically assaulted Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/11/2024	Special Investigation Intake - 2024A0584030.
07/11/2024	Special Investigation Initiated - On Site Face to face interviews with direct care staff Amadeaus Foster, Resident A, B, Umbrellex Client Services Manager Cierra Tillis, and Andrea Andrykovich, Recipient Rights, Shiawassee Health and Wellness.
07/12/2024	APS Referral sent via email to Central Intake.
08/19/2024	Exit conference with Bianca Wilson, licensee designee.

ALLEGATION:

On 7/7/2024, direct care staff Kermit Craig verbally threatened and physically assaulted Resident A.

INVESTIGATION:

On 7/11/2024, the Bureau of Community and Health Systems (BCHS) received the above allegation via telephone call.

I conducted an unannounced onsite investigation with Andrea Andrykovich, Shiawassee Health and Wellness Recipient Rights office, and together we interviewed direct care staff members Amadeaus Foster, Cierra Tillis, and Residents A and B.

Mr. Foster stated that on 7/7/2024, he was on an outing with Resident B when at approximately 3:30pm he received a text from staff member Kermit Craig asking him to return to the facility because Resident A was crying. Mr. Foster stated that when he arrived back to the facility around 3:50pm, he witnessed Resident A sitting on the couch with Mr. Craig. According to Mr. Foster, he witnessed Mr. Craig poke Resident A in the stomach and knees with a wooden crutch and say, “I know you have bad knees, try walking after this”. Mr. Foster stated Resident A called Mr. Craig

“the N word”. According to Mr. Foster, he witnessed Mr. Craig pull Resident A so he was laying face up on the couch. He then witnessed Mr. Foster get on top of Resident A, place his left arm over his throat, and slap him “four or five times” on the face with his right hand. Mr. Foster stated he called to alert a facility house manager and then left the facility with Resident B, who was very distressed, to a neighboring facility.

Ms. Tillis stated that on 7/7/2024, she was at a neighboring facility when she was made aware of the situation by Mr. Foster. According to Ms. Tillis, she immediately responded to the facility to address the situation. Ms. Tillis stated that when she arrived, she witnessed Mr. Craig sitting at the kitchen table and Resident A sitting on the couch. Ms. Tillis checked Resident A for injuries and found red marks and bruises on Resident A's face and arms. According to Ms. Tillis, she took pictures of Resident A’s injuries, and then went to talk with Mr. Craig. Ms. Tillis stated she was already aware of the incident details as told to her by Mr. Foster. However, Mr. Craig denied the allegations. Ms. Tillis stated she called the police, who after conducting interviews, arrested Mr. Craig. According to Ms. Tillis, immediately following his arrest, Mr. Craig’s employment was terminated.

Resident A was unwilling or unable to answer questions.

Resident B’s statements were consistent with the statements Mr. Foster provided to me.

According to Special Investigation Report (SIR) #2023A0584033, dated 06/30/2023, the facility was in violation of AFC administrative licensing rule R 400.14308 (2) (f) when it was established that on 4/29/2023, direct care staff Deante Johnson threatened and verbally abused a resident, who was identified as Resident A in SIR #2023A0584033. According to the facility’s approved CAP, dated 07/25/2023, Mr. Johnson was suspended from all shifts pending the outcome of the investigation on 04/26/2023, and was terminated from employment on 05/01/2023 due to the established violation.

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: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.** **(iv) Threats.**

ANALYSIS:	Based on interviews conducted with multiple facility staff members and Resident B, there is significant evidence to substantiate the allegation that on 7/7/2024, direct care staff Kermit Craig verbally threatened and used physical force against Resident A.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SI #2023A0584033, DATED 06/30/2023, AND CAP, DATED 07/25/2023**

ADDITIONAL FINDINGS:

During my interview with Mr. Foster on 7/11/2024, he stated that on 7/7/2024, he witnessed Mr. Craig verbally threaten and use physical force against Resident A. Mr. Foster stated that upon witnessing this, he called to alert another facility house manager and then left the facility with Resident B to a neighboring facility, leaving Resident A alone with Mr. Craig.

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 on interviews with multiple facility staff members it has been determined that on 7/7/2024, direct care staff member Amadeaus Foster left Resident A alone with direct care staff member Kermit Craig after witnessing Mr. Craig verbally threaten and use physical force against Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/19/2024, I conducted an exit conference via email with licensee designee Bianca Wilson and in a follow up phone call informed her of the findings of this investigation.

IV. RECOMMENDATION

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

8/23/2024

Candace Coburn — Date
Licensing Consultant

Approved By:

8/26/2024

Michele Streeter — Date
Area Manager