GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 22, 2026

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

RE: License #: AS780413559
Investigation #: 2026A1033028
Umbrellex 6

Dear Ms. Wilson:

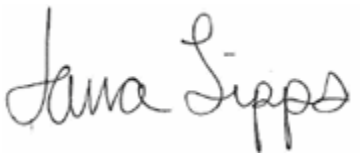
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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,



Jana Lipps, 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 #:	2026A1033028
Complaint Receipt Date:	04/03/2026
Investigation Initiation Date:	04/08/2026
Report Due Date:	06/02/2026
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:	06/22/2025
Expiration Date:	06/21/2027
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION:

	Violation Established?
Resident A did not receive his pain medication in a timely manner because there was not a direct care staff trained in medication administration available at the facility at the time he requested the medication.	Yes

III. METHODOLOGY

04/03/2026	Special Investigation Intake 2026A1033028
04/03/2026	Contact - Document Sent- Email correspondence sent to Angela Wend, Recipient Rights Advisor with Central Michigan Community Mental Health.
04/08/2026	Special Investigation Initiated – Telephone- Interview conducted with Central Michigan Community Mental Health, Office of Recipient Rights Advisor, Keegan Sarkar.
04/08/2026	Inspection Completed On-site- Interviews conducted with Resident A, direct care staff, Amadeaus Foster & Chris Thomas. Review of resident medication lists initiated.
04/08/2026	Contact - Document Sent- Email correspondence sent to licensee designee, Bianca Wilson, requesting MARs for March 2026 for all current residents and the staff schedule for March 2026.
04/08/2026	Contact - Document Sent- Email correspondence sent to CMCMH, Keegan Sarkar.
04/09/2026	Contact - Document Received- Email correspondence received from direct care staff, Anastasia Foster, including direct care staff schedule.
04/14/2026	Contact - Document Received- Email correspondence received from direct care staff, Cierra Tillis, including resident MARs.
04/14/2026	Contact - Document Received- Email correspondence received from direct care staff, Anastasia Foster, including direct care staff telephone numbers.

04/16/2026	Contact - Document Received- Email correspondence received from Compliance Specialist 1, Andrea Perry, including direct care staff training records.
04/20/2026	Contact - Telephone call made- Interview conducted with direct care staff, Laquavis Stitt, via telephone.
04/21/2026	Inspection Completed-BCAL Sub. Compliance
04/21/2026	APS Referral- No current suspicion of abuse, neglect, exploitation.
04/22/2026	Exit Conference Conducted via telephone with licensee designee, Bianca Wilson.

ALLEGATION: Resident A did not receive his pain medication in a timely manner because there was not a direct care staff trained in medication administration available at the facility at the time he requested the medication.

INVESTIGATION:

On 4/3/26 I received an online complaint regarding Umbrellex 6, adult foster care facility (the facility). The complaint alleged that on 3/31/26 at 3:13pm, Resident A called the Central Michigan Community Mental Health, Office of Recipient Rights, to report that he had not yet received his 2pm pain medications. The complaint noted that Resident A has rib pain from an injury he sustained following a seizure. The complaint reported that Recipient Rights Advisor, Angela Wend, spoke with direct care staff, Laquavis Stitt, regarding the allegation. The complaint reported that Mr. Stitt identified that he and the other direct care staff, Troy Spaulding, were the only two direct care staff at the facility at the time and neither of them were trained in medication administration and could not administer Resident A's medication. The complaint identified that Mr. Stitt stated he had called the "on-call clinical" number at 2:15pm and spoken with Kennadie Krish regarding getting a direct care staff trained in medication administration to come to the facility and administer Resident A's pain medication. Mr. Stitt reported that as of 3:13pm a direct care staff member had yet to administer Resident A's pain medication.

On 4/8/26 I had email correspondence with Central Michigan Community Mental Health, Office of Recipient Rights Advisor, Keegan Sarkar. Ms. Sarkar reported that she had additional information that after the initial telephone conversation Ms. Wend had with Resident A and Mr. Stitt, Resident A did return a telephone call to Ms. Wend around 4:30pm on 3/31/26 and noted that the home manager had come in and administered his medication.

On 4/8/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Resident A regarding the allegation. Resident A reported that he experienced a seizure a couple of weeks prior and fell out of his bed, causing a fracture

to his ribs. He reported that he takes pain medication for this injury which includes Tylenol and a narcotic. Resident A could not recall the name of the narcotic. Resident A reported that frequently there are times when there is not a direct care staff trained in medication administration available when he needs his medication. He reported, “They need someone who can do meds 24/7.” Resident A further reported that third shift is more likely to not have a direct care staff trained in medication administration than any of the other shifts. Resident A reported that he could not recall the exact date, but he did recall needing his pain medication and having to contact the Office of Recipient Rights (ORR) to intervene because there was not a direct care staff member trained in medication administration on-site when he required his medication.

During the on-site investigation on 4/8/26 I interviewed direct care staff, Chris Thomas. Mr. Thomas was the only direct care staff member at the facility when I arrived. Mr. Thomas reported that he has not yet completed his medication administration training as he has only been employed by the licensee for about one month. Mr. Thomas reported that today he was scheduled to work his shift with direct care staff, Amadeaus Foster. He reported that Mr. Foster is trained in medication administration but was away from the facility as he took Resident B on an outing. Mr. Thomas reported that he did not have access to resident medications while Mr. Foster was on the outing. Mr. Thomas was caring for Resident A and Resident C when I arrived on-site.

During the on-site investigation on 4/8/26 I interviewed Mr. Foster regarding the allegation. Mr. Foster arrived at the facility about ten minutes after I arrived on-site. Mr. Foster reported that he has been trained in medication administration and was the scheduled medication passer on this date for the shift he was working. Mr. Foster reported that there is “usually” a direct care staff member trained in medication administration scheduled for each shift. He reported that the protocol is if there is not a direct care staff trained in medication administration scheduled, then the direct care staff members are instructed to call the “clinical line” and speak with Ms. Krish about getting someone sent to the facility to administer medications. Mr. Foster reported that he is unsure where Ms. Krish’s location is or how long it takes for a medication trained direct care staff member to be sent to the facility to administer medications in this scenario. Mr. Foster reported that he is unaware of an issue with Resident A’s medications not being administered as whenever he works he administers medications and he ensures this occurs on his shifts.

On 4/9/26 I received email correspondence from direct care staff, Anastasia Foster. Ms. Foster provided the direct care staff schedule for the month of March 2026 for the facility. This information identified that on “2nd Shift” Mr. Stitt and Mr. Spaulding were scheduled together at the facility.

On 4/14/26 I received email correspondence from direct care staff, Cierra Tillis. This correspondence contained Medication Administration Records (MARs) for Resident A, Resident B, and Resident C. I observed the following information:

- Resident A is prescribed six “As Needed” medications. Three of these medications are for symptoms of pain. The MAR identifies on 3/31/26, Mr. Foster

administered Hydrocodone APAP 5-325MG and Lidocaine Pad 5%. The MAR does not identify what time of day these medications were administered to Resident A by Mr. Foster.

- Resident B is prescribed three “As Needed” medications. Two of these medications are prescribed for agitation and mood.
- Resident C is prescribed five “As Needed” medications. Two of these medications are prescribed for anxiety or agitation and one is prescribed for pain relief.

On 4/14/26 I responded to an email correspondence including Ms. Tillis, Ms. Foster, licensee designee, Bianca Wilson, and Damon Daniels (role not identified to this consultant). I inquired how the direct care staff know when an “As Needed” medication has been administered as the MARs did not reflect times of day “As Needed” medications were administered. I did not receive a response to this inquiry.

On 4/16/26 I received an email from Andrea Perry with the facility. She provided the requested direct care staff training records for Mr. Stitt and Mr. Spaulding. I observed the following information:

- Medication Administration Training completed for Mr. Stitt on 4/8/26 and Mr. Spaulding on 4/22/26.

On 4/20/26 I interviewed direct care staff, Laquavis Stitt, via telephone regarding the allegation. Mr. Stitt reported that he has worked at the facility for just over a month. He reported that he has received medication administration training and noted he completed this training on 4/8/26. Mr. Stitt reported that he is still not administering medications independently as there is a process to complete where a trained direct care staff member must shadow him and sign off on his ability to administer medications correctly seven times before he is cleared to administer medications independently. Mr. Stitt reported that he is usually paired with another direct care staff member who is trained in medication administration when he works at the facility. He reported that there are times when he is paired with someone else who is not trained in medication administration procedures. He reported that in this instance the procedure is to call “clinical” and whoever answers this telephone line will send a direct care staff member to the facility who is trained in medication administration. He reported that this person will then administer resident medications. Mr. Stitt reported that it is usually around a 30 minute period between speaking with the “clinical” line and someone arriving to administer medications. He reported that this individual does not stay on shift, they simply administer the required medications and leave the facility.

Mr. Stitt reported that on 3/31/26 he was working at the facility with Mr. Spaulding. He reported that neither he nor Mr. Spaulding had been trained in medication administration. Mr. Stitt reported that his shift started at 2pm on this date and he called “clinical” to let them know a direct care staff trained in medication administration was not available on-site. Mr. Stitt reported that around 5pm Resident A approached him and reported that he had a “PRN” medication for pain that was supposed to be administered around 6pm that evening. Mr. Stitt reported that he instructed Resident A that a trained

direct care staff member was on their way to administer his medications. Mr. Stitt reported that Resident A then called ORR and reported the situation as he was upset about not receiving his medications. Mr. Stitt reported that he spoke with the ORR representative (name he could not recall). Mr. Stitt reported that the ORR advisor asked him to contact her as soon as the medication had been administered. Mr. Stitt reported that a direct care staff member trained in medication administration arrived at the facility around 7:15pm to administer the medications. Mr. Stitt reported that he first called "Clinical" around 2:15pm reporting a direct care staff member trained in medication administration was not available on-site, Resident A requested his pain medication around 5pm, and a direct care staff member did not administer his medication until after 7:15pm. Mr. Stitt reported that he did not recall the name of the direct care staff member who arrived to administer Resident A's pain medication. Mr. Stitt reported that he did not return a call to ORR as he believed the direct care staff member who administered the medication completed this task.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based upon the interviews conducted and documentation reviewed it can be determined that on 3/31/26 the facility was staffed with two direct care staff members on second shift who were not trained in medication administration. There was no available direct care staff, on-site, who was trained in medication administration. On this shift, Resident A requested his “As Needed” pain medication and could not receive this medication for several hours due to the lack of availability of a trained direct care staff member who could administer the medication. Ms. Wend was called on this date and Mr. Stitt confirmed that neither he nor Mr. Spaulding were able to administer Resident A’s requested medication. Upon reviewing the resident MARs I identified that each of the three residents has “As Needed” medications ordered on their medication profiles. Several of these medications are ordered for pain relief, agitation, and/or anxiety. Due to the presence of “As Needed” medications for these three residents, this facility must be staffed continuously with a direct care staff member trained in medication administration. The residents should not have to wait for a telephone call to be made to “Clinical” for an on-call medication administration. The residents should be able to rely on immediate availability and administration of their “As Needed” prescription medications. Therefore, a violation is being established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**

ANALYSIS:	Based upon the interviews conducted and documentation reviewed it can be determined that both Mr. Stitt and Mr. Spaulding were scheduled to work on 3/31/26 and neither had completed medication administration training prior to being scheduled on this date. The two individuals were not scheduled with another direct care staff member trained in medication administration and therefore could not administer required medications for Resident A. The training records provided for Mr. Stitt and Mr. Spaulding indicate that they received their medication administration training, after 3/31/26, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

4/21/26

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Jana Lipps Date
Licensing Consultant

Approved By:

04/22/2026

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Dawn N. Timm Date
Area Manager