GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2022

Melissa Bentley
2099 W Wilson Rd
Clio, MI 48420

RE: License #: AM250014855
Investigation #: 2022A0572011
Bentley Manor #6

Dear Ms. Bentley:

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 (906) 226-4171.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AM250014855
Investigation #:	2022A0572011
Complaint Receipt Date:	12/10/2021
Investigation Initiation Date:	12/14/2021
Report Due Date:	02/08/2022
Licensee Name:	Melissa Bentley
Licensee Address:	2099 W Wilson Rd Clio, MI 48420
Licensee Telephone #:	(810) 547-1763
Administrator:	Melissa Bentley
Licensee Designee:	N/A
Name of Facility:	Bentley Manor #6
Facility Address:	14356 Nichols Road Montrose, MI 48457
Facility Telephone #:	(810) 639-7585
Original Issuance Date:	05/25/1993
License **Status:**	REGULAR
Effective Date:	03/27/2020
Expiration Date:	03/26/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A received an extra dose of his prescribed Wellbutrin medication after he intimidated a facility staff to give it to him.	Yes

III. METHODOLOGY

12/10/2021	Special Investigation Intake 2022A0572011
12/10/2021	APS Referral APS Referral was made.
12/14/2021	Special Investigation Initiated - On Site
12/14/2021	Contact - Face to Face Assistant Manager, Lareen Scott, and Resident A.
01/31/2022	Contact - Document Sent APS Investigator, Monica Voltz.
02/01/2022	Contact - Telephone call made Staff, Susan Dunklin.
02/01/2022	Exit Conference Licensee, Melissa Bentley.
02/01/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:
Resident A received an extra dose of his prescribed Wellbutrin medication after he intimidated a facility staff to give it to him.

INVESTIGATION:
On 12/10/2021, the local licensing office received a complaint for investigation. Recipient Rights and Adult Protective Service (APS) both conducted their own investigations.

On 12/14/2021, an unannounced onsite was conducted at Bentley Manor #6, located in Genesee County, Michigan. Interviewed were Assistant Manager, Lareen Scott, and Resident A.

On 12/14/2021, I interviewed Assistant Manager, Lareen Scott regarding an allegation that Resident A received an extra dose of his prescribed Wellbutrin medication after he intimidated a facility staff to give it to him. Ms. Scott informed that this incident occurred over the weekend, and they have documents showing that Resident A asks for additional medications all the time. Resident A cornered one of the staff over the weekend and he would not let her pass until she gave him an extra dose of Wellbutrin which is for his anxiety. Third shift noticed that one pill was missing and notified Ms. Scott as soon as she arrived to work that morning. Staff, Susan Dunklee called Ms. Scott later that morning to inform her what happened. They had an emergency Med Review for Resident A with the Psych Doctor after it happened, and the physician took Resident A off the medication.

On 12/14/2021, I interviewed Resident A regarding an allegation that he received an extra dose of his prescribed Wellbutrin medication after he intimidated a facility staff to give it to him. Resident A denied that he intimidated the staff member into giving him an extra dose of medication and indicated that she is making this up so that she does not get in trouble. He informed that he received some bad news regarding his son and there was nothing he could do to help himself mentally without being admitted to the hospital, so he simply asked Ms. Dunklee for another pill, and she gave it to him. Resident A said that him and Ms. Dunklee got along very good, and he wouldn't dare threaten her because he would go to jail. Resident A said no one was around to witness what happened, and the other residents are low functioning.

On 12/14/2021, Ms. Scott showed me Resident A's listed medications on the electronic MARs (Medication Administration Records). She informed that there was nothing that could be added in the system for the additional dose, but they documented it on an Incident Report. The Wellbutrin is discontinued.

On 12/14/2021, I received a copy of the Incident Report. It indicates that Resident A cornered Staff, Susan Dunklee and asked for additional medication and would not allow her to pass. Staff felt scared of what he might do if she didn't give him the extra pill, so she gave it to him. Med Cart was moved to an open area, that way staff will have an escape route in case a resident attempt to corner them again.

On 01/13/2022, I interviewed APS Investigator, Monica Voltz regarding an allegation that Resident A received an extra dose of his prescribed Wellbutrin medication after he intimidated a facility staff to give it to him. She informed that Ms. Dunklee admitted to providing Resident A with the medication against doctor's orders, but she reported that she was intimidated and afraid of Resident A and that is why she did it. Resident A denied that he forced Ms. Dunklee to provide him with additional medication. Ms. Voltz believes that she will substantiate against Ms. Dunklee because she gave Resident A the additional medication although she knew that it was against the doctor's orders.

On 02/01/2022, I interviewed former staff, Susan Dunklee regarding an allegation that Resident A received an extra dose of his prescribed Wellbutrin medication after he intimidated her into giving it to him. Ms. Dunklee informed that she gave Resident A an extra does of Wellbutrin because he kept begging for it and would not allow her to move passed without giving it to him. She indicated that she felt threatened, and this was the first time in 45 years of doing this line of work that she had felt threatened. She recently retired and indicated that at her age and with her various ailments, she would not have been able to fight him off, so she just gave him the medication, then contacted her boss and told her what happened. Resident A did not say anything threatening to her, but he had a mean look, a look of evil on his face. She had never had any issues with him before. This was the first time that Resident A had asked her for additional medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The Assistant Manager, Resident A and Ms. Dunklee all indicated that Ms. Dunklee administered an additional Wellbutrin to Resident A which was against the doctor's order.
CONCLUSION:	**VIOLATION ESTABLISHED**

An Exit Conference was held on 02/01/2022 with Licensee, Melissa Bentley. She was informed of the results of the investigation.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this medium-sized group home, pending the receipt of an acceptable corrective action plan (Capacity 1-12).

02/02/2022

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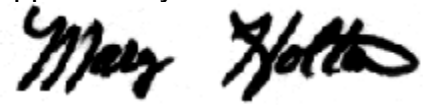
Anthony Humphrey Date
Licensing Consultant

Approved By:



02/02/2022

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Mary E Holton Date
Area Manager