GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 4, 2025

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

RE: License #: AS380418712
Investigation #: 2025A0007036
Umbrellex 202

Dear Bianca 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) 284-9720.

Sincerely,

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380418712
Investigation #:	2025A0007036
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/08/2025
Report Due Date:	09/05/2025
Licensee Name:	Umbrellex Behavioral Health Services, LLC
Licensee Address:	13854 Lakeside Circle Ste Sterling Heights, MI 48313
Licensee Telephone #:	(586) 765-4342
Administrator:	Bianca Wilson
Licensee Designee:	Bianca Wilson
Name of Facility:	Umbrellex 202
Facility Address:	304 E Monroe Jackson, MI 49202
Facility Telephone #:	(517) 796-3073
Original Issuance Date:	01/24/2025
License Status:	TEMPORARY
Effective Date:	01/24/2025
Expiration Date:	07/23/2025
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents are reportedly being left to sleep in their own urine, staff are neglectful and sleep on the job, and molded food is being served.	No
Resident A utilized her wheelchair 98% of the time. The facility is not wheelchair accessible.	Yes

III. METHODOLOGY

07/07/2025	Special Investigation Intake- 2025A0007036
07/08/2025	Special Investigation Initiated - On Site - Face to face contact with Employee 1, DCW, Employee 2, DCW, Employee 3, DCW, Resident A, Resident B, Resident C, Ricki Turner, Home Manager, and Ranisha Ross, Area Supervisor.
07/08/2025	Contact - Telephone call made to Complainant #1. Message left. I requested a return phone call.
07/09/2025	Contact - Telephone call made - Interview with Individual #1.
07/10/2025	Contact - Face to Face - Robert Wilson, Administrative Staff, Ranisha Ross, Area Supervisor, and Ricki Turner Home Manager at Umbrellex 200 AS380418753.
08/29/2025	Contact - Document Sent to Ashlee Griffes, ORR. Facility update provided.
08/29/2025	Contact - Document Received - Email from Ashlee Griffes, ORR. Update provided.
09/02/2025	Inspection Completed On-site - Unannounced - Face to face contact with Kenyanna McCoy, DCW, Steffenie Anderson, DCW, Resident B.
09/02/2025	APS Referral made.
09/03/2025	Email and telephone call to Bianca Wilson, Licensee Designee. Exit conference scheduled for 09/04/2025.
09/04/2025	Exit Conference conducted with Bianca Wilson, Licensee Designee.

ALLEGATIONS: Residents are reportedly being left to sleep in their own urine, staff are neglectful and sleep on the job, and molded food is being served.

INVESTIGATION:
On July 8, 2025, I conducted an unannounced on-site investigation and made face to face contact with Employee #1, DCW, Employee #2, DCW, Employee #3, DCW, Resident A, Resident B, and Resident C.

Upon arrival, I introduced myself and the reason for the visit. Employee #2, DCW, informed me that they grocery shop every Friday, they have plenty of food, that is dated, and restocked. I observed the refrigerator to be clean, stocked with food, and I did not see any food that appeared to be moldy or spoiled.

While at the facility, it was noted that Resident A wanted a cigarette, so staff assisted her off the couch into a wheelchair and pushed her outside on the back deck to smoke.

I interviewed Resident B. Resident B appeared to be happy. She reported that the food was good, and she had no concerns about the care she was receiving in the home. She also reported that she was going to be moving to a different home on August 1, 2025.

I spoke with and interviewed Employee #2. Employee #2, DCW, informed me that Resident A does not like to take showers or utilize the facility bathroom. She stated there were no issues with Resident A urinating on the floor. However, if Resident A was in a behavior, she would threaten not to use the bathroom. I also observed the bedside commode in Resident A's room, next to her full-sized bed. According to Employee #2, Resident A always sleeps in her bed. Staff informed me that they assist with wiping Resident A each time after utilizing the bedside commode.

I interviewed Resident C. Resident C informed me that she has resided in the facility for about six months as she left, went to reside with her daughter and then returned. Resident C reported that things were going well, and staff were responsive when she needed assistance. Resident C had just awakened from a nap, and informed me that she slept in her bed, not on the floor. She also informed me that the other residents do not sleep on the floor. Resident C reported that the food was good, and she had not observed or eaten spoiled or moldy food.

Once Resident A finished her cigarette, I interviewed her in her room. Resident A reported that she had a fall and broke her ankle, and that she utilizes the walker in the facility and the wheelchair is for the community. She reported there were (small) portable ramps installed at both doors. Resident A reported that the food was "Great" and always fresh. She informed me that she received three meals a day and had never seen moldy food in the facility. The staff are available and assist when

called and help when needed. Resident A informed me that the staff assisted her with utilizing the bedside commode, as there was an incident and her knees buckled on her, and the staff caught her. Resident A reported receiving bedside baths. Resident A reported that she slept in her bed and never slept on the floor. She had not observed any other residents sleeping on the floor. Resident A denied that she or other residents were left in their urine and appeared surprised regarding the allegations. Resident A stated that the staff at the facility really cared about the residents, and she considered them her family. She recalled that they recently completed a fire drill, and the staff came in the room and grabbed her special blanket from her mom and took it with them across the road. Resident A reported that she can't ambulate without her walker, but that she could get to her commode and in and out of bed without staff assistance.

While I was at the facility, Ricki Turner, who has the role of Home Manager, and Ranisha Ross, who has the role of Area Supervisor, arrived at the facility and they were also informed of the allegations and the investigation.

On September 2, 2025, I conducted an unannounced on-site investigation and made face to face contact with Kenyanna McCoy, DCW, Steffenie Anderson, DCW. The direct care staff informed me that Resident A was in the hospital, and Resident B and Resident C were asleep. I observed Resident B asleep at the facility.

I interviewed Kenyanna McCoy, DCW, who informed me that she does not sleep while on duty and she has not observed staff sleeping while on shift. However, she has heard that there may have been an issue with staff sleeping on shift, but she personally had not witnessed this.

Steffenie Anderson, DCW, reported that staff are to be awake during their shift, she has not slept while on duty or observed others sleeping on shift.

While at the facility, I also observed the food in the refrigerator and freezer. While there was enough food for some meals, I inquired when they would be grocery shopping and Kenyanna McCoy, DCW, informed me that the groceries would be delivered soon. I did not observe any moldy or spoiled food in the refrigerator.

On September 4, 2025, I conducted the exit conference with Bianca Wilson, Licensee Designee. We discussed the investigation and my recommendations. She concurred with the conclusion of the investigation.

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 on-site investigations, interviews with facility and administrative staff, residents, and ORR, it's concluded that there is not a 51% preponderance of the evidence to support the allegations that the residents are being left to sleep in their own urine and the staff are neglectful and sleep on the job.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	Based upon my investigation, which consisted of on-site investigations, interviews with facility and administrative staff, residents, and ORR, it's concluded that there is not a 51% preponderance of the evidence to support the allegations that the residents are being served moldy or spoiled food.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS: Resident A utilized her wheelchair 98% of the time. The facility is not wheelchair accessible.

INVESTIGATION:
On July 8, 2025, a subsequent complaint was received, and it was alleged that Resident A utilized her wheelchair 98% of the time. The facility is not wheelchair accessible.

It should be noted that I was at the facility, prior to receiving the subsequent complaint I had already begun to address the concern that Resident A was utilizing a wheelchair in the facility even though the facility was not licensed as wheelchair accessible. Resident A was admitted into the facility on May 19, 2025.

On July 8, 2025, during the on-site investigation, it was noted that Resident A wanted a cigarette, so staff assisted her off the couch into a wheelchair and pushed her outside on the back deck to smoke. I interviewed Resident A, and the following information was reported as related to these allegations: Resident A reported that she had a fall and broke her ankle, and that she utilizes the walker in the facility and the wheelchair is for the community. She reported there were (small) portable ramps installed at both doors. Resident A also informed me that the staff assisted her with utilizing the bedside commode, as there was an incident and her knees buckled on

her, and the staff caught her. Resident A reported receiving bedside baths. Resident A reported that she can't ambulate without her walker, but that she could get to her commode and in and out of bed without staff assistance.

While I was at the facility, Ricki Turner, who has the role of Home Manager, and Ranisha Ross, who has the role of Area Supervisor, arrived at the facility. I discussed the allegations. Regarding Resident A, Ricki Turner informed me that the wheelchair for Resident A was not necessary, and it was more of a comforting thing. We also observed the portable ramp by the back door leading to the deck. It was noted that there were steps leading to the ground level. According to Ricki Turner, Resident A could ambulate up and down the (two) steps (located off the back deck) with staff assistance. Resident A is assigned 1:1 staff supervision. I requested copies of the most recent Health Care Appraisal and AFC Assessment Plan for Resident A, which were later provided.

On July 9, 2025, I interviewed Individual #1. Regarding Resident A, Individual #1 stated that she recently refused to participate in a fire drill and that it would take two staff to assist with getting her into the wheelchair. Resident A refuses to use her walker and wants to be pushed in the wheelchair. Individual #1 stated this takes direct care staff away from their assigned consumer to assist. According to Individual #1, Resident A can walk but she refuses, and the staff would try and encourage her to use her walker but most of the time, she would not use it.

On July 10, 2025, during an inspection at Umbrellex 200 (AS380418753) I made face to face contact with Robert Wilson, Administrative Staff, Ranisha Ross, Area Supervisor, and Ricki Turner Home Manager. Robert Wilson informed me that Resident A was released from the hospital and admitted into the facility last month. He informed me that Resident A utilized the wheelchair to get into the car and when she went out to smoke, or on days that she did not want to walk. I informed him that a license was required for a wheelchair to be utilized in the facility, and that the assistive devices had to be authorized by her physician. Robert Wilson contacted Damon Daniels, as this was his area of expertise. Damon Daniels provided an overview of the history leading up the placement in the facility, which included that Resident A had broken her ankle, she walked miles and got injured. She was transferred to a rehab facility and there were issues there, psychological services program contacted them and requested placement. When Resident A was in the hospital after her injury, she would just lay in bed. There was no physical therapy. According to Damon Daniels, Resident A's goals included her being mobile again. The wheelchair was in the facility when she first got admitted and the hospital promised she would have supports but they were not provided. The treatment team has met to discuss her needs, she has a new PCP, and Resident A utilizing the wheelchair is not a long-term plan. It was reported that Resident A was acting like she couldn't do things, but when they talked to her, she started moving more. With staff assistance, she can lift her leg and get over into the tub. She refuses to step into the shower; therefore, wipes are provided, and staff assist and wipe her after she has BMs.

I reviewed the Health Care Appraisal, dated April 10, 2025, (Prior to placement in the facility) for Resident A and the following was documented: Resident A is 5'5" and weighs 311 lbs. She is diagnosed with bipolar disorder and personality disorder. She was prescribed medications and had several allergies. It was also documented that her general appearance was obese and disheveled, she required a two-person assist and uses a wheelchair. Resident A is prescribed a regular diet.

Robert Wilson reported that the plan would be to get an updated HCA to reflect her current situation and remove the wheelchair from the facility. I informed Robert Wilson that any assistive device must be ordered by the physician.

I reviewed with *AFC Assessment Plan for AFC Residents* for Resident A, dated April 14, 2025, and the following was noted: Regarding moving about independently in the community, "[Resident A] is currently requiring support for transferring, and has been utilizing a wheelchair since she fell and broke her tibia. [Resident A] is overweight which also supports a two person assist." Regarding bath and personal care, it was noted that Resident A would require assistance with showering and assistance with some personal care, due to challenges with bearing weight. For walking, mobility, and stair climbing, it was documented that a two-person assist was required with transferring. Regarding the use of Assistive Devices, it was documented that Resident A uses a wheelchair, walker, and a gait belt.

I reviewed the *Behavior Treatment Plan* for Resident A. It was noted on 5/16/2025, 1:1 supervision for 16 hours a day was added to the plan, to facilitate the move to Umbrellex. In the plan, it was also documented that "[Resident A] will have 1:1 line of sight supervision for 16 hours during the day. This means she will have her own staff to support her. [Resident A's] staff will help her with personal care tasks and physical assistance in the bathroom. [Resident A's] staff do not need to watch her while she's in the bathroom. They do need to be immediately ready to help if she needs physical assistance while in her bedroom."

On August 29, 2025, Ashlee Griffes, ORR, informed me that she was not sure that Resident A was permanently utilizing the wheelchair, as she had broken her foot about a year ago in Owosso, and she (Ashlee Griffes) thought a wheelchair was used as needed then. She also thought that Resident A could not move to Jackson until she was ambulatory.

On September 2, 2025, during my on-site investigation. Staff informed me that Resident A was in the hospital as she had recently had a seizure.

On September 4, 2025, I conducted the exit conference with Bianca Wilson, Licensee Designee. We discussed the investigation and my recommendations. Bianca Wilson disagreed with the findings. She stated that Resident A was in the hospital for months, with no one getting her up, and no other places would accept her. She stated that it was part of Resident A's behaviors to not utilize her strength,

and that she didn't feel comfortable without the wheelchair. The hospital staff also warned them that Resident A would try to get away with as much as she could. Bianca Wilson stated that Resident A didn't need the wheelchair and that she could ambulate. We discussed the information documented in the *Health Care Appraisal* (HCA) and *AFC Assessment*, and she informed me that the information was incorrect. She stated that people make mistakes, and the forms were not accurate. In addition, that the forms had been updated, they were available but maybe I did not ask to see them. I informed her that Robert Wilson reported that the plan would be to get an updated HCA to reflect her current situation and remove the wheelchair from the facility. Bianca Wilson stated that the wheelchair did not need to be removed from the facility, as she utilized it in the community, and Resident A could sit in the wheelchair if she wanted. I informed her that the facility is not wheelchair accessible, and that at the time of her admission, a different setting would have been more appropriate for Resident A; as when she was admitted into the facility, it's documented that she utilized a wheelchair and required a two-person assist. I also encouraged her to be mindful of staffing ratios. Bianca Wilson stated that Resident A required one staff. We discussed the risks involved with admitting someone who required a wheelchair but the facility not being wheelchair accessible. Bianca Wilson stated she understood the risks and that was why she would never have admitted someone who could not ambulate. Bianca Wilson expressed concerns about the AFC Licensing Rules and red tape, and stated that agencies should work together to provide helpful solutions for the residents, especially when they have challenging situations. I thanked Bianca Wilson for her input. I informed Bianca Wilson that I would be requesting a written corrective action plan to address the established violation, and she could include copies of the updated forms as a part of her plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	Based upon my investigation, which consisted of an on-site investigation, interviews with facility and administrative staff, residents, and review of relevant documents, it's concluded that there is a 51% preponderance of the evidence to support the allegations that when Resident A was admitted into the facility, she required the use of a wheelchair and was utilizing the wheelchair in the facility. The facility is not licensed for wheelchair accessibility and was unable to fully meet the needs of Resident A at the time of the investigation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

09/02/2025

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

09/04/2025

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Dawn N. Timm Date
Area Manager