



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 15, 2025

Bianca Wilson
Umbrellex Behavioral Health Services, LLC
1064
335 Haggerty
Walled Lake, MI 48390

RE: License #: AS780400203
Investigation #: 2026A0577006
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.
- 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) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	2026A0577006
Complaint Receipt Date:	11/21/2025
Investigation Initiation Date:	11/24/2025
Report Due Date:	01/20/2026
Licensee Name:	Umbrellex Behavioral Health Services, LLC
Licensee Address:	Suite 255 13854 Lakeside Circle Sterling Heights, MI 48313
Licensee Telephone #:	(586) 765-4342
Licensee Designee:	Bianca Wilson
Administrator:	Bianca Wilson
Name of Facility:	Umbrellex 1
Facility Address:	1207 Devonshire CT Owosso, MI 48867
Facility Telephone #:	(586) 765-4342
Original Issuance Date:	10/07/2019
License Status:	REGULAR
Effective Date:	04/07/2024
Expiration Date:	04/06/2026
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Curtis Thigpen entered Resident A's room without permission and took Resident A's candy.	Yes
Resident A is being denied phone access.	No
Resident A is fearful of retaliation from direct care staff if a complaint is filed.	No
Resident A was not allowed to attend a community pizza party due to having a behavior.	No
Resident A eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/21/2025	Special Investigation Intake, 2026A0577006
11/24/2025	Special Investigation Initiated - Letter Via email with Andrea Andrykovich, ORR-Shiawassee Co.
11/24/2025	APS Referral
11/24/2025	Referral - Recipient Rights, Tuscola County ORR.
11/24/2025	Contact - Telephone call made, Interview with Complainant.
11/25/2025	Contact-Telephone call made, Interview with Cierra Tillis, Clinical Area Supervisor.
11/25/2025	Contact - Telephone call made, Interview with Resident A.
12/04/2025	Contact - Telephone call made, Victor Gomez, Tuscola Co ORR.
12/04/2025	Contact - Document Received Via email from Victor Gomez, Tuscola Co ORR, IR's for Resident A.
12/04/2025	Contact - Telephone call made, Interview with Guardian A1.
12/05/2025	Inspection Completed On-site
12/05/2025	Inspection Completed-BCAL Sub. Compliance
12/05/2025	Contact - Telephone call made Attempted interview with Curtis Thigpen, DCS.

12/08/2025	Exit Conference, Bianca Wilson, LD.
12/08/2025	Contact - Document Received, Cierra Tillis, Resident A's Plans requested.
12/08/2025	Contact - Document Received, Victor Gomez, TCCMH-ORR, via email PCP and BTP.
12/10/2025	Contact - Telephone call made, Interview with DCS.

ALLEGATION: Direct care staff Curtis Thigpen entered Resident A's room without permission and took Resident A's candy.

INVESTIGATION:

On November 21, 2025, a complaint was received alleging Resident A reported direct care staff (DCS) Curtis Thigpen entered Resident A's without permission bedroom and took her candy even after Resident A refused to give any to Mr. Thigpen.

On November 24, 2025, via email, I contacted Office of Recipient Rights (ORR) Officer Andrea Andrykovich from Shiawassee County Behavioral Health (SBH) and requested a copy of Resident A's *Person Centered Planned* and *Behavioral Treatment Plan* if applicable. Ms. Andrykovich reported this complaint has been sent to Victor Gomez, Tuscola County Community Mental Health Officed of Recipient Rights (TCCMH-ORR) for investigation.

On November 24, 2025, I contacted ORR Officer Victor Gomez with TCCMH who reported Resident A's *Person Centered Plan* and *Behavioral Treatment Plan* should be available to me at the facility for my review. Mr. Gomez reported he will be interviewing Resident A November 25, 2025, if I would like to do a joint interview.

On November 24, 2025, I interviewed Complainant who reported not witnessing DCS Curtis Thigpen taking Resident A's candy but was told about this by Resident A.

On December 05, 2025, I completed an unannounced onsite investigation and interviewed Resident A who reported DCS Curtis Thigpen entered Resident A's bedroom one night telling Resident A he was looking for his debit card. Resident A reported she recently had attended a Halloween Party and got a bunch of candy and DCS Thigpen asked if he could have a piece earlier in that day and was given a piece, but then asked again that evening and Resident A stated she told him "no" but he took candy from her room anyway.

On December 05, 2025, I interviewed DCS Samantha Schulte who reported she did not witness DCS Thigpen take Resident A's candy, but stated Resident A reported this happened on multiple occasions.

On December 05, 2025, I attempted to interview DCS Curtis Thigpen and left a message with no return call.

On December 05, 2025, I received an email from Anastasia Foster, Area Supervisor, reported DCS Curtis Thigpen is no longer employed with Umbrellex Behavioral Health Services, LLC due to the treatment of the residents related to entering the residents bedrooms and taking items without consent.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the evidence gathered during the investigation, it has been found DCS Curtis Thigpen did not treat Resident A with dignity and respect by entering her bedroom without permission and taking Resident A's candy even after Resident A told him "no."
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

- **Resident A is being denied phone access.**
- **Resident A is fearful of retaliation from direct care staff if a complaint is filed.**
- **Resident A was not allowed to attend a community pizza party, due to having a behavior.**

INVESTIGATION:

On November 21, 2025, a complaint was received alleging that Resident A was not allowed to use the telephone to call Recipient Rights or attend a community pizza party due to having a behavior. The complaint also alleged that Resident A is fearful of retaliation when making a recipient rights complaint.

During the interview with Complainant on November 24, 2025, Complainant reported all the allegations of the complaint are based off Resident A reporting these allegations. Complainant reported Resident A stated there are direct care staff that deny Resident A access to the phone and Resident A is fearful of retaliation if she contacts Recipient Rights. Resident A also told Complainant Resident A was not allowed to attend the community pizza party due to Resident A having a behavior.

On November 25, 2025, I interviewed Cierra Tillis, Clinical Area Supervisor, who reported the community pizza party was originally going to be held at the facility, but Resident A came to supervision and requested the party be moved to a different location and threatened to have a behavior if the party was held at the facility. Ms. Tillis reported the pizza party was moved to another facility and Resident A chose not to

attend the pizza party. Ms. Tillis reported she is not aware of Resident A wanting to call Recipient Rights and not being allowed to do make the telephone call. Ms. Tillis reported Resident A does have telephone restrictions, such as only being able to call Guardian A1 daily on Guardian A1’s lunch break unless it is an emergency. Ms. Tillis reported Resident A uses the phone as often as she would like, to include calling 911, Recipient Rights, Clinical, Therapist, Case Manager, and Adult Protective Services.

On November 25, 2025, ORR Officer Victor Gomez from TCCMH and I interviewed Resident A who reported she should be able to use the telephone when she wants and should be able to talk on the telephone by herself. Resident A would not explain why she cannot use the telephone without direct care staff assistance and reported this restriction is in her *Person Centered Plan*. Resident A did not want to talk about the concerns in the complaint and stated, “I can call Rights when I want to, and staff do not stop me.” Resident A reported she did not want to attend the pizza party, that she was offered to attend and chose not to. Resident A denied being told she cannot make a complaint to Recipient Rights. Resident A denied being fearful of retaliation by direct care staff when making a referral to the Office of Recipient Rights.

On December 08, 2025, I received copies of Resident A’s *Person Centered Plan* and *Behavioral Treatment Plan* from Victor Gomez, Tuscola County CMH ORR. Per Resident A’s PCP Addendum completed on August 18, 2025, it documented that a direct care staff will hold the phone for Resident A to assure she is kind to the person on the phone. Per the PCP, Resident A has a history of making threats while using the phone and calling 911 for nonemergency purposes. Per Resident A’s PCP, Resident A’s behavior has been reported as being unpredictable and her mood can change without notice. Resident A is not very attentive to environmental cues as well and does not consistently respond to verbal cues. Resident A will throw things when she is dis-regulated emotionally; thus, posing a potential threat to others.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	<p>(3) A licensee and staff shall respect and safeguard all of the following residents’ rights to:</p> <p>(e) Have reasonable access to a telephone for private communications, but a licensee may charge a resident for the cost of long-distance telephone calls.</p> <p>(g) Voice grievances and present recommendations pertaining to the policies, services, and facility rules without fear of retaliation.</p> <p>(i) Participate in social and community group activities of choice.</p>

ANALYSIS:	<p>Per Resident A's <i>Person Centered Plan</i>, Resident A has access to the telephone, but staff are required to dial the number and observe the conversation due to Resident A making verbal threats and making non-emergency 911 calls.</p> <p>Resident A denied the allegations of not being able to file a Recipient Rights complaint without fear of retaliation.</p> <p>Resident A also stated she was provided the opportunity to attend the community pizza party and chose not to attend the party of her own will.</p> <p>Through investigation, it has been determined licensee and staff are respecting and safeguarding Resident A's rights.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A eloped from the facility and direct care staff were not aware.

INVESTIGATION:

On December 04 , 2025, a second complaint was received alleging that on December 01, 2025, Resident A was not feeling well as Resident A was feeling dizzy and nauseated and requested to be transported to the hospital but was denied by direct care staff. The complaint reported Resident A walked to the hospital which is a mile away from the AFC facility in 18 or 19 degree temperatures. The complaint reported that Resident A walked to the hospital by herself and it is unknown if direct care staff were aware that Resident A left the facility. The complaint reported Resident A is not supposed to be in the community unsupervised.

On December 04, 2025, I spoke with ORR Officer Victor Gomez who reported he was not aware Resident A eloped from the facility on December 1, 2025. Mr. Gomez reported an *AFC Licensing Division-Incident/Accident Report (IR)* was submitted through their system reporting Resident A eloped on December 02, 2025. Mr. Gomez provided me with a copy of the IR, which was completed on December 02, 2025, by direct care staff Emmanuel Asare explaining Resident A woke up at 4:55am to use the bathroom and proceeded to run out the front door. The IR stated Mr. Asare attempted to verbally redirect Resident A, but she left the facility without permission or supervision. The IR stated a staff member was able to get to the hospital right after Resident A to provide supervision and guidance. In the "Actions Taken" section of the IR it documented that staff contacted clinical, crisis, and home manager to locate Resident A who eloped to the hospital. In the "Corrective Measures Taken" section of the IR it documented direct care staff will remind Resident A they are there for her and she can talk to them instead of eloping from the facility.

On December 04, 2025, I interviewed Guardian A1 who reported being aware that Resident A walked to the hospital on her own on December 02, 2025, because Guardian A1 reported she received a phone call from the hospital requesting permission to treat Resident A and permission was denied. Guardian A1 reported that Resident A cannot regulate her anger and when she gets mad she becomes violent or will run away. Guardian A1 reported she was told by hospital staff that Resident A arrived at the hospital on foot with no direct care staff with her. Guardian A1 reported that she contacted Kennadie Krish, Clinical Supervisor Assistant, and reported Resident A was at the hospital and could not be discharged without direct care staff at the hospital to pick her up. Guardian A1 reported Kennadie Krish reported she was not aware that Resident A had eloped from the facility, but that Ms. Krish was going to the facility immediately. Guardian A1 reported she later received a telephone call from Ms. Krish and Brandy Foster, Team Leader, that they were at the hospital to take Resident A back to the facility.

On December 05, 2025, during the onsite investigation I interviewed Resident A who reported DCS Emmanuel Asare was the only direct care staff working on December 02, 2025. Resident A reported she was not feeling well and asked DCS Asare if she could call Kennadie Krish and Resident A stated, "Emmanuel told me no, it was too early in the morning." Resident A reported DCS Asare offered Resident A medication for the upset stomach and anxiety, and Resident A declined the medication, became upset, yelled at DCS Asare, and left out the front door. Resident A reported DCS Asare asked Resident A to come back into the facility, but Resident A stated DCS Asare did not follow Resident A.

On December 05, 2025, I interviewed DCS Samantha Schulte who reported she arrived to work on December 02, 2025, around 6:00am and DCS Emmanuel Asare, DCS was working the floor by himself. DCS Schulte reported DCS Asare reported to her that Resident A eloped and he attempted to block the door to prevent Resident A from leaving, but Resident A shoved DCS Asare out of the way. DCS Schulte reported Resident A does require a 1:1 staff supervision during waking hours and while in the community. DCS Schulte reported DCS Asare called the clinical office and the crisis line and Brandy Foster, Team Leader who contacted Kennadie Krish to meet Resident A at the hospital.

On December 08, 2025, I received copies of Resident A's *Person Centered Plan* and *Behavioral Treatment Plan* from ORR Officer Victor Gomez from Tuscola County CMH. Resident A's PCP Addendum, completed on August 18, 2025, which documented that Resident A has a staff person who always remains with her to make sure she is safe. The PCP stated direct care staff are supposed to always be within arm's length of Resident A, except when she is sleeping.

On December 09, 2025, I interviewed DCS Emmanuel Asare who reported that on December 02, 2025, he was working third shift by himself when Resident A woke up around 4:00am, went to the bathroom and then went back to her bedroom. DCS Asare reported Resident A then walked out of her room, headed straight to the door, and

exited the facility. DCS Asare reported Resident A did not say anything to DCS Asare, just came out of her bedroom and headed for the door. DCS Asare reported that as Resident A was walking down the driveway, Resident A yelled she was going to the hospital. DCS Asare reported he verbally redirected Resident A, attempted to block Resident A from leaving the facility but was shoved out of the way by Resident A before she left the facility. DCS Asare reported he immediately started calling Umbrellex Behavioral Health Services Clinical Services and Crisis to come to the home for assistance. DCS Asare reported he was eventually able to reach Brandy Foster, Team Leader, who contacted Kennadie Krish, Clinical Supervisor Assistance, and both came to the facility to assist in locating Resident A. DCS Asare reported Resident A normally does not get up in the middle of the night or if Resident A does she goes back to bed with no concerns, so this was an unusual incident.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Per Resident A's PCP, Resident A has a history of elopement, but the elopements normally occur during waking hours requiring Resident A to have enhanced 1:1 staffing supervision with direct care staff being within arm's length of Resident A which was provided. Based on the information gathered during the investigation, I determined that Resident A left the facility unsupervised on the morning of December 02, 2025. This elopement occurred during early morning hours which was an abnormal occurrence and behavior for Resident A. DCS Emmanuel Asare followed protocol by attempting to block Resident A from leaving and verbally redirecting Resident A to return to the facility but could not follow Resident A as he was the only direct care staff working. DCS Asare immediately contacted Umbrellex Behavioral Health Services Clinical Services and Crisis for immediate assistance in finding Resident A. Resident A was provided supervision and protection according to her PCP during this time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

During the onsite investigation on December 05, 2025, I requested to review and receive a copy of Resident A's *Assessment Plan for AFC Residents*, *Person Centered Plan*, and *Behavioral Treatment Plan* but the only plan available in the facility for review was Resident A's *Person Centered Plan*.

I also requested copies of these same documents from Umbrellex Behavioral Health Services, LLC on December 01, 2025, December 04, 2025, and December 09, 2025, without receipt of the documents.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of the admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	During the onsite investigation on December 05, 2025, Resident A's <i>Assessment Plan for AFC Residents</i> and <i>Behavioral Treatment Plan</i> were not available for department review within the facility.
CONCLUSION:	VIOLATION ESTABLISHED

