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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 17, 2021

Melissa Bentley
2099 W Wilson Rd
Clio, MI 48420

RE: License #: AL250015880
Investigation #: 2022A0779007
Bentley Manor #8

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,

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 #:	AL250015880
Investigation #:	2022A0779007
Complaint Receipt Date:	11/10/2021
Investigation Initiation Date:	11/12/2021
Report Due Date:	01/09/2022
Licensee Name:	Melissa Bentley
Licensee Address:	2099 W Wilson Rd, Clio, MI 48420
Licensee Telephone #:	(810) 547-1763
Administrator:	Melissa Bentley
Name of Facility:	Bentley Manor #8
Facility Address:	G-5325 Detroit Street, Flint, MI 48505
Facility Telephone #:	(810) 789-7363
Original Issuance Date:	05/01/1994
License **Status:**	REGULAR
Effective Date:	06/04/2021
Expiration Date:	06/03/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A went missing at 5:00pm on 11/5/2021 and was brought home at 10pm by a stranger. At 1:00am Resident A awoke being violent to staff, 911 was called but staff did not go with him to hospital and he eloped from there.	Yes

III. METHODOLOGY

11/10/2021	Special Investigation Intake 2022A0779007
11/10/2021	APS Referral Complaint was referred to AFC licensing by APS centralized intake.
11/12/2021	Special Investigation Initiated - Telephone Phone interview was conducted with home supervisor, Angie Work.
11/12/2021	Contact - Telephone call made Spoke to Complainant.
11/12/2021	Contact - Telephone call made Spoke to APS worker, Kizzie Baker.
11/16/2021	Contact - Telephone call received Spoke to APS worker, Ms. Baker.
11/16/2021	Inspection Completed On-site
11/24/2021	Contact - Telephone call made Interview conducted with staff person, Carla Hall.
11/24/2021	Contact - Telephone call made Interview conducted with staff person, Rayshele Simmons.
12/13/2021	Contact - Telephone call made Spoke to Resident A's legal guardian.
12/13/2021	Exit Conference Conducted with licensee, Melissa Bentley.

ALLEGATION:

Resident A went missing at 5:00pm on 11/5/2021 and was brought home at 10pm by a stranger. At 1:00am Resident A awoke being violent to staff, 911 was called but staff did not go with him to hospital and he eloped from there.

INVESTIGATION:

On November 12, 2021, a phone interview was conducted with home supervisor, Angie Work, who stated that she was aware of the situation in question but that she was not directly involved in the events that took place. She stated that Resident A has a traumatic brain injury and poor decision-making skills, but does not have a history of elopement. She reported that Resident A spends most of his time outside smoking and pacing. Ms. Work stated that Resident A eloped from the home somewhere around 5:00pm on November 5, 2021, and that when staff realized that Resident A was gone, the police were called, a message was left for Resident A's guardian and she spent three hours driving around looking for him. Ms. Work reported that Resident A returned to the home later that night intoxicated and looking like he got beat up, but was not seriously hurt. She stated that after Resident A was fed, he went to his room, but came out a few hours later being aggressive and he assaulted one of the staff. Ms. Work stated that 911 was called and police removed Resident A from the home at approximately 1:00am on November 6, 2021. She reported that at 7:00am on November 6, 2021, home manager, Kelly Quintanilla, called the hospital, who stated that they had no record of Resident A being there, which is not uncommon if a resident is placed on a psych hold. Ms. Work stated that it was then staff assumption that Resident A was either in the psych unit at the hospital or in jail. She stated that during the afternoon of November 7, 2021, the hospital called the home and said that Resident A had returned to the hospital beat up and injured, so a staff person immediately went to the hospital and stayed there until Resident A was admitted. Ms. Work reported that Resident A returned to the home later that day. She reported that Resident A continues to talk about wanting to leave the home and that staff are trying to keep a closer eye on him. Ms. Work stated that Resident A does not have a behavioral plan in place and does not have any specific supervision requirements, other than not being able to be in the community unsupervised. She stated that they provided Resident A, his guardian, and his placing agency a written 30-day discharge notice.

On November 12, 2021, a phone conversation took place with Complainant. She stated that when Resident A originally eloped from this home, staff last saw him at 3:45pm and that they did not realize he was gone from the home until 5:00pm. Complainant reported that when Resident A went to the hospital on November 6, 2021, he was dropped off by an ambulance, no police and that staff from this home did not go with him. Complainant stated that when Resident A returned to the hospital on November 7, 2021, he was again dropped off there by ambulance and not police.

On November 12, 2021, a phone call made to APS worker, Kizzie Baker, who confirmed that she had seen and spoken to Resident A on November 10, 2021. Ms. Baker stated

that Resident A was confused about the details of what happened to him between November 5-7, 2021. She stated that Resident A admitted to her that he just walked away from this home and stated that he does not know what his purpose was for leaving. A second phone conversation took place with Ms. Baker on November 16, 2021. Ms. Baker stated that she had been in contact with Resident A's guardian, who confirmed that staff from this home left their office a voicemail message on November 5, 2021, stating that Resident A eloped from the home. Ms. Baker reported that Resident A's guardian's office said that they were kept aware of Resident A's situation between November 5-7, 2021.

On November 16, 2021, an on-site inspection was conducted at this home. Interviews were conducted with Resident A and home manager, Kelly Quintanilla.

Resident A admitted that he just left this home on November 5, 2021, without telling staff he was leaving. He stated that he thinks staff were busy helping other residents when he left and walked away. Resident A reported that he went to his old neighborhood looking for information regarding his kids. He stated that he does not remember anything about the time that he was gone from this home between November 5-7, 2021. Resident A stated that everyone is telling him that he had all kinds of alcohol and drugs in his system, but that all he remembers is that he got beat up. Resident A claims to not remember assaulting staff at this home.

Home manager, Kelly Quintanilla, confirmed that she worked on November 5, 2021, and during the time that Resident A eloped. She stated that the last confirmed time that Resident A was seen by staff on November 5th was at 3:45pm and that when staff went to Resident A's room to get him for dinner at 5:00pm, they noticed he gone. Ms. Quintanilla reported that she immediately called 911 and left a message with Resident A's guardian, Guardian A1, after the police left the home. Ms. Quintanilla stated that Resident A was dropped off back at the home by a neighborhood stranger at 10:00pm. She stated that Resident A smelled of alcohol, was extremely intoxicated and repeatedly asked for a sandwich. Ms. Quintanilla reported that 3rd shift staff were preparing Resident A some food when she left the home for the night. She stated that during the night, Resident A became aggressive and assaulted staff person, Rayshele Simmons, the police were called and Resident A was removed from the home. Ms. Quintanilla admitted there was some lack of communication between her and the 3rd shift staff and that it was not clear to her if Resident A was taken away by the police or by ambulance. She stated that when she arrived to work early morning on November 6th, she called two hospitals and the county jail and Resident A was not present at any of them. Ms. Quintanilla stated that she assumed that Resident A was in the hospital psych ward, as they will not confirm that fact to anyone over the phone. She reported that they did not hear anything else related to Resident A until the hospital called the home at approximately 2:00pm on November 7th to say that Resident A just returned to the hospital and appeared to have been beaten up. Ms. Quintanilla stated that a staff person immediately went to the hospital to stay with Resident A until he was admitted and this was when they were informed that Resident A had walked away from the hospital the day before (11/6/21). She stated that the hospital never called the phone to

inform them he had left the hospital. She stated that Resident A was returned to the home by ambulance later that night on November 7th. Ms. Quintanilla reported that Resident A does not have a behavior plan, there is nothing in writing regarding any specific supervision requirements, and that Resident A is allowed to go outside and smoke throughout the day. She stated that this was the first time that Resident A has ever eloped and that there were no known triggers or signs that he was going to do so.

Resident A's written assessment plan was reviewed and confirms that Resident A requires supervision while out in the community. It does not state that Resident A is in need of any increased supervision while inside the home. The assessment plan states that Resident A is quite independent and only needs verbal prompting in order to complete all his activities of daily living on his own

The home provided copies of three separate incident reports (IR's) regarding Resident A's elopement incidents. The first IR documented that at 5:00pm on November 5, 2021, staff realized that Resident A was not present any where inside the home. Staff immediately called 911 to report him missing. The corrective measures to prevent reoccurrence were to continue one hour bed checks and speak with Resident A about the safety issues with him leaving the home without supervision.

The second IR documented that after Resident A returned to the home on November 5th, he became physically aggressive and hit when of the staff in the face and chest at approximately 1:10am on November 6th. Staff called 911 and Resident A was removed from the home by ambulance. The corrective measures documented were to follow all hospital discharge instructions and to increase supervision of Resident A upon his return to the home.

The third IR documented the situation regarding Resident A going back to the hospital on November 7th. It stated that staff at the home received a call from the hospital at 1:50pm on November 7th stating that Resident A had just arrived at the hospital and was bloody and beaten up. Staff immediately went to the hospital to learn that Resident A had walked away from the hospital sometime the day before (11/6/21). The corrective measures were to follow hospital discharge instructions, increase supervision of Resident A and that a 30-day discharge notice will be provided to Resident A.

On November 24, 2021, a phone interview was conducted with staff person, Carla Hall, who confirmed that she was one of two 3rd shift staff that worked at this home during the night of November 5th and 6th. Ms. Hall stated that Resident A had returned from his elopement from the home at 10:00pm on November 5th. She stated that he smelled of alcohol and looked like he had gotten into a fight, as he had bruising under each eye. Ms. Hall reported that he was fine but that he was hungry, so they fixed him a meal before Resident A went to his room for the night. Ms. Hall stated that at around 1:00am, Resident A came out of his room being very aggressive and hit staff person, Ms. Simmons. She stated that 911 was called, the police called for an ambulance and that Resident A left the home via ambulance. Ms. Hall admitted that no staff went with Resident A in the ambulance or to the hospital.

On November 24, 2021, a phone interview was conducted with staff person, Rayshele Simmons, who confirmed that she was the other staff that worked 3rd shift during the night of November 5th and 6th. Ms. Simmons stated that Resident A was in his bedroom when she arrived to work on the night of November 5th . She reported that Resident A came out of his room during the night being aggressive and punched her in the face. Ms. Simmons stated that 911 was called and the police called for an ambulance. She stated that she provided the EMT's with Resident A's pertinent information and that Resident A was taken away by the ambulance. She reported that the EMT's told her that they were taking Resident A to Hurley Medical Center. Ms. Simmons admitted that neither her nor Ms. Hall went to the hospital to be with Resident A.

On December 13, 2021, a phone conversation took place with Resident A's legal guardian, Guardian A1. She confirmed that her office was notified by this home's staff of Resident A's elopement from the home and kept them informed of what transpired over the next couple days. Guardian A1 stated that Resident A has to be supervised while in the community, but that there is no specific supervision criteria for him while he is inside the home. She confirmed that he is allowed to go directly outside the home to smoke. Guardian A1 stated that Resident A was doing very well at this home, had no prior elopement history and that these elopement incidents were totally unexpected.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's written assessment plan states that Resident A is not to be out in the community without staff supervision. Resident A received a lack of supervision and protection on two separate occasions. On November 5, 2021, Resident A was able to walk away from this home without staff's knowledge. It is unknown exactly when Resident A left the home and/or how long Resident A had been gone when staff realized he was no where inside the facility at 5:00pm.

	On November 6, 2021, Resident A was taken to the hospital by ambulance after assaulting staff person, Rayshele Simmons. No staff person went to the hospital to supervise Resident A, until he was admitted, and Resident A was able to walk away from the hospital and be in the community supervised until returning to the hospital injured on November 7, 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

On December 13, 2021, an exit conference was conducted with licensee, Melissa Bentley. She was informed that the result of this investigation warranted a licensing rule violation and that a written corrective action plan was required.

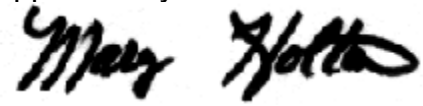
IV. RECOMMENDATION

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

12/17/2021

Christopher Holvey Date
Licensing Consultant

Approved By:



12/17/2021

Mary E Holton Date
Area Manager