



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 9, 2026

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

RE: License #: AS780404958
Investigation #: 2026A0622051
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS780404958
Investigation #:	2026A0622051
Complaint Receipt Date:	07/13/2026
Investigation Initiation Date:	07/14/2026
Report Due Date:	09/11/2026
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?
On 07/11/26, several men pinned Resident A on the ground attempting to restraining her. One male had his knee in her back while the other had his hand on the back of her head, pushing her face into the ground. There appeared to be another male jabbing their knee into her leg. Resident A was screaming. This was not an appropriate response to Resident A's behavior.	Yes
On 07/30/2026, flies were observed flying around in the home, on the windowsill, and dead on the ground. The bathroom was unsanitary and dirt was observed on the walls and light switches.	Yes
Resident B resides in the AFC home with Resident A. Resident A has been assaultive towards Resident B and staff members. Resident B is stressed out, is having sleeping issues and is anxious about Resident A living in the home. Direct care staff are not doing anything to address Resident B's concerns.	No
Additional Finding	Yes

III. METHODOLOGY

07/13/2026	Special Investigation Intake 2026A0622051
07/14/2026	APS Referral not required as APS is also investigating
07/14/2026	Special Investigation Initiated – Additional information and police report received from Adult Protective Services worker, Rebecca Schalow
07/16/2026	Contact - Telephone call made to Adult Protective Services worker, Rebecca Schalow
08/04/2026	Contact- Voicemail left for complainant.
08/11/2026	Contact - Document Received from Adult Protective Services worker, Rebecca Schalow
08/12/2026	Inspection Completed On-site, contact- telephone call to case manager, Shannon Diebel
08/13/2026	Contact – Email sent to licensee designee, Bianca Wilson
08/26/2026	Contact - Document Received from direct care worker, Kennadie Krish.

08/27/2026	Inspection Completed-BCAL Sub. Compliance
08/27/2026	Contact- Telephone call to direct care worker, Vernon Deihl. Voicemail left for direct care worker, Jeremiah Loren
08/28/2026	Contact- Telephone call to case manager, Kate Britz
08/31/2026	Contact- Telephone call to case manager, Matt Dorhing
8/31/2026	Exit conference with licensee designee, Bianca Wilson.
09/02/2026	Contact- Document requested and received.
09/03/2026	Contact- Telephone call to Community Mental Health case manager, Shannon Diebel, direct care workers, Jasmine Harps and Isaiah Loren. Email sent to clinical director, Damon Daniels. Voicemails left for direct care workers, Ruby Boykins, Jessica Fritz and Makayla Etton.
09/04/2026	Contact- Telephone call with direct care worker, Makayla Elton. Email response received from Damon Daniels.
09/09/2026	Exit conference with licensee designee, Bianca Wilson via email

ALLEGATION: On 07/11/26, several men pinned Resident A on the ground attempting to restraining her. One male had his knee in her back while the other had his hand on the back of her head, pushing her face into the ground. There appeared to be another male jabbing their knee into her leg. Resident A was screaming. This was not an appropriate response to Resident A's behavior.

INVESTIGATION:

On 07/13/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, on 07/11/2026, several men pinned Resident A on the ground attempting to restrain her. The complaint stated that one male had his knee in her back while the other one had his hand on the back of her head, pushing her face into the ground. According to the complaint, there appeared to be another male jabbing their knee into her leg and Resident A was screaming. The complaint reported that three men were restraining Resident A and there were three or four others standing around. The complaint stated that law enforcement was called and it was unknown if Resident A had any marks or bruises. The complaint did not specify if these males were direct care staff members of the facility.

On 07/14/2026, I received additional information from Adult Protective Services worker, Rebecca Schalow, along with a police report from 7/11/2026.

On 07/14/2026 a police report from Owosso Police Department was reviewed and was dated 7/11/2026 at 6:30pm.

"The police officer was dispatched to the AFC as two bystanders observed a female being dragged by several subjects, have her pinned down to the ground. Second caller stated they are pinning someone down in the front yard and thinks they hit the female. I made contact with the bystander, and she stated that she called 911 and observed an African American male punch a female and then three males picked up the female and carried her into the house. While speaking with the caller I could hear the female screaming while on the phone with her. I entered the AFC residence and observed staff members, Vernon Diehl and Jeremiah Loren had [Resident A] pinned down to the ground. I advised them to let [Resident A] go and they did. After a short period of time, [Resident A] calmed down and went to her room. I continued speaking with [Resident A] in her room until she kept trying to leave her room as she was going to run away. After [Resident A] continued to try running away, I put her in double locking handcuffs. I made contact with Jeremiah Loren. She reported that [Resident A] tried to leave the home multiple times and stated that she (Resident A) was attempting to get into the roadway to get hit by a car. Jeremiah stated that he was able to get her diverted away from the road and she went around the back of the house and picked up sticks and was trying to cut her wrists with sticks. Jeremiah stated that he approached [Resident A] and she started flailing with sticks at him. Jeremiah stated that [Resident A] did stab him in the chest with a stick but it didn't leave a mark. Jeremiah reported that he, Vernon and Zoey all assisted [Resident A] to the ground in an attempt to restrain her from harming herself or others. Jeremiah stated that [Resident A] was able to grab a hold of him and dig at him in his left forearm/elbow area. I asked Jeremiah if he punched [Resident A] and he advised he did not. I made contact with Zoey Ramirez and she stated [Resident A] was acting out and was trying to leave the residence. Zoey reported that [Resident A] was picking up sticks trying to harm herself. Zoey stated that Jeremiah tried to calm [Resident A] down and it was determined that they were going to bring [Resident A] into the house. Zoey stated that once staff had [Resident A] on the ground she bit her and left teeth marks on her left forearm. Zoey stated that on the previous day, [Resident A] had an outburst and bit her on the inside of her right bicep, to which she had a large bruise. Zoey reported that she wanted to press charges on [Resident A]. I made contact with Vernon Diehl and he stated that [Resident A] was trying to leave the residence and then picked up sticks trying to hurt herself and others. Vernon stated that they put [Resident A] on the ground and carried her inside the residence. Vernon stated that he was not assaulted, and he did not see Jeremiah punch [Resident A]. [Resident A] was taken to the hospital and was petitioned."

On 07/16/2026, I had contact with Adult Protective Services worker, Rebecca Schalow and she provided me with additional allegations she received.

On 08/11/2026, I had contact with Adult Protective Services worker, Rebecca Schalow and she informed me that Resident A was in jail for at least 30 days due to a prior assault on a staff member. She also provided me with her contacts with Resident A.

Adult Protective Services worker, Rebecca Schalow contact with [Resident A]:
"Visit had with [Resident A] at the Shiawassee County Jail. She advised that she had court on July 28 and got 32 days in jail, that she is scheduled to get released on August 28, that she has 18 more days. When asked she denied having to complete any probation following her jail time. When asked, she advised that the plan is for her to go back to King Street home. She stated that she does not want to go back to the home because she doesn't like the staff putting her in CPI holds, but that she does feel safe at the King Street home. When asked why she does not like staff putting her in a CPI hold she advised that it is a trigger for her. ASW asked why they are putting her in a CPI hold, and she said that is because she keeps going outside. ASW inquired if she was put in a CPI hold after throwing items at staff or taking off with sharp items, she denied this. She then stated the staff yell at her a lot too, and that is another reason she does not want to go back to the facility. ASW advised that they are speaking with the Recipient Rights office and LARA and that as of now the plan is for her to go back to King Street though that may change prior to her release from incarceration. She advised that she understood and she had no questions for ASW prior to departure."

On 08/12/2026, I completed an unannounced onsite investigation to Umbrellex 2. During my unannounced onsite investigation, I interviewed direct care workers, viewed the home, viewed documentation and interviewed residents.

On 08/12/2026, I interviewed Resident C in person. He reported that Resident A will yell and scream and that she runs away from the home often. Resident C stated that staff will hold Resident A on the ground, and he has seen some staff members push her down and call her names. Resident C was unable to provide any staff members names.

On 08/12/2026, I interviewed Resident B in person. He reported that he called the police as Resident A bit a staff member and Resident D was throwing items at staff. Resident B reported that staff put Resident A in a CPI hold, but she continued to not listen, therefore he stated that he told Resident A if she did not stop, he was calling the police. Resident B reported that Resident A then threatened to kill him and was going to punch him. He explained that Resident A charged him and tried to hit him. Resident B stated that staff stopped her from hitting him. Resident B stated that when Resident A is in a behavior, she will try and dump liquids on him and says "shut the fuck up" to him. Resident B reported that he threatens that he will call the police on her and she ends up in a CPI hold. Resident B reported that having Resident A out of the house has been much better as she increases his anxiety and gives him a panic attack. Resident B reported that on 7/11/2026, none of the direct care workers hurt Resident A, had her head pushed into the ground or knee in her

back. He stated that Resident A was trying to attack him and an officer had to stand in front of the door to block her. Resident B stated that he was moved to the home many years ago because he does not do well with females, yet they still continued to place Resident A in the home.

On 08/12/2026, I interviewed direct care worker (DCW), Josh Merrifield. He stated that he has worked for the company for two years. DCW Merrifield reported that he was not working at the home on 7/11/2026. He stated that he has never seen Resident A try to attack Resident B. DCW Merrifield stated that Resident A and Resident B get along pretty well, as Resident A likes to bake for Resident B, but when they get upset, they will yell at each other. DCW Merrifield reported that he worked with Resident A at a previous placement and she has not changed since he started employment. He stated that if a staff member is not giving her 110% of their attention, she will have a behavior.

On 08/12/2026, I interviewed direct care worker, Judy Sailor who identified as the home manager. She reported that she was not present on 7/11/26, but it was her understanding that Resident A was trying to run into traffic and was attempting to hurt herself so direct care staff had to use a CPI hold. She stated that direct care staff were directed to bring Resident A back into the home and offer her coping skills and her prescribed as needed medication. DCW Sailor reported that Resident B called the police and that Resident C does not like loud noises, therefore he was upset too. She stated that Resident A has never done anything to another resident.

On 08/12/2026, Resident A was unavailable to be interviewed as she was currently incarcerated.

On 08/13/2026, I requested incident reports as they were unavailable within the home.

On 08/27/2026, I interviewed Vernon Deihl via phone. He confirmed that he was working on 7/11/26 and Resident A was trying to harm herself and staff with sticks and attempting to run away. DCW Deihl stated that DCW Jeremiah Loren was the one-on-one staff for Resident A and he was holding Resident A's legs, as she was kicking staff members. DCW Deihl reported that he was observing on the lawn as he was the one-on-one staff member for Resident D. DCW Deihl explained that the other staff member Zoey Ramiez was assisting with Resident A. He reported that no staff member punched Resident A, put her head into the ground or put their knees in her back. He explained that a bystander was very concerned and they tried explaining that it was an AFC home.

On 08/27/2026, DCW Zoey Rameiz phone number was no longer in service.

On 08/27/2026 and 8/28/26, a voicemail was left for DCW Jeremiah Loren with no return phone call received.

On 09/02/2026, I requested documentation that direct care workers Zoey Rameiz, Vernon Deihl and Jeremiah Loren were trained to provide CPI holds. Documentation was received and confirmed that all three direct care workers were trained in using CPI (nonviolent, crisis intervention, 3rd edition).

Resident A's *behavioral treatment plan* was reviewed and was dated 5/12/2026. According to her *behavioral treatment plan* if Resident A elopes, the following is the reactive strategy:

"Staff will follow [Resident A] immediately. Maintain visual range, no more than 6–8 feet away. Prompt return to the home once every 60 seconds. No conversational dialogue during active elopement other than return prompts and "we can talk about this once we are home." Once home, provide specific praise for returning. Briefly identify one alternative for next time. Do not bring up the elopement again during the shift."

The intrusive strategy regarding elopements documented in Resident A's *behavioral treatment plan* was the following:

"Dedicated Staffing Support – 1:1 Arms-Length [Resident A] will receive 1:1 arms-length staffing in the home and in the community due to the documented frequency and severity of SIB, physical aggression, and elopement. This support is intended to equip Chelsea with tools she can apply with increasing independence over time."

Based upon Resident A's *behavioral treatment plan*, no documentation or interventions were available to review if Resident A is running into traffic. No documentation or interventions were available within Resident A's *behavioral treatment plan* regarding staff using CPI holds, (nonviolent, crisis intervention, 3rd edition).

According to her *behavioral treatment plan* if Resident A has physical aggression, the following is the reactive strategy:

"At the first sign of impending aggression, prompt "safe hands" immediately. If [Resident A] uses safe hands, praise immediately and offer two preferred activity options. If aggression continues, name the observed emotion ("[Resident A] you seem very upset") and offer two preferred activity choices. Maintain calm and ensure safety. Do not engage in extended discussion during escalation. Post-Incident Reset: When [Resident A] is ready, acknowledge her calm specifically ("Thank you for calming down—that was a good choice"). Keep the reset brief. Do not revisit the behavior during the same shift."

According to her *behavioral treatment plan*, if Resident A has suicidal ideation the following is the reactive strategy:

"Attention-maintained statements (casual tone, no behavioral indicators): Do not engage the statement directly. Begin a preferred activity nearby, invite [Resident A] to join, and redirect attention to the activity without referencing the statement. Genuine distress indicators (active item-seeking, written notes, mood congruence, strangulation attempt): Follow the SIB reactive strategy below and contact clinical

immediately. All suicidal ideation statements will be documented with context to support psychiatric review."

According to her *behavioral treatment plan*, if Resident A has self-injurious behavior the following is the reactive strategy:

"Respond immediately and calmly without exaggerated reaction. Redirect hands to an alternative activity ("Here, hold this"/"Here is a marker, let's color"). If head banging, guide [Resident A] away from hard surfaces to a safe space and offer a calming activity.

If strangulation is attempted: remove the item, remain calm, and immediately secure all ligature items in the environment. Address any wounds with minimal verbal acknowledgment of the behavior.

If [Resident A] engages in any alternative behavior, provide specific, immediate praise."

Resident A's *behavioral treatment plan* was reviewed in detail, and no information was available regarding staff using a CPI hold. On 09/03/2026, I contacted Resident A's Community Mental Health case worker, Shannon Diebel for additional information. She reported the following: "CPI holds and police intervention are not allowed to be documented in the BTP due to HCBS rules, and that it is strongly encouraged that less restrictive interventions outlined in the BTP are to be utilized."

On 09/03/2026, Josie Grannell from Tuscola Behavioral Health Systems provided the following information from the 2024 *Behavior Treatment Plan Technical Requirements*, "Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations."

On 09/03/2026, I interviewed direct care worker Isiah Loren via phone. He reported that he no longer works at the home but was involved with Resident A and used CPI holds. He reported that he was trained to use a CPI hold in drastic situations or when Resident A was harming others. He stated that they would use the mats to hold Resident A's legs down, but they could not use their hands to hold her legs down. DCW Loren also reported that the home manager, Judy Sailor instructed staff to carry Resident A back into the home if she was hurting herself or others. DCW Loren stated that he would bear hug Resident A and carry her back to the sidewalk and then try to redirect her back into the home.

On 09/03/2026, I interviewed direct care worker, Jasmine Harps via phone. She reported that she no longer works at the home. She reported that she never needed to use a CPI hold but was trained. DCW Harps reported that holding of a resident's legs is not allowed with a CPI hold. She also stated that staff are not allowed to pick up Resident A and move her.

On 09/04/2026, I interviewed direct care worker, Makalya Elton via phone. She confirmed that she no longer works at the home. DCW Elton stated that she did not have to use CPI holds when she was Resident A's one to one staff member as she would take her for long walks. DCW Elton reported that she observed other staff members use CPI holds and staff would hold Resident A's legs flat on the ground. She stated that Resident A would kick her legs, therefore staff would attempt to complete a CPI hold on the couch, so she was not kicking her legs as much and it was softer for Resident A.

On 09/03/2026, I sent an email to Umbrellex Clinical director, Damon Daniels as he was the trainer listed on the CPI cards received for direct care workers. Mr. Daniels responded with the statement of "there is not a training on holding legs."

APPLICABLE RULE	
R 400.643	Crisis intervention.
	(4) Crisis intervention must be employed to allow the resident the greatest possible comfort and to avoid physical injury and mental distress.
ANALYSIS:	Based upon the police report received and interviews with Resident B and direct care worker Vernon Deihl it was determined that physical intervention hold (CPI) was conducted in an inappropriate manner. Although direct Care worker Vernon Deihl and Resident B confirmed that Resident A's head was not held into the ground, she was not punched by a staff member, and no staff member had their knee in her back, it was determined through interviews with direct care workers, that staff were holding Resident A's legs down during CPI holds. Three direct care workers interviewed confirmed that staff were holding Resident A's legs down to prevent her from kicking. Clinical director, Damon Daniels confirmed that no training is provided through CPI to use holding of legs as a crisis intervention hold. A violation was established as it was determined that direct care workers were not using the crisis intervention trained that would allow Resident A the greatest possible comfort and avoid physical injury.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: On 07/30/2026, flies were observed flying around in the home, on the windowsill, and dead on the ground. The bathroom was unsanitary and dirt was observed on the walls and light switches.

INVESTIGATION:

On 08/04/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint on 07/30/2026, flies were observed flying around in the home, on the windowsills, and dead on the floor in the home. The bathroom was unsanitary and dirt was observed on the walls and light switches. The complaint reported that the bathroom was "gross" and the toilet and the area around the toilet was dirty. The complaint also stated that the toilet bowl had fecal matter streaks but it's unknown if someone used the toilet earlier that day. According to the complaint, the home had no paper towel or rags to clean with and the supervisor, Anastasia Foster, was texted about the condition and they denied the house being dirty.

On 08/04/2026, I left a voicemail for the complainant. As of 8/28/2026, no response has been received.

On 08/12/2026, I completed an unannounced onsite investigation to Umbrellex 2. During the unannounced onsite investigation, I viewed the living room, kitchen, hallway and bathroom.

During my unannounced onsite investigation on 8/12/2026, I observed a large hole in the wall in the living room next to the couch. I also observed dirt and grease covering the entire width of Resident B's bedroom door. DCW Sailor reported that they clean Resident B's door daily, but he works on mechanical items in the back garage, so it gets dirty daily. Resident B was interviewed and he stated that staff do not clean his door daily. Based upon my observation of Resident B's door, it did not appear to be cleaned daily, as I arrived at 2:00pm and the door was grease stained. He reported that Resident D had broken the toilet a few times and the mirror in the bathroom.

On 8/12/26, I did not observe dead flies on the ground or within the windowsills. A few flies were observed within the home, as the residents tend to leave the front door open.

I viewed the bathroom on 8/12/26 and the toilet was clean. The bathroom was missing a mirror and the DCW Judy Sailor reported that Resident A broke the mirror. She could not explain why the mirror had not been replaced. I viewed the bathroom and along the bottom of the bathtub the molding was missing to prevent water damage between the bathtub and floor. DCW Sailor reported that Resident A damaged the bathtub also.

On 8/13/2026, I requested all maintenance requests that have been submitted for the bathroom. I received three documents. Two regarding the toilet being broken on 7/10/26 and 7/18/26 and needing to be fully replaced. One request was for the mirror and provided no date. According to the maintenance request, the mirror was loose on the wall and was removed until it could be properly hung. On 08/26/2026, I

requested a date the maintenance request was submitted for the mirror. As of 8/28/2026, no response has been received.

On 08/28/2026, I interviewed Resident D's case manager, Kate Britz via phone. She reported that she was not receiving incident reports from the home at first and then received six incident reports once she followed up and requested them. Ms. Britz explained that she remembered reading an incident report where Resident D broke the mirror. She stated that a mirror could be in the bathroom, as Resident D should have supervision and assistance while using the bathroom.

On 08/28/2026, I followed up with licensee designee, Bianca Wilson and direct care workers, Damon Daniels, Kennadie Krish and Ciara Tillis via email regarding an incident report for Resident D breaking the mirror. I received a response stating that the mirror was not broken by Resident D rather it was removed voluntarily from the bathroom and the situation was clarified with the case manager.

APPLICABLE RULE	
R 400.647	Safety and maintenance of premises.
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the unannounced onsite investigation, I did not observe any dead flies on the floor of the home or in the windowsills. Although there were a few flies in the home, there was not a concerning number in the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.647	Safety and maintenance of premises.
	(2) Home furnishings and housekeeping standards must present a comfortable, clean and orderly appearance.

ANALYSIS:	Based upon my unannounced onsite investigation, there was no mirror in the bathroom for residents to use during grooming and the resident bathtub was missing molding where the bathtub meets the floor leading to water damage. The home was not orderly during the unannounced onsite investigation on 08/12/2026. I observed a large hole in the living room wall near the couch, along with Resident B's bedroom door being covered in dirt residue. A violation was established as it was determined that the walls and doors are not maintained clean and in good repair.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident B resides in the AFC home with Resident A. Resident A has been assaultive towards Resident B and staff members. Resident B is stressed out, is having sleeping issues and is anxious about Resident A living in the home. Direct care staff are not doing anything to address Resident B's concerns.

INVESTIGATION:

On 07/12/2026, I received additional allegations from Adult Protective Services. According to the complaint, Resident B resides in the AFC home with Resident A. Resident A has been assaultive toward Resident B and staff members. Resident B is stressed out, is having sleeping issues and is anxious about Resident A living in the home because of these assaultive behaviors. According to the complaint, law enforcement has been called to the home for Resident A seven times since 6/14/2026. The complaint stated that on 7/15/26, Resident A became assaultive toward Resident B and was chasing him. Law enforcement was contacted and Resident A was sent to the hospital.

On 08/12/2026, I interviewed Resident B in person. He reported that he called the police as Resident A bit a staff member and Resident D was throwing items at staff. Resident B reported that staff put Resident A in a CPI hold, but she continued to not listen, therefore he stated that he told Resident A if she did not stop, he was calling the police. Resident B reported that Resident A then threatened to kill him and was going to punch him. He explained that Resident A charged him and tried to hit him. Resident B stated that staff stopped her from hitting him. Resident B stated that when Resident A is in a behavior, she will try and dump liquids on him and says "shut the fuck up" to him. Resident B reported it has been much better living at the facility since Resident A has been out of the home. Resident B stated her behavior increases his anxiety leading to panic attacks.

On 08/31/2026, I interviewed Resident B's case manager, Matt Dohring via phone. He stated that since Resident B moved into the home in 2023, he has always

complained about his roommates. Mr. Dohring reported that Resident B can come and go on his own from the home. He also stated that he has offered Resident B other AFC options out of county, but his Guardian is currently happy with his placement at Umbrellex 2. Mr. Dohring reported that Resident B will often leave the home to visit a friend close by or take a walk if he needs space from Resident A or the other residents of the home.

On 09/03/2026, I interviewed direct care worker, Isaiah Loren via phone. He reported that if Resident B is upset with Resident A, staff will talk with him, or they will encourage Resident B to go for a walk or bike ride to calm down. DCW Loren stated that he has not observed Resident A attack Resident B.

On 09/03/2026, I interviewed direct care worker, Jasmine Harps via phone. She stated that she has not observed Resident A attack Resident B, but Resident B can become affected by Resident A's behaviors. She stated that staff will talk with Resident B and try and calm him down. They will also ask Resident B if he needs time alone in a quiet place or encourage Resident B to visit his friend that lives close to the home.

On 09/04/2026, I interviewed direct care worker, Makayla Elton via phone. She reported that she observed Resident A and Resident B to both pick at each other. She stated that if Resident B becomes annoyed or frustrated with Resident A, he stays in his bedroom or staff encourage Resident B to go for a walk.

APPLICABLE RULE	
R 400.671	Resident Care
	(2) Care and services provided to a resident must be designed to maintain or improve a resident's physical and intellectual functioning and independence.
ANALYSIS:	Based upon documents reviewed and interviews conducted it was found that direct care workers were providing interventions to prevent Resident A from harming Resident B. Through interviews it was also determined that direct care workers were following up with Resident B regarding his mental stability if Resident A was in a behavior. Direct care workers were able to identify Resident B's positive coping skills and encouraged these coping skills for Resident B if he was affected by Resident A's negative behaviors. A violation was not established as direct care workers were providing care and services to Resident B to help maintain his physical and intellectual functioning.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 08/12/2026, I completed an unannounced onsite investigation to Umbrellex 2. I requested all *AFC Licensing Division Incident/Accident Report* dated 7/9/26-8/12/26. It should be noted that that Resident A went to jail on 7/28/26 for 32 days.

Resident A's *behavioral treatment plan* was reviewed and was dated 5/12/2026. According to her *behavioral treatment plan* if Resident A elopes, the following is the reactive strategy:

"Staff will follow [Resident A] immediately. Maintain visual range, no more than 6–8 feet away. Prompt return to the home once every 60 seconds. No conversational dialogue during active elopement other than return prompts and "we can talk about this once we are home." Once home, provide specific praise for returning. Briefly identify one alternative for next time. Do not bring up the elopement again during the shift."

The intrusive strategy regarding elopements documented in Resident A's *behavioral treatment plan* was the following:

"Dedicated Staffing Support – 1:1 Arms-Length [Resident A] will receive 1:1 arms-length staffing in the home and in the community due to the documented frequency and severity of SIB, physical aggression, and elopement. This support is intended to equip Chelsea with tools she can apply with increasing independence over time."

Based upon Resident A's *behavioral treatment plan*, no documentation or interventions were available to review if Resident A is running into traffic. No documentation or interventions were available within Resident A's *behavioral treatment plan* regarding staff using CPI holds, (nonviolent, crisis intervention, 3rd edition).

According to her *behavioral treatment plan* if Resident A has physical aggression, the following is the reactive strategy:

"At the first sign of impending aggression, prompt "safe hands" immediately. If [Resident A] uses safe hands, praise immediately and offer two preferred activity options. If aggression continues, name the observed emotion ("[Resident A] you seem very upset") and offer two preferred activity choices. Maintain calm and ensure safety. Do not engage in extended discussion during escalation.

Post-Incident Reset: When [Resident A] is ready, acknowledge her calm specifically ("Thank you for calming down—that was a good choice"). Keep the reset brief. Do not revisit the behavior during the same shift."

According to her *behavioral treatment plan*, if Resident A has suicidal ideation the following is the reactive strategy:

"Attention-maintained statements (casual tone, no behavioral indicators): Do not engage the statement directly. Begin a preferred activity nearby, invite [Resident A] to join, and redirect attention to the activity without referencing the statement."

Genuine distress indicators (active item-seeking, written notes, mood congruence, strangulation attempt): Follow the SIB reactive strategy below and contact clinical immediately. All suicidal ideation statements will be documented with context to support psychiatric review."

According to her *behavioral treatment plan*, if Resident A has self-injurious behavior the following is the reactive strategy:

"Respond immediately and calmly without exaggerated reaction. Redirect hands to an alternative activity ("Here, hold this"/"Here is a marker, let's color"). If head banging, guide [Resident A] away from hard surfaces to a safe space and offer a calming activity.

If strangulation is attempted: remove the item, remain calm, and immediately secure all ligature items in the environment. Address any wounds with minimal verbal acknowledgment of the behavior.

If [Resident A] engages in any alternative behavior, provide specific, immediate praise."

Resident A's *behavioral treatment plan* was reviewed in detail, and no information was available regarding staff using a CPI hold. On 09/03/2026, I contacted Resident A's Community Mental Health case worker, Shannon Diebel for additional information. She reported the following: "CPI holds and police intervention are not allowed to be documented in the BTP due to HCBS rules, and that it is strongly encouraged that less restrictive interventions outlined in the BTP are to be utilized."

On 09/03/2026, Josie Grannell from Tuscola Behavioral Health Systems provided the following information from the 2024, Behavior Treatment Plan Technical Requirements "Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations."

Based on the *AFC Licensing Division Incident/Accident Reports from 7/9/26-7/28/26*, Resident A was put in a CPI hold (physical intervention hold) on the following dates and times:

- 7/10/26 @ 5:55pm low level for 1 minute, another medium hold performed for 2 minutes, continued to punch staff. Staff called clinical to talk to her.
- 7/11/22026 @ 6:30pm. According to the *AFC Licensing Division Incident/Accident Reports* "[Resident A] said I am going to kill myself. She then put the sharp end of the stick to her right forearm and cut it. Staff were able to do low level cpi hold for one second to grab the stick. There were no marks from the stick." One CPI hold starting at 6:30pm-6:35pm, high level CPI hold starting at 6:45pm-6:50pm. Third CPI hold starting at 7:15pm-7:20pm. Fourth high level CPI hold starting at 7:20pm-7:27pm. Police arrived, Fifth CPI hold due to Resident A still trying to hit, kick, spit, pinching, and scratching the other staff. Fifth CPI hold

only lasted a few seconds before police intervened and placed Resident A in handcuffs. Resident A was taken to the hospital.

- 7/14/2026 @ 9:45am. CPI hold started at 9:45am-9:48am for Resident A starting to throw a stick. Resident A then bit the staff's arm and drew blood. Another staff member intervened and completed a CPI hold from 9:50am-9:53am. Resident A went to hit staff again, staff blocked the attack and staff attempted another CPI hold that was unsuccessful due to Resident A biting staff. Police were called by another resident.
- 7/14/2026 @ 6:45pm. Resident A put a sharp item to her arm, CPI hold was performed from 6:45pm-6:50pm. Resident A continued to bite staff, another CPI hold was performed for 1 minute. Another resident called the police; Resident A was taken to the hospital.
- 7/14/2026 @ 9:20pm. Resident A returned from the hospital, started to punch and bite staff members. CPI hold completed.
- 7/15/2026 @ 3:30pm. Resident A started to hit staff in stomach. Two staff performed a CPI hold for 5 minutes.
- 07/15/2026 @ 4:30pm. Resident A started to hit staff in the stomach. Two staff performed a CPI hold for 5 minutes.
- 07/16/2026 @ 3pm. Resident A screamed "I'm going to kill myself" and tried cutting herself. Staff started a low-level CPI hold from 3:30-3:35pm. Resident A started coming at staff again and a CPI hold was performed from 4:30pm-4:35pm. After CPI hold, Resident A spit in staff's face, ran to her room and then came out and tried to throw a basketball at staff. Staff performed a CPI hold from 5pm-5:05pm.
- 07/21/2026 @ 9:30am. CPI hold started at 9:45am-9:48am for Resident A starting to throw a stick. Resident A then bit the staff's arm and drew blood. Another staff member intervened and completed a CPI hold from 9:50am-9:53am. Resident A went to hit staff again, staff blocked the attack and staff attempted another CPI hold that was unsuccessful due to Resident A biting staff. Police were called by another resident. Police would not take her, and the clinical team was able to calm her down.

None of the *AFC Licensing Division Incident/Accident Reports* from 7/9/26-7/28/26 documented the use of verbal redirection as outlined in Resident A's *behavior treatment plan*.

On 08/12/2026 and 08/31/2026, I interviewed Resident A's case manager, Shannon Diebel. Ms. Diebel stated that Resident A returned to the home on 8/28/2026 and she has not been notified of any incidents. She stated that she will be visiting Resident A on 9/1/26. Ms. Diebel reported that this is her longest jail sentence, but she had four other charges in three other counties. Ms. Diebel explained that from what she heard, Resident A's time in jail didn't seem to bother her. Ms. Diebel reported that before any CPI holds are performed on Resident A, staff should follow Resident A's behavioral intervention plan and try all redirections.

APPLICABLE RULE	
R 400.643	Crisis intervention.
	(5) Crisis intervention must not be used as a routine intervention.
ANALYSIS:	Based upon the documentation reviewed for the nineteen-day period (7/9/26- 7/28/26), Resident A was placed in a CPI (physical intervention hold) twenty times. During this nineteen-day period, she was also taken to the hospital twice by law enforcement. A violation was established as it was determined that direct care workers are routinely using crisis intervention prior to using interventions outlined in Resident A's <i>behavioral treatment plan</i> . It was found when reviewing <i>AFC Licensing Division Incident/Accident Reports</i> , dated 7/11/26, 7/14/26 and 7/16/26, that direct care workers used a CPI hold as the first intervention when Resident A threatened to self-harm or started to self-harm.
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.



09/04/2026

Amanda Blasius
Licensing Consultant

Date

Approved By:



09/09/2026

Dawn N. Timm
Area Manager

Date