GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 7, 2025

Melissa Bentley
Bentley Manor Inc.
P.O. Box 460
Clio, MI 48420

RE: License #: AM250071550
Investigation #: 2025A0779020
Bentley Manor #3

Dear Melissa 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 (517) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250071550
Investigation #:	2025A0779020
Complaint Receipt Date:	01/28/2025
Investigation Initiation Date:	01/29/2025
Report Due Date:	03/29/2025
Licensee Name:	Bentley Manor Inc.
Licensee Address:	P.O. Box 460, Clio, MI 48420
Licensee Telephone #:	(810) 547-1763
Administrator:	Melissa Bentley
Licensee Designee:	Melissa Bentley
Name of Facility:	Bentley Manor #3
Facility Address:	14461 Clio Road, Clio, MI 48420
Facility Telephone #:	(810) 686-7677
Original Issuance Date:	06/01/1997
License **Status:**	REGULAR
Effective Date:	09/04/2024
Expiration Date:	09/03/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was given another resident's medications.	Yes

III. METHODOLOGY

01/28/2025	Special Investigation Intake 2025A0779020
01/29/2025	Special Investigation Initiated - On Site
01/30/2025	APS Referral Complaint was referred to APS centralized intake.
01/30/2025	Exit Conference Held with licensee designee, Melissa Bentley.

ALLEGATION:

Resident A was given another resident's medications.

INVESTIGATION:

On 1/29/2025, an on-site inspection was conducted and home manager, Samantha Adamczewski, was interviewed. Manager Adamczewski confirmed that Resident A had taken Resident B's medication on 1/25/2025. Manager Adamczewski stated that both Resident A and Resident B were in line while she was passing out medications and she had given Resident B his medications in a med cup. Manager Adamczewski reported that she then heard another resident yell for help, so she left to help that resident and when she returned, she found that Resident B had given his medications to Resident A and that Resident A had already swallowed them. Manager Adamczewski stated that she immediately called poison control and was told that Resident A should have no major reactions to the medications he took and to just monitor him and keep him hydrated. Manager Adamczewski stated that she kept a close eye on Resident A the rest of the shift and that, other than being a little sleepy, Resident A seemed to be fine.

Resident A and Resident B's Medication Administration Records (MAR's) were reviewed. The MARs showed that both residents received their appropriate prescribed medications on 1/25/2025. The medications that Resident A took that were not prescribed to him are as follows: Aspirin, Cetirine, Divalproex, Donepezil, Memantine, Midodrine, Paroxetine, Stimulant LX tab, Tamsulosin, and Vraylar.

The home provided a copy of an AFC Licensing Division Incident/Accident Report (IR) regarding the medication incident. The information on the IR matched the information obtained during the interview with Manager Adamczewski. The corrective measures listed on the IR were for staff to stand by a resident's side at all times while administering medications and that the staff person involved will retake medication training.

During the on-site inspection on 1/29/2025, an attempt was made to interview Resident A, but he could not remember taking anyone else's medications. Due to his cognitive deficiencies, Resident A was not able to provide any relevant information.

On 1/29/25, Resident B was interviewed. Resident B stated that he does remember giving Resident A his med cup and said that it was an accident. Resident B confirmed that Manager Adamczewski gave him his medications in a cup and that he gave the cup to Resident A. Resident B apologized for doing that and said he knows not to ever do that again.

On 1/29/2025, supervisor, Tiffany Thomas, stated that Samantha Adamczewski was just recently promoted to home manager. Supervisor Thomas stated that this was Manager Adamczewski first known medication error and that Manager Adamczewski did receive disciplinary action. Supervisor Thomas reported that Resident A took his prescribed medications before taking Resident B's and that poison control was aware of that fact.

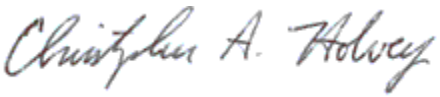
On 1/30/2025, an exit conference was held with licensee designee, Melissa Bentley. LD Bentley confirmed that this was the first significant error made by Manager Adamczewski and she hopes Manager Adamczewski will use this as a learning experience and improve. LD Bentley stated that Manager Adamczewski will be required to attend new medication training.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was confirmed that on 1/25/25, Resident A was allowed to take prescription medication that was not prescribed to him. Home manager Samantha Adamczewski admits that she gave Resident B his medications and then walked away without watching Resident B take them, which resulted in Resident B giving his medications to Resident A to take. Before Manager

	Adamczewski knew what happened, Resident A had already swallowed the medication. There was sufficient evidence found to warrant citation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

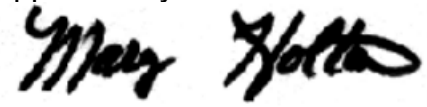


2/7/2025

_____

Christopher Holvey Date
Licensing Consultant

Approved By:



2/7/2025

_____

Mary E. Holton Date
Area Manager