GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 19, 2025

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

RE: License #: AM250291561
Investigation #: 2026A0569001
Bentley Assisted Living

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 party responsible 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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250291561
Investigation #:	2026A0569001
Complaint Receipt Date:	10/07/2025
Investigation Initiation Date:	10/08/2025
Report Due Date:	12/06/2025
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 Assisted Living
Facility Address:	6252 W Mt Morris Rd Mt Morris, MI 48458
Facility Telephone #:	(810) 686-6976
Original Issuance Date:	01/13/2010
License Status:	REGULAR
Effective Date:	07/15/2024
Expiration Date:	07/14/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
• **Resident A was administered another resident's medication on 10/03/2025.**	Yes

III. METHODOLOGY

10/07/2025	Special Investigation Intake 2026A0569001
10/08/2025	APS Referral Referral to APS.
10/08/2025	Special Investigation Initiated - Letter Email to ORR.
10/31/2025	Contact- Document received Written statement from Tia Houston, staff person.
11/18/2025	Inspection Completed On-site
11/18/2025	Inspection Completed-BCAL Sub. Compliance
11/18/2025	Exit Conference Exit conference with Melissa Bentley, licensee designee.
11/18/2025	Corrective Action Plan Requested and Due on 12/05/2025

ALLEGATION:

Resident A was administered another resident's medication on 10/03/2025.

INVESTIGATION:

This complaint was received via LARA-BCHS-Complaints@michigan.gov. The complainant reported that Resident A took another resident's medications on 10/03/2025. The complainant reported that Tia Houston, staff person, set another resident's medication on the dining room table next to Resident A, and Resident A took the medications.

An unannounced inspection was conducted on 11/18/2025. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that he was not aware that he took incorrect medications on 10/03/2025. Resident A stated that he takes his medications every day and drinks milk when he takes the medications. Resident A stated that he has not become sick from taking medications. Resident A stated that the staff at this facility are nice, and he has had no problems with the staff at this facility. Resident A stated that he did not have any other information regarding this allegation.

Resident A's file contains an incident report (IR) dated 10/03/2025. The IR documents that during the morning medication pass, Resident A "reached over, picked up another resident's medications, and took the medications". The IR documents that staff immediately contacted poison control and were instructed, based on the medications taken, to monitor Resident A for drowsiness and vomiting for the next 4-6 hours. The IR documents that the corrective measures were to retrain staff in medication administration and to administer only one resident's medications at a time and monitor to ensure the resident has taken the medications before administering the next resident's medications.

Resident A's medication administration record was reviewed. No other medication errors were documented.

Tia Houston, staff person, stated on 10/31/2025 that she was administering the residents' medications around 6:52am on 10/03/2025. Tia Houston stated that she handed another resident their medications and informed Resident A that she would give him his medications once she had finished the breakfast dishes. Tia Houston stated that the other resident came to her in the kitchen looking for a note pad. Tia Houston stated that they then walked back into the dining room, and she discovered that Resident A had taken the medications. Tia Houston stated that at that moment, Charlotte Guinther, facility manager, entered the facility. Tia Houston stated that she immediately informed Charlotte Guinther what had happened, and she then called poison control. Tia Houston stated that she was instructed to monitor Resident A for dizziness and vomiting for 4 to

6 hours. Tia Houston stated that Resident A did not exhibit any side effects and did not require any additional medical treatment.

Charlotte Guinther, facility manager, stated on 11/18/2025 that she arrived at the facility at 6:54am on 10/03/2025. Charlotte Guinther stated that Tia Houston informed her that Resident A had just taken the wrong medications, so she instructed Tia Houston to call poison control with the list of medications given to Resident A. Charlotte Guinther stated that they were instructed by poison control that the medications taken should not cause any side effects for Resident A, but to monitor him for 4-6 hours for dizziness and nausea. Charlotte Guinther stated that Resident A did not experience any side effects and did not need further medical treatment. Charlotte Guinther stated that Tia Houston admitted to her that she gave another resident their medications, then walked away to the kitchen to do some dishes. Charlotte Guinther stated that the other resident set the medications down on the table, and Resident A picked them up and took them. Charlotte Guinther stated that she completed a written discipline for Tia Houston and conducted a retraining with staff regarding medication administration. Charlotte Guinther stated that the other resident did receive their medications and did not miss any doses.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The complainant reported that Resident A took another resident's medications on 10/03/2025. Tia Houston admitted that she handed another resident their medications then left the room. The resident then set the medications on the table, and Resident A picked the medications up and took them. Staff immediately contacted poison control and Resident A did not require any additional medical treatment. Based on the documentation reviewed and statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Melissa Bentley, licensee designee, on 11/18/2025. The findings in this report were reviewed, and a corrective action plan was requested.

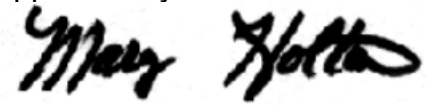
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

11/19/2025

Kent W. Gieselman — Date
Licensing Consultant

Approved By:



11/19/2025

Mary E. Holton — Date
Area Manager