GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 14, 2023

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

RE: License #: AS780413559
Investigation #: 2023A0584034
Umbrellex 6

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 #:	AS780413559
Investigation #:	2023A0584034
Complaint Receipt Date:	05/03/2023
Investigation Initiation Date:	05/05/2023
Report Due Date:	07/02/2023
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 6
Facility Address:	2260 M-21 Owosso, MI 48867
Facility Telephone #:	(586) 765-4362
Original Issuance Date:	12/22/2022
License Status:	REGULAR
Effective Date:	12/22/2022
Expiration Date:	06/21/2023
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is made to eat his meals in his room because the facility's dining room table is not large enough to accommodate the residents.	No
Resident A did not receive supervision and protection as indicated in his Community Mental Health Personal Care Plan.	Yes
Staff is not suitable to work, as evidenced by their drinking while at work.	No
Staff are not trained correctly to handle residents' behavioral outbursts.	No
Managers are smoking marijuana in the driveway.	No
The facility is not adequately furnished.	No
The facility does not have a vehicle for use.	No
Additional findings	Yes

III. METHODOLOGY

05/03/2023	Special Investigation Intake 2023A0584034.
05/03/2023	Contact – via telephone spoke to the home manager, Brandy Foster.
05/05/2023	Special Investigation Initiated - Email to complainant.
05/05/2023	Contact - Document emailed requesting resident register and the list of staff names and phone numbers.
05/08/2023	Contact - Document received via email from Adult protective services worker, Rebbeca Schalow, Shiawassee County.
06/08/2023	Contact - Face to Face interview with Umbrellex Staff Manager, Anastasia Birge, direct care staff Bailey Brant, conducted an onsite inspection of the home and observed Resident B.
06/26/2023	Contact - Document received via email staff information.
06/26/2023	Exit Conference via email with Bianca Wilson, Licensee Designee.
06/29/2023	Contact – Email sent to Rebecca Shalow, APS.

06/30/2023	Contact – Telephone interview of direct care staff Donovan Gerace and Justin Lawrence.
07/3/2023	Contact – Document received of Resident A's resident file.
07/05/2023	Contact – Telephone interview with Guardian A 1.
07/06/2023	Contact – Telephone interview with home manager Brandy Foster.
07/10/2023	Contact – Email received from Rebbeca Schalow, APS.

ALLEGATIONS:

- **Resident A is made to eat his meals in his room because the facility's dining room table is not large enough to accommodate the residents.**
- **Resident A did not receive supervision and protection as indicated in his Community Mental Health Personal Care Plan.**
- **Staff are not suitable to work, as evidenced by their drinking while at work.**
- **Staff are not trained correctly to handle residents' behavioral outbursts.**
- **Managers are smoking marijuana in the driveway.**
- **The facility is not adequately furnished.**
- **The facility does not have a vehicle for use.**

INVESTIGATION:

On 5/03/2023 and 05/05/2023, the Bureau of Community and Health Systems (BCHS) received the above allegations via the BCHS online complaint system. The written complaint indicated that on 5/02/2023, despite requiring "one on one supervision" at all times, Resident A drank laundry soap and then eloped from the facility.

On 5/8/2023, via email, I received the following documentation from Adult Protective Services Specialist Rebbeca Shalow regarding her recent interviews with Resident A, Guardian A 1, and facility staff members about the allegations, as well as regarding her observation of the facility:

Interview with Resident A:

"He said he did see the one staff member drink though doesn't know what happened to him. He does not want to be at this facility. He has called 911 many times in the last few weeks for self-harming behaviors and because of staff behaviors. He denied that he has ever burned or attempted to burn himself. He advised he took a sip of laundry soap, that he poured it into the laundry cup and took a sip, that staff was right there and took the cup from him as soon as he put it down, that it tasted "like shit" and he didn't attempt to drink anymore. [Resident A] advised he talks with his guardian regularly and tells her of his concerns. [Resident A] advised he eats in his room because he wants to and denied that he has ever been told that he can't eat in the kitchen or dining area".

Interview with home manager Brandy Foster:

"[Resident A] has had self-harming behaviors and threats that have increased significantly in the last 2 weeks. They have been having 2 staff all day, even at night due to the increased behaviors. [Resident A] is also trying to get staff fired and has advised he does not want to be at the facility any longer. She advised he called 911 on worker Brandon Caldwell and advised that he was drinking on the job. She knows police responded but did not know the outcome and advised the other manager Anastasia would know more details. She advised [Resident A] is not on a 1:1, that he has an assigned staff member for every shift and that worker must be within "ear shot" from him and be able to hear if he yells. She advised it has been this way since he joined their facility and that he is allowed to have private time in his room with no staff. She doesn't know where guardian got the idea that he is on a 1:1. She advised stove handles were removed because [Resident A] made threats that he would turn the stove on and touch the burner to self-harm. She advised laundry soap is now locked up since the incident, that it has never been a problem before, and that staff were present and took the laundry soap as soon as it happened. She advised that the guardian has just recently asked that she be contacted when [Resident A] calls 911, that prior to this she had never been asked to be contacted. She agreed to contact guardian to clarify the 1:1 situation for [Resident A] and rectify where the misunderstanding is".

Observance of home:

"Laundry soap and all other cleaning supplies were locked in a room off the laundry room. Stove knobs were removed. There was a table big enough to seat 4, there are only 2 residents in the home. There is a futon style couch and enclosed TV in the living room area which does not present concern with the number of clients. [Resident A] also has a TV in his room, the room of the other resident was not observed. There were many frozen meals but there was also ample food in the refrigerator. Staff advised that [Resident A] likes to cook his own meals and that he uses the microwave, stove, and oven to do this. Two vehicles observed at the facility with flat tires, and one appeared to have been wrecked also. Staff Deasia [no longer

employed] advised that if they need a vehicle, that they borrow one from the other Umbrellex homes, that she doesn't know if they plan to fix the vehicles".

Interview with Guardian: [Guardian A 1]

"She advised she has asked that [Resident A] be relocated to a different location. She reports that [Resident A] told her that he is not allowed to eat in the dining room and must eat in his room. She advised [Resident A] calls her often, sometimes multiple times in a day. She denied that she has heard anything from the staff since APS has been involved despite manager Brandy agreeing to reach out to her to clarify the 1:1 status. She advised that [Resident A] has not been happy in a group home yet that he has been placed in, and that it is common for him to have these self-harming behaviors and threats. That she has tried to get his case manager to increase therapy sessions and ensure they are done in person though has had no success. She has even asked that [Resident A] be put in a facility that is much more stringent on rules, behaviors, and routine, in hopes that when transitioned back to a normal AFC that he would be more appreciative of what he has but was not able to make this happen either".

On 6/8/2023 I conducted an unannounced investigation at the facility and found that there was no alcohol present on the property. I did not witness any staff members, including managers, smoking marijuana or drinking alcohol nor did I observe any evidence of individuals engaging in these activities.

Resident A had already moved out of the home and relocated to another facility located in different county. Subsequently, he was not available to be interviewed.

The facility was observed to be very clean. The bedrooms have the required twin bed, dresser, mirror, and chair, which all appeared to be in good condition. The living room has a couch and an end table with a television mounted on the wall. The dining area table is large enough to accommodate all of the residents.

I observed Resident B, who appeared well groomed. Resident B stated he had just moved into the facility and he liked his room.

I interviewed home manager Anastasia Birge. Ms. Birge stated that on 5/02/2023, she was alerted that police were investigating a staff member who reportedly drank alcohol while on the job. Ms. Birge stated she spoke with and observed the staff member Brandon Caldwell and he did not appear to be under the influence of alcohol. Ms. Birge stated she searched the entire facility and found no evidence of alcohol on the premises. Ms. Birge stated the police confirmed that Mr. Caldwell had alcohol detected in his blood test. Ms. Birge stated Mr. Caldwell told her and the police he was heavily drinking in the early morning hours before his afternoon shift and denied being intoxicated and/or drinking while he was on the job. Ms. Birge stated the police searched Mr. Caldwell's vehicle and found no evidence of alcohol containers present. Ms. Birge stated Mr. Caldwell was relieved of his duties

immediately, and subsequently, his employment was terminated because of having alcohol found in his system while working. Ms. Birge stated the vehicle assigned to this facility was in an accident. However, the facility has access to other vehicles to use for planned appointments and resident outings, as well as the ability to use emergency services when needed.

I interviewed home manager Bailey Brant, who stated she did not have any personal knowledge of the allegations involving Resident A. Ms. Brant also denied having any knowledge of staff using alcohol or marijuana at the facility.

On 6/28/2023, via email, Umbrellex training manager Joi Mitchell provided written confirmation that all current facility employees completed training on non-aversive techniques for the prevention and treatment of challenging behaviors of residents through the Shiawassee Health and Wellness Recipient Rights' Office.

I received a telephone call from the facility's Human Resources Administrator Katrina Love. Ms. Love stated that in early April, she had a conversation with an employee who was being terminated for attendance issues. At that time, the employee mentioned that staff were smoking marijuana at the facility. Ms. Love stated she asked the employee if she had witnessed this activity and if she could provide the names the employees who were smoking marijuana. According to Ms. Love, the employee said she did not witness the allegation personally and had only heard of it secondhand. Subsequently, the employee had no names to provide to Ms. Love. Ms. Love stated she asked the employee why she didn't report the allegation immediately to her direct supervisor, as well as to the appropriate Recipient Rights Office, and the employee was unable to answer this question.

On 6/29/2023, I interviewed Shiawassee Health and Wellness Recipient Rights Director Andrea Andrykovich. Ms. Andrykovich confirmed their agency trains Umbrellex staff on behavior intervention techniques and the licensee is prompt with training all new employees.

On 6/30/2023, I conducted a telephone interview with direct care staff members Donovan Gerace and Justin Lawrence. Both Mr. Gerace and Mr. Lawrence stated they had no knowledge of Resident A drinking laundry soap, eloping from the facility, and being told to eat in his room. They both stated they were aware that he required "one on one supervision" per his Community Mental Health Personal Care Plan (PCP). Both Mr. Gerace and Mr. Lawrence confirmed they were trained upon their hire on behavior intervention techniques. They also reported not witnessing any staff members using alcohol or marijuana at the facility.

On 7/3/2023, I reviewed Resident A's PCP, last updated on 11/2022, where it documented staff are to provide "one to one eyesight monitoring" to Resident A at all times when he is not inside his room. I reviewed transportation documentation that outlined transportation was to be provided to Resident A for appointments and arranged outings as needed, with no additional exceptions or costs noted.

On 7/5/2023, I conducted a telephone interview with Guardian A 1. Guardian A 1 stated she never received any reports of Resident A drinking, or attempting to drink, laundry soap or eloping from the facility on 05/02/2023 directly from facility staff members. Guardian A 1 stated she heard about the incident from Resident A after it occurred. Guardian A 1 stated that Resident A informed her that on 5/02/2023 the police discovered him across the street from the facility and that he had contacted the police himself to get a ride to the hospital after ingesting a sip of laundry soap. Guardian A 1 stated she had a conversation with Ms. Foster who told her she would check Resident A's PCP to see if it included "one to one eyesight monitoring". According to Guardian A 1, Ms. Foster believed Resident A only required staff members to be within "earshot" of him. Guardian A 1 stated that Resident A told her that he felt he had to eat in his room because the staff would sit at the dining room table with their laptops and he had no place to set his food. Guardian A 1 felt there was no communication or reporting of incidents to her regarding Resident A by facility staff and she had no knowledge of any other incidents involving Resident A. Guardian A 1 had no concerns about the facility's transportation for Resident A, nor did she report any concerns regarding staff members alleged use of alcohol and/or marijuana while working at the facility.

On 7/6/2023, I conducted a telephone interview with Ms. Foster, who stated that on 5/2/2023 it was reported to her by a former employee that Resident A grabbed the lid of the laundry soap, tasted it, and put it back while staff was standing right next to him. Ms. Foster stated that she had no firsthand knowledge of staff forcing Resident A to eat in his room and that she has never witnessed any staff members smoking marijuana and/or drinking alcohol while at the facility. Ms. Foster confirmed she had a conversation with Guardian A 1 regarding Resident A's PCP and confirmed that it was her understanding staff members were only required to be within "earshot" of Resident A, as opposed to providing "one to one supervision" to Resident A while he was not in his room.

On 7/10/2023 I received the following documentation from Ms. Schalow, APS:

"*This case will be closed without a substantiation for neglect of [Resident A] by Umbrellax[sic] Homes".*

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 interviews with multiple facility staff members, APS, and Guardian A 1, it has

	been established that there was not enough evidence that Resident A was violated by being forced to eat in his room by staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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 multiple facility staff members, APS, and Guardian A 1, it has been established that according to Resident A's PCP, Resident A required "one on one supervision" at all times when he was not in his bedroom. Based upon evidence collected during my investigation, it has been determined some staff members interviewed were not aware that Resident A required this level of supervision. In addition to this, there is enough evidence to confirm that on 5/2/2023, Resident A took a sip of laundry soap and then eloped from the facility. Subsequently, it has been establish that Resident A did not receive supervision and protection as indicated in his PCP.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**

ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, as well as an inspection of the facility, there is no evidence that any staff members, including managers, are smoking marijuana at this facility. It was established that Brandon Caldwell did have alcohol detected in a blood test while he was working, and subsequently, he was terminated. However, there is no way to determine when Mr. Caldwell consumed this alcohol. According to an interview with home manager Anastasia Birge, prior to taking a blood test, Mr. Caldwell did not appear to be under the influence of alcohol. Ms. Birge stated that once learning of the allegation, she immediately searched the entire facility and found no evidence of alcohol on the premises at the time Mr. Caldwell was working. According to Ms. Birge, also during the time Mr. Caldwell was working, police searched Mr. Caldwell's vehicle and found no evidence of alcohol containers present. Subsequently, there is not enough evidence to substantiate the allegation that any staff members, including Mr. Caldwell, were drinking and/or under the influence of alcohol while working at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas: **(h) Non-aversive techniques for the prevention and treatment of challenging behavior of clients.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, Shiawassee Health and Wellness Recipient Rights Director Andrea Andrykovich, APS Specialist Rebecca Schalow, and Guardian A 1, there is no evidence to substantiate the allegation that staff are not trained correctly to handle residents' behavioral issues. The licensee provided the

	department adequate verification that current facility staff members have been trained on non-aversive techniques for the prevention and treatment of challenging behaviors of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14405	**Living space.**
	(8) A home shall have dining space that can accommodate all residents of the home at the same time.
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members and APS Specialist Rebecca Schalow, as well as a visual inspection of the property, there is no evidence to substantiate the allegation the facility's dining room table is not big enough to accommodate the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(1) The bedroom furnishings in each bedroom shall include all of the following: **(a) An adequate closet or wardrobe.** **(b) Lighting that is sufficient for reading and other resident activities.** **(c) A bureau or dresser or equivalent.** **(d) At least 1 chair.**
ANALYSIS:	Based upon my investigation, which included a visual inspection of the property, there is no evidence to substantiate the allegation the facility is not adequately furnished.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members, APS Specialist Rebecca Schalow, and review of the signed admission paperwork in Resident A's file, while it was established the facility's vehicle was currently unavailable due to an accident, it has been established that other transportation was available to the residents of this facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 7/3/2023, I reviewed the contents of Resident A's record, and found no written incident report regarding Resident A drinking laundry soap and eloping from the facility on 5/02/2023.

During my interview with Guardian A 1 on 7/5/2023, she stated she did not receive any reports of Resident A drinking laundry soap or eloping from the facility on 5/02/2023 from facility staff members. Guardian A 1 stated she heard about the incident from Resident A after it occurred.

R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible

	agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.** **(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.**
ANALYSIS:	Based upon my investigation, which included a review of Resident A's facility record and an interview with Guardian A1, it has been established that facility staff members did not contact Guardian A 1 via telephone to report that on 5/02/2023, Resident A took a sip of laundry soap and eloped from the facility. It has also been established that a written report regarding this incident was not completed and maintained in Resident A's record.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/26/2023, an exit conference was conducted via email with licensee designee Bianca Wilson notifying her of the findings of the investigation.

IV. RECOMMENDATION

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

7/14/2023

Candace Coburn — Date
Licensing Consultant

Approved By:

7/14/2023

Michele Streeter — Date
Area Manager