GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 17, 2026

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

RE: License #: AS780404958
Investigation #: 2026A0622044
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) 335-5985.

Sincerely,

Amanda Blasius, 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 #:	2026A0622044
Complaint Receipt Date:	05/24/2026
Investigation Initiation Date:	05/26/2026
Report Due Date:	07/23/2026
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 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:	02/21/2025
Expiration Date:	02/20/2027
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Owosso police department responds to multiple trouble calls per week regarding Resident A. On 5/22/2026, Officers were dispatched to 805 E. King St. on four separate occasions, due to Resident A's assaultive behavior and the employees being unable to control her. On 5/23/2026, Resident A was arrested for assaulting an employee.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/24/2026	Special Investigation Intake 2026A0622044
05/26/2026	Special Investigation Initiated – Telephone and email to complainant.
06/01/2026	Contact – FOIA Request completed. Police reports received
06/24/2026	Inspection Completed On-site
07/01/2026	Contact- documents received.
07/06/2026	Inspection Completed-BCAL Sub. Compliance
07/09/2026	Contact- phone calls to direct care workers, Dallesha Chesnut, Demetrius Smoots, Arizona Jones, Damon Daniels, Kennadie Krish, Guardian A1, Case worker Shannon Diebel. Documentation received.
07/13/2026	Contact- phone calls to direct care workers, Kennadie Krsih, Christopher Thomas and Alexander Braden.
07/14/2026	APS referral was made through police department. APS is also investigating.
07/15/2026	Exit conference with licensee designee, Bianca Wilson

ALLEGATION: Owosso police department responds to multiple trouble calls per week regarding Resident A. On 5/22/2026, Officers were dispatched to 805 E. King St. on four separate occasions, due to Resident A's assaultive behavior and the employees being unable to control her. On 5/23/2026, Resident A was arrested for assaulting an employee.

INVESTIGATION:
On 05/24/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Owosso police department responds to multiple trouble calls per week regarding Resident A. On 5/22/2026, Officers were dispatched to 805 E. King St. on four separate occasions, due to Resident A's assaultive behavior and direct care staff being unable to control her. On 5/23/2026, Resident A was arrested for assaulting a direct care staff. The complaint stated that if this continues the company will be charged with disorderly place per Owosso City Ordinance.

On 05/26/2026, I completed a phone call and sent an email to Complainant listed to gather additional information.

On 06/01/2026, I completed a FOIA request and received documents related to Resident A and reviewed all police reports received. I viewed the police report from 5/22/2026 about the allegation.

I received two police reports dated 5/22/2026. The two are summarized below:

- *On 05/22/2026, officers responded several times to the AFC home for Resident A assaulting staff members. On 5/22/2026, staff members did not want to press charges for the incidents. The assaults continued over several hours. Resident A then started assaults again on 5/23/26 and Demetruis Smoots reported that he wanted to press charges. On 5/23/2026 at 3:11pm, police were dispatched to the AFC home due to a call from the caretaker, Demetruis Smoots called 911 and stated that he was walking with Resident A and she has been punching, kicking and slapping staff members. The police officer located them walking and went to talk with Resident A. She started running down another street. Another officer pulled up to talk with Resident A. Mr. Smoots was interviewed regarding the incident. Smoots stated that Resident A was punching and slapping him at the home. Resident A left on foot and he followed her. Resident A was walking into traffic, and Smoots was trying to get her out of the road and she continued to hit him several more times. Demetruis Smoots reported that he wanted to press charges. Resident A was arrested and lodged at the jail.*
- *On 05/22/2026, officers received a call at 6:50pm from staff member, Dallesha who works at Umbrellex 2. She stated that Resident A charged her when she entered the door. She stated that Resident A hit and kicked her and then left the residence. A staff member was following Resident A*

and they were downtown. Dallesha informed the officer that they were all set and did not need assistance.

Additional police reports were received about Resident A at Umbrellex 2.

The police report dated 4/23/26 is summarized below:
On 04/23/2026 at 3:52pm, an officer was dispatched to the AFC home in reference to trouble with Resident A. Upon arrival, Resident A had eloped and was armed with a sharp piece of plastic. Police located Resident A walking towards a playground full of kids on school property. Officers were able to detain Resident A before she reached the school and transported her back to the AFC per staff's request.

The police report dated 6/01/26 is summarized below:
On 06/01/2026, at 6:49pm, an officer was dispatched to the home as Resident A was assaulting staff. During interviews with direct care workers on shift, they reported that Resident A was throwing gravel and rocks at staff, but neither were injured. Resident A was attempting to elope from the home and also made suicidal statements as she attempted to jump in front of three moving vehicles. Resident A was transported to the hospital for suicidal statements.

The police report dated 6/02/26 is summarized below:
On 06/02/2026, at 5pm, an officer responded to a 911 call from Resident A. She reported that staff would not allow her to use the bathroom. An officer arrived and made contact with Resident A. Staff informed the officer that they needed to check the bathroom first to confirm that there were no sharp objects before Resident A entered. Resident A used the bathroom without incident and the officer left.

The police report dated 6/03/26 is summarized below:
On 06/03/2026 at 8:15pm an officer arrived at the AFC due to a call from a direct care worker, Aleesha Kelly stating that she would need assistance from the police soon in regard to Resident A. Resident A was walking around outside and the police officer asked her to go inside to calm down. Resident A refused. Another call was taken by the officer. When the officers arrived they interviewed Resident A and DCW Kelly. Resident A asked questions about being on probation and requested to go to the hospital for anxiety and suicidal thoughts. Resident A then attempted to run away from the home. An officer caught up with her and she was uncooperative. Resident A was placed her in a patrol car. Resident A was transported back to her bedroom at the AFC home and her handcuffs were removed. Resident A attempted to elope out her bedroom window and the officers stopped her. They were unable to calm her down and she became aggressive. She punched both officers in the shoulders. Resident A was arrested and taken to the local jail.

The police report dated 6/10/26 is summarized below:
On 06/10/2026 at 5:25pm, officers were dispatched to the AFC for trouble with Resident A. Officers found them at a corner near the home. When they arrived, staff informed them they were switching shifts and everything was fine.

The police report dated 6/11/26 is summarized below:
On 06/11/2026 at 5:07pm, officers were dispatched the AFC due to Resident A wanting to her hurt herself with a stick. The officer approached Resident A and asked her to hand him the stick. Resident A ran into the house into her bedroom and locked the door. Before staff could find the correct key, Resident A opened the door. The police officer asked Resident A if she wanted to kill herself and she stated yes. The officer asked her if she wanted to be transported to the hospital by ambulance or police car and she stated a patrol car. Resident A stated to the police officer that if they don't complete a petition, they will just discharge her. The police officer asked her how she planned to kill herself and she stated stab herself with a stick. The officer filled out a petition for hospitalization and left Resident A at the hospital.

The police report dated 6/12/26 is summarized below:
On 06/12/2026 at 6:44pm, an officer responded to the AFC for a suicidal resident. Typically, Resident A calls 911 stating she is suicidal as she wants out of the house and wants to stay at the stress unit at the hospital. Resident A stated that she was suicidal as no one liked her. The officer talked with her and asked staff if everything was under control. Staff advised yes, and the officer left.

The police report dated 6/14/26 is summarized below:
On 06/14/2026 at 7:39pm, an officer was dispatched to the AFC home as Resident A called because she was suicidal. Resident A stated that she was trying to strangle herself and refused to stop. On the phone she also stated that she locked herself in the bathroom and would refuse to open the door for police. Upon arrival, the officer met with staff who were unaware of the situation. The officer went to the bathroom and advised Resident A to open the door. Upon opening the door, the officer found Resident A with a hair tie around her neck trying to strangle herself. The officer removed the hair tie from her neck. The officer transported Resident A to the hospital and completed a petition for her to be hospitalized.

The police report dated 6/20/26 is summarized below:
On 06/20/2026 at 3:05pm, an officer was dispatched to the AFC home for a suicidal resident. Resident A had cut herself with a pair of scissors and was suicidal. Upon arrival Resident A was sitting outside with staff and the scissors had been put away. The officer observed a wound on her left hand, which was a small scratch and no bleeding. The officer asked why Resident A did this to herself and she stated that nobody here one cares about her. The officer asked

Resident A if she wanted to go to the hospital and she reported yes. The officer transported Resident A to the hospital without incident. The report stated that since 5/8/26, the police department has responded to the home for Resident A 16 times.

The police report dated 06/21/26 is summarized below:
On 06/21/2026 at 7:57am, an officer was dispatched to the AFC for Resident A being suicidal. Dispatched advised that Resident A had a pair of scissors again and was suicidal. Upon arrival, Resident A was outside the home and still had a hold of the scissors. The officer was eventually able to convivence Resident A to put the scissors on the ground. Officer transported Resident A to the hospital without incident.

According to the *Resident Register* received, Resident A moved into the home on 1/12/2026. According to police records received, the police responded to the home for Resident A once in January, six times in February, one time in March, five times in April, five times in May and nine times in June from 6/1/26-6/24/26 for various reasons including elopement, assault of others, danger to self and unable to control behavior.

I requested documentation for Resident A and received incident reports and some progress notes. I requested an incident report for 5/22/2026. I received an *AFC Licensing Division Incident/Accident Report* (IR) dated 05/20/2026 at 7pm but was signed by managers on 5/22/2026. According to the IR, Resident A was touching and getting in staff's face. After being prompted for personal space, Resident A started getting physically aggressive and hitting staff. Due to the physical aggression Resident A was placed in a CPI hold for seven minutes from 7:04pm-7:11pm before police arrived due to the other staff member calling the police. When Resident A heard the police were coming, she eloped from the home. Upon returning to the home, she started punching staff in the back. According to IR, in the action taken section it noted direct care staff put Resident A into a CPI hold and called the police and clinical team. Staff followed Resident A while she eloped. Police escorted Resident A back to the home.

I received an *AFC licensing division incident/accident report* dated 04/23/2026 at 2:30pm. The IR stated that Resident A returned from an outing and saw staff. She told them she was triggered and ran to her room and locked the door. Staff were able to unlock the door and Resident A came out and started pushing staff. In the action taken section of the IR, it noted direct care staff followed Resident A as she ran out the door. While running the staff's phone hit the emergency button, therefore the police heard everything. Staff also called clinical to inform them of the incident.

I received an *AFC licensing division incident/accident report* dated 6/01/2026 at 2:43pm. The IR stated that Resident A started exhibiting behaviors after staff prompted her to take her medications. Without verbalizing any concerns, Resident A eloped from the home, then very shortly after returning she asked to go to Dollar Tree. At the very start of the walk, Resident A stated that she lied and was eloping. Staff maintained visual supervision and told Resident A that if she came back to the home and took her

medications, staff would assist her with cleaning her room like she wanted. In the action taken section of the IR, it documented that direct care staff maintained supervision during elopements, staff told Resident A that taking her medications would help, staff attempted deescalation techniques when Resident A made suicidal attempts and performed behaviors. Staff also told Resident A the consequences if she continues and escalates her behavior. Resident A called 911 and was transported to the hospital. Guardian A1 denied admission and Resident A was sent back to the home.

I received an *AFC licensing division incident/accident report* dated 06/11/2026 at 5pm. The IR stated that staff and Resident A were sitting on the couch watching TV when she asked for medication for a blister on her foot. When staff was in the medication room preparing the medication, Resident A took the phone and called 911. Staff waited for the police to arrive and then the staff member went with Resident A to the hospital.

I received an *AFC licensing division incident/accident report* dated 06/14/2026 at 6:14pm. The IR stated that Resident A needed to use the bathroom. When client went to restroom, staff went around the back of the house to make sure Resident A would not elope outside the back door. Resident A opened and closed the medication room door and called 911. She then went back to the couch with another resident. Five minutes later the police arrived and EMS and took Resident A to the hospital. Staff informed management and followed Resident A to the hospital.

I received an *AFC licensing division incident/accident report* dated 06/20/2026 at 3:52pm. The IR stated that a staff member arrived at the hospital to relieve another staff member. Staff provided deescalation techniques for Resident A while waiting at the hospital. No mention was documented stating why Resident A was at the hospital.

I received an *AFC licensing division incident/accident report* dated 06/25/2026 at 1pm. The report stated that Resident A was returning from her doctor's appointment and asked who the next staff was coming onto shift. The staff member informed her they could not give that information and then Resident A ran outside grabbed a brick and threw it at staff. Staff called the home manager and informed them that a CPI hold was needed for two minutes. Staff was able to redirect Resident A from getting hair ties. Staff was able to continue to redirect her the rest of the shift.

I received an *AFC licensing division incident/accident report* dated 06/25/2026 at 3:52pm. The report stated that Resident A went to use the bathroom for one minute and then went into the medication room and grabbed the phone. Resident A called 911 and told them she was suicidal and wanted to die. The police and ambulance transported Resident A to the hospital.

No incident reports were received from the following dates which involved police involvement: 06/12/2026 and 06/14/2026- statements documented on incident report, don't align with statements on police report. On 06/20/2026 no information was provided on what lead up to the hospitalization.

I received a document for Resident A labeled *PCP Meeting (MI)*, from Tuscola Behavioral Health Systems. which was dated 4/23/2026. Safety concerns documented on the *PCP Meeting (MI)* document stated:

> *"Behavior has been reported as being unpredictable and her mood can change without notice. [Resident A] is not very attentive to environmental queues as well and does not consistently respond to verbal queues as well. [Resident A] will throw things when she is dis-regulated emotionally; thus, posing a potential threat to others. She does not respond well to change, and careful planning should occur prior to changing her routine. [Resident A] exhibits verbal, physical aggression towards staff and others along with suicidal ideation, and self-harming behaviors."*

Per Resident A's , *PCP Meeting (MI)* document it documented that Resident A displays target Behaviors that include: physical aggression, verbal aggression, elopement, suicidal ideation, self-harm, and inappropriate touching. From the *PCP Meeting (MI)* document, a *Behavior Treatment Plan* was created on 5/12/2026 by Umbrellex and approved through Tuscola Behavioral Health Systems. The strategies outlined from the *Behavior Treatment Plan* and the *PCP Meeting (MI)* document include:

- "Coping Skills Training: Encourage [Resident A] to participate in journaling and/or identify how she feels multiple times per day on paper.
- Positive reinforcement: Provide praise to [Resident A] whenever possible. Whenever [Resident A] is engaged in appropriate behaviors staff should identify what specifically she did per the praise.
- Boundaries: Staff should demonstrate personal space boundaries between staff and [Resident A]. This is multi-fold as, if she attempted to hit staff and they were closer than 1 arm's length, someone could get hurt.
- Professionalism: Staff will be aware of and execute being professional with [Resident A] at all times. Staff should always remember that there exists a power differential between staff who provide service to [Resident A] and a friendship. This is not a friendship; this is a professional relationship
- Meaningful interaction: Staff should engage with [Resident A] once in the AM for 30 minutes and once in the PM staff should provide [Resident A] with 1:1 meaningful interaction.
- 1 step instructions: Simple 1 step instructions should be provided to [Resident A] at this time.
- Decrease demands: The more demands placed on [Resident A] the more likely she is to engage in target behaviors.
- Keep her active: The more [Resident A] is bored the increase in engagement in target behaviors.
- Create a daily and predictable schedule.
- Sensory Stimulation: Staff will ensure that [Resident A] has time to indulge in sensory activities throughout the day.
- Learning to Accept "No" without engaging in target behaviors the goal: [Resident A] will be able to wait for up to 10 minutes without engaging in target behaviors:

- Token Economy System
- Positivity: Staff should be as positive as possible.
- Anger Management training (STRIF): STRIF stands for Stop and Think, redirect to do something that makes a person happy;
- Emotion Identification: [Resident A] and staff should go over the emotion regulation sequence 3 times per shift.
- Paraverbals: Staff will mind the way they say what they say. This includes the "tone of voice"
- Staff will teach [Resident A] to use "safe hands," jazz hands or gentle hands
- If [Resident A] proceeds to/continues to try to be physically assaultive staff should identify how [Resident A] appears to be feeling; [Resident A], you seem upset, and then provide 2 options of activities that have been known for the to enjoy engaging in. The idea is to remind her of what she can do instead. Staff should remain neutral and calm at all times during this event. Staff should make sure that everyone is safe.
- If [Resident A] elopes out of the home staff should follow. [Resident A] should be kept in eye sight of staff and no more than 6-8 feet away. Staff should encourage [Resident A] to return home once every 60 seconds while she is eloping actively. While eloping there should be no conversational dialogue (no talking with her other than reminding her to return to the home). There should be no talk other than reminding her to return home
  and that "we can talk about that once we are back at the home.
- If [Resident A] makes statements in regard to wanting to hurt herself staff should not engage in that topic of conversation with her. Instead, staff should engage in an activity, vicariously first, without saying anything, that they know is of interest to [Resident A] in order to prompt her motivation to participate) and ignore the statement and instead ask her if she wants to participate with you.
- If [Resident A] begins to self-harm staff should instantly redirect [Resident A] to do something else with whatever she is attempting to self-injure with. If she is using her hands staff should ask her to do something else that is more functionally appropriate with her hands, such as "hold this," "here is a marker let's color. If [Resident A] is banging her head staff should encourage [Resident A] to move to a place that her head is not next to a place that she can bang it against. Upon redirecting her to another area staff should encourage an activity that she can participate in. Staff should not provide any attention to the self-harm itself. Staff should remain neutral and calm and avoid an exaggerated facial expression or response. If anything needs to be bandaged or cleaned up staff should do so with as minimal attention to acknowledging the inappropriate behavior as possible. When bandaging anything staff should not engage in a discussion with [Resident A].
- [Resident A] will be able to use the house phone in the following manner: For more privacy purposes staff will hold the phone for [Resident A] while she is on the phone. This will continue until a better option has been found for privacy purposes. Staff will dial the phone number of the person she wants to call. There will be a guardian approved list of people [Resident A] can talk with.
- [Resident A] will not have access to a cell phone.

- Locking up of sharps/weapons: Any items that have previously been utilized either towards others or towards herself to harm herself will be locked up for a period of 24 hours until there has been no history of self-injury or physical aggression towards self or others.
- Bathroom Supervision Protocol: Staff will position themselves directly outside the bathroom door, which will always remain unlocked. Staff will conduct a verbal check-in with [Resident A] every 2 minutes during bathroom use. If [Resident A] does not respond to a verbal check-in within 30 seconds, staff will immediately open the door to conduct a visual welfare check. The following items will be removed from or secured within the bathroom when not in active supervised use: hanging towels, plastic bags, cords, and fabric items longer than approximately 12 inches. Towels will be provided for [Resident A] at the time of use and retrieved by staff when bathroom use is complete.

On 07/09/2026, I interviewed direct care worker, Dallesha Chesnut via phone. She reported that she no longer works for the company. She stated that the police came out to the home many times and direct care staffs' rights were violated as Resident A was always hitting them. DCW Chesnut stated that every time they would call 911, they were required to call a clinician. She stated that Resident A was always eloping and assaulting staff members. DCW Chesnut reported that Resident A's *Behavioral Treatment Plan* was available within the home, but most interventions were not helpful. She reported that she would try to redirect Resident A and would use a CPI hold if Resident A was harming herself or others. DCW Chesnut stated clinicians did not want staff to call 911 often but supported them calling 911 when she was assaulting staff in public or trying to harm herself in public. DCW Chesnut reported that she was trained to support Resident A during a behavior by encouraging her coping skills. She described Resident A's coping skills as journaling, finding a craft to do or baking. DCW Chesnut also stated that she was told to attempt to verbally redirect Resident A.

On 07/09/2026, I interviewed direct care worker, Demetrius Smoots via phone. He reported that he no longer works at the home. He stated that the police were called many times due to Resident A putting her hands on staff members. DCW Smoots stated that he called the police two or three times. He explained that they would use a CPI hold, but he did not find them effective as Resident A found it funny to be put in a CPI hold. He explained that before using a CPI hold, he would tell Resident A "safe hands" or he would keep his distance from her. He stated that clinicians instructed him to use a CPI hold until Resident A was calm and could be redirected. He explained that he would then let go of Resident A and keep his distance, but often she would continue with being aggressive. DCW Smoots described Resident A as very persistent and aggressive if Resident A's demands were not met. DCW Smoots stated that staff are supposed to dial any numbers for her and he tried to keep the phone on him at all times. DCW Smoots stated that scissors should not be in her room and her items would go on a 24 hour hold if she used them for self-harm or harming others.

On 07/09/2026, I interviewed direct care worker Arizona Jones via phone. She reported that she has not worked at home when the police arrived. She stated that she was

trained on Resident A's *Behavioral Treatment Plan* and some days she could have scissors and other days she could not have them. DCW Jones stated that if Resident A was eloping, they would put a message in the group chat to management. DCW Jones stated that Resident A was very difficult to care for and could benefit from two direct care staff members solely caring for her.

On 07/09/202, I interviewed community mental health case worker, Shannon Diebel via phone, as she is Resident A's assigned case worker. She reported that they should be trying every intervention before asking for police involvement. Ms. Diebel stated that staff should be within arms reach of Resident A at all times and when she is sleeping staff should be checking on her every 15 minutes. She stated that staff should also have the phone on them at all times, as Resident A has been making a lot of false 911 reports that she is suicidal due to having access to the house phone. Ms. Diebel stated that sharps should be locked up if she tried to harm herself with them and she needs to show stabilization for 24 hours in order to obtain the items back. Ms. Diebel reported that she is concerned that staff are not completing her required daily schedule with her or the other daily interventions as it's not being documented on her progress notes she receives. She stated that staff are not contacting her until she receives an incident report, therefore she has requested a weekly zoom meeting to maintain communication and support Resident A. As of 07/09/2026, the zoom meeting had not been confirmed by Umbrellex staff. Ms. Diebel reported that she would like to see the home document that all interventions outline in the *Behavior Treatment Plan* are being implemented before police involvement.

On 07/09/2026, I interviewed Guardian A1 via phone. She reported that staff contact her every time the police are called. She stated that she feels the home is doing a great job caring for Resident A. Guardian A1 stated that Resident A only wants to be arrested and/or go to the hospital for attention, therefore Guardian A1 stated she denies all hospital inpatient requests.

On 07/09/2026, I interviewed direct care worker, Damon Daniels via phone. He identified as the clinical director. He stated that he receives an update twice a month on Resident A. He also stated that staff will often put him on speaker when she is eloping and he will attempt to remind Resident A to use her coping skills and return to the home. DCW Daniels reported that staff use a CPI hold when Resident A is too aggressive. He stated that staff are trained often on her *Behavioral Treatment Plan* but staff will often freeze up, such as forgetting to keep the phone on them at all times and not engaging in conversation with Resident A when she is in a behavior. He also reported that Resident A will target newer staff members. DCW Daniels reported that they can occasionally have staff not be as attentive as they should be too, such as leaving the phone unattended, along with not properly supervising Resident A when she has scissors. DCW Daniels reported that they have attempted to accommodate Resident A's mental health needs and improve her coping skills by buying a bike for her room and having staff engage one on one with Resident A by focusing on positive coping skills and helping her identify her emotions. He stated that they also provide her with a gym membership and support the decision to not hospitalize her when she states

she is suicidal as it's a behavior for attention. DCW Daniels stated that they recently moved Resident A to the current home from a previous Umbrellex AFC, as they felt it would be a better fit for her and they wanted to give the previous neighborhood a break as Resident A requires a lot of attention outside of the home during her walks and elopements. Permission from Guardian A1 and case worker were obtained before the move occurred. DCW Daniels stated that he believes Resident A's behaviors have improved since moving to the new Umbrellex location.

According to police reports received, Resident A has had police involvement since May, 2024-December 2025 at her previous Umbrellex placement in Owosso. Police reports documented similar incidents involving self-harm attempts and assaulting direct care workers.

On 07/13/2026, I interviewed direct care worker, Kennadie Krish via phone. She identified as a clinical supervisor and stated that she has daily contact with Resident A and the staff at Umbrellex. She reported that Resident A has obtained the home phone on several occasions recently despite the intervention for direct care staff to always keep the facility phone on them so Resident A does not make false 911 calls. DCW Krish stated that staff call her or the other clinician before calling the police. She stated either herself or the other clinician tell direct care staff to call 911 when Resident A has eloped or physically hitting staff members or trying to hit them with a rock or stick. DCW Krish stated that they instruct staff to call 911 during these times as bystanders will become concerned and end up calling the police. She stated that when a male staff member is following Resident A during an elopement and Resident A starts hitting them, bystanders will be concerned that the staff member is harming Resident A. DCW Krish stated that when Resident A is at the home, they do not encourage staff members to call 911 and encourage them to verbally redirect Resident A to use her coping skills or tell direct care staff to use a CPI hold. DCW Krish stated that Resident A will lose certain items for 24 hours if she harms herself or others. DCW Krish explained that staff should always supervise Resident A when she is using scissors. DCW Krish stated that they recently let go of a staff member due to the constant lack of attention to always keep the facility telephone on their person. DCW Krish stated that she feels that staff are doing a great job, but work needs to be done to line up the progress notes and incident reports to document all interventions used. DCW Krish reported that staff have thirty minutes before and after their shift to complete their documentation. She stated that she also holds a training every Thursday at 4:30pm for staff who need further assistance. On 07/15/2026, I interviewed DCW Kennadie Krish via phone. She explained that Resident A was moved to the current home as she was bullying the other residents as they were an older population. She explained that they felt Resident A might interact better with residents closer to her age. She explained that she guides staff to handle Resident A's behaviors by using redirection towards Resident A's coping skills. She stated that the coping skills used depend on the staff working, but in general they encourage Resident A to listen to music, write, bake, go for a walk, play with her fidget toys and crafting. She stated that Resident A has a PRN, but Resident A mostly refuses the PRN. She reported that staff are often re-trained if they are informed of concerns or if she notes concerns while reading progress notes. DCW Krish stated that

they try to support staff by offering additional CPI training refreshers. She stated that they also try to mix seasoned staff members with new staff members to limit Resident A's ability to target new staff. DCW Krish stated that all staff are trained to work with all residents and go through all the same trainings. She reported that some staff have requested not to work with Resident A and they have been kept off the schedule at Umbrellex 2.

On 07/13/2026, I interviewed direct care worker Christopher Thomas via phone. He reported that he no longer works at Umbrellex and left employment about four weeks ago. He stated that when Resident A elopes, direct care staff follow her, keep eyes on her and put in the group chat that she eloped. He stated that they will be directed by an Umbrellex clinician, usually DCW Kennadie Krish to call the police if she is hitting staff. DCW Thomas stated that Resident A can use the bathroom alone and staff are to check on her every two minutes. He stated that they will knock and ask her if she is okay. DCW Thomas stated that when Resident A is in a bad mood, he will go to the back of the house, as there is a door in the bathroom that leads to the medication room and out the back of the house. DCW Thomas stated that he would wait in the back as Resident A would try to elope out the back door often. DCW Thomas stated Resident A has been more easily able to access the facility phone while it's charging because the door to the room where the phone charges no longer locks. Consequently, Resident A can easily grab the phone from the charging stand and call 911. DCW Thomas stated that staff are supposed to always keep the phone on them, but prior shifts would let the phone die, therefore it needed to be charged. DCW Thomas provided additional details on 7/15/26 and stated that he was trained to have Resident A use her coping skills when she was having negative behaviors. He described Resident A's coping skills as mainly using redirection and having her spin a wheel to find a new activity. DCW Thomas reported that he did not need to use CPI on Resident A and just tried switching the subject and talking with her.

On 07/13/2026, I interviewed direct care worker Alexander Braden via phone. He stated that he still currently works at the home. DCW Braden reported that if there are no sharp objects, Resident A can use the bathroom without supervision. He stated that staff are required to be outside the door and check on her every 15 minutes while she is using the bathroom. He stated that the medication room door can be locked and the key needs to be jiggled. DCW Braden explained that when Resident A is eloping, they only call the police if she is hitting staff or trying to run in front of cars. DCW Braden stated that Resident A only has safety scissors and staff should always be supervising her when she is awake.

On 07/14/2026, I interviewed the licensee designee, Bianca Wilson via phone. She reported that she is not actively involved in Resident A's care rather she manages the operations of Umbrellex business. Ms. Wilson directed me to call the clinical team for additional details on what led Resident A to be moved to Umbrellex 2, along with determining how they can confirm staff are competent to work with Resident A. Mrs. Wilson also directed me to the clinical team for an understanding on how staff are supported in attempting to manage Resident A's behaviors.

On 07/14/2026, an exit conference also occurred via phone with Ms. Wilson and she reported that she feels its unfair that we are only focusing on the dates that Resident A's *Behavioral Treatment Plan* was not followed and we should focus on the overall percentage of the days when Resident A's *Behavioral Treatment Plan* is being implemented correctly without police intervention.

APPLICABLE RULE	
R 400.707	**Staff training.**
	(1) Staff who work with residents shall have successfully completed training that provides basic concepts required in providing specialized dependent care before working independently. Staff shall show the ability to comprehend and be competent to deliver each resident's individual plan of service as written. Training must include all of the following before working independently: **(b) Understanding and carrying out individual plans of service for residents.**

ANALYSIS:	Based upon interviews and documentation received it was found that not all direct care workers are following Resident A's *Behavioral Treatment Plan* that was updated on 5/12/2026. Based upon police reports and incident reports received, it was found that Resident A had access to the facility phone on 6/2/26, 6/11/26, 6/12/26, 6/14/26, 6/20/26,6/21/26 and 6/25/26. While having access to the facility phone, Resident A called 911 and reported she was suicidal which prompted an officer coming to the AFC home. Based on the police reports dated 6/20/2026 at 3:05pm, the police responded to the home due to Resident A having scissors and attempting suicide. On 06/21/2026 at 7:57am, the police responded to the home again due to Resident A having scissors and attempting suicide and not being willing to let go of the scissors. Based on the police reports, Resident A's behavioral plan was not followed as she had access to scissors before her 24-hour hold had ended. Based upon interviews conducted with direct care workers it was found that Resident A's bathroom protocol was not being followed as some workers were checking on her every 15 minutes while in the bathroom, others waiting at the back door of the house in case she eloped and in the police report dated 6/14/26 at 7:39pm, Resident A was found in the bathroom by the police with a hair tie around her neck. According to the police report, staff were unaware that Resident A had called 911 when arriving and were unaware that Resident A was in the bathroom with a hair tie around her neck. A violation has been established as there were consistent dates found where staff are not correctly understanding and correctly carrying out Resident A's *Behavior Treatment Plan*.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 07/09/2026, I requested and received documentation confirming that all direct care staff required to work with Resident A were trained on her *Behavior Treatment Plan.* Based on my review of the documentation received, the following direct care staff were not trained on Resident A's *Behavior Treatment Plan*: Justin Lawrence, Olivia Teeples, Isaiah Loren, Jeremiah Loren, Leo Nixon, Ruby Boykins, Laquavis Stitt, Dallesha Chestnutt and Keandre Riggs.

According to the staff schedule, direct care staff members Justin Lawrence, Olivia Teeples, Isaiah Loren, Jeremiah Loren, Leo Nixon, Ruby Boykins, Laquavis Stitt, Dallesha Chestnutt and Keandre Tiggs were all on the staff schedule after 5/12/2026, which was when the most recent training occurred for Resident A's *Behavior Treatment Plan*.

APPLICABLE RULE	
R 400.707	**Staff training.**
	(3) Documentation of training must be maintained in the staff records to demonstrate that training has been completed and is current.
ANALYSIS:	Based upon documentation received, a violation has been established as no documentation was available to be reviewed confirming that the following direct care workers, Justin Lawrence, Olivia Teeples, Isaiah Loren, Jeremiah Loren, Leo Nixon, Ruby Boykins, Laquavis Stitt, Dallesha Chestnutt and Keandre Riggs have been trained on Resident A's most recent *Behavior Treatment Plan*.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

7/13/2026

Amanda Blasius Date
Licensing Consultant

Approved By:

07/17/2026

Dawn N. Timm Date
Area Manager