GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 5, 2022

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

RE: License #:	AM250071550
Investigation #:	2022A0872030
	Bentley Manor #3

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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250071550
Investigation #:	2022A0872030
Complaint Receipt Date:	04/08/2022
Investigation Initiation Date:	04/08/2022
Report Due Date:	06/07/2022
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:	09/04/2020
Expiration Date:	09/03/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, AGED MENTALLY ILL, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 04/06/22, Resident A had a seizure. Staff did not seek medical attention for him for almost an hour at which time 911 was contacted and he was transported to the hospital.	Yes

III. METHODOLOGY

04/08/2022	Special Investigation Intake 2022A0872030
04/08/2022	APS Referral This complaint was assigned to APS
04/08/2022	Special Investigation Initiated - Letter I exchanged emails with APS Supervisor, Kathryn Dennis. Shwanda Lee is the APS worker on this case
04/19/2022	Inspection Completed On-site Unannounced
04/27/2022	Contact - Document Received AFC documentation received
05/04/2022	Contact - Telephone call received I spoke to VAAA Waiver Supports Coordinator, Jackie Maliszewski
05/04/2022	Contact - Telephone call made I interviewed staff Gwen Roberts
05/04/2022	Exit Conference I conducted an exit conference with the licensee designee, Melissa Bentley
05/04/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 04/06/22, Resident A had a seizure. Staff did not seek medical attention for him for almost an hour at which time 911 was contacted and he was transported to the hospital.

INVESTIGATION: On 04/08/22, I emailed Adult Protective Services Supervisor, Kathryn Dennis. She said that this complaint was received and assigned to Shwanda Lee.

On 04/19/22, I conducted an unannounced onset inspection of Bentley Manor #3 Adult Foster Care facility. I interviewed the home manager, Shana Cochran, and Resident A.

Ms. Cochran said that Resident A has lived at this facility for approximately two years. When he first moved in, he was prone to seizures, but he has not had a seizure since approximately the summer of 2021. According to Ms. Cochran, on 04/05/22 Resident A had a seizure which began at approximately 10:35am. Staff called Ms. Cochran at approximately 10:47am to let her know about the seizure and then staff called Relative A1. Ms. Cochran said that since Resident A did not come out of the seizure, staff called 911 and Resident A was transported to the hospital. Ms. Cochran is unsure of how much time went by before staff called 911 but she believes it was less than one hour.

Ms. Cochran said that the facility was never given a seizure protocol to follow by Resident A's doctor and since he had gone so long without having a seizure, there was not a timeline in place as to when to contact 911. According to Ms. Cochran, as a result of this incident, she has talked to Resident A's neurologist asking for a protocol to follow if Resident A has another seizure. Ms. Cochran is also going to work on developing a company-wide seizure protocol for staff to follow.

I interviewed Resident A in his room, while he was sitting in his wheelchair. He was clean and dressed appropriately. Resident A confirmed that he has lived at this facility for approximately two years and said, "Staff takes good care of me." Resident A confirmed that he used to have seizures but has not had any for a long time. He said that he does not remember having a seizure on 04/06/22 and only remembers being in the hospital. Resident A told me that staff always makes sure he takes his medications, and they help him with all his activities of daily living.

On 05/03/22, I reviewed AFC documentation related to this complaint. According to the Incident/Accident Report (IR) dated 04/05/22, "(Resident A) was sitting in doorway of bathroom and staff went to help him thinking he was asleep in his chair. When staff got to him, she realized he was in a seizure. By the time staff got him by the office his seizure had intensified. Staff called management and guardian. Guardian did not want him sent out at 30 minutes in. Staff got okay from supervisor to send him to hospital when he was almost an hour in, and staff called 911. EMT's arrived and took him to Hurley."

According to Resident A's discharge paperwork from Hurley Medical Center dated 04/08/22, he remained in the hospital from 04/06/22 through 04/08/22 and was treated for a prolonged seizure.

According to Resident A's Health Care Appraisal dated 08/11/21, he is diagnosed with a traumatic brain injury (TBI), seizure disorder, and abnormal weight loss. He has mental and physical limitations due to his TBI and uses a wheelchair for mobility. He also has spastic joints and cognitive deficits.

According to Resident A's Assessment Plan dated 02/14/22, he uses a wheelchair and gait belt, and he needs assistance from staff with toileting, bathing, grooming, personal hygiene, and dressing. He also uses a C-pap machine at night.

On 05/04/22, I spoke to Resident A's Valley Area Agency on Aging (VAAA), Waiver Supports Coordinator, Jackie Maliszewski, RN, via telephone. RN Maliszewski said that Resident A has been involved with VAAA for a few years. She confirmed that he is prone to seizures but said that she thinks he has had a seizure more recently than the summer of 2021. RN Maliszewski said that she was contacted when Resident A was sent to the hospital on 04/06/22 and when she learned that it took staff almost an hour to contact 911, she was concerned. She said that if anyone is experiencing a seizure, one hour is too long to wait to contact medical personnel. According to RN Maliszewski, she feels that overall, Bentley Manor #3 staff does a good job of taking care of Resident A. She said that he has some challenging medical conditions and requires a high level of care. RN Maliszewski said that she has talked with the Home Manager, Shana Cochran and is aware that Ms. Cochran is working with Resident A's neurologist to develop a seizure protocol.

On 05/04/22, I interviewed staff Gwen Roberts via telephone. Ms. Roberts said that she has worked at this facility for almost two years, and she is very familiar with Resident A. She told me that prior to this last seizure, she witnessed two other seizures that Resident A experienced. The first one occurred shortly after he was admitted to Bentley Manor #3 (approximately two years ago) and it was very severe so she immediately contacted 911 and Resident A was transported to the hospital. Ms. Roberts said that in February 2022, Resident A had a mild seizure and came out of it within 25 minutes so outside medical attention was not sought at that time.

According to Ms. Roberts, on 04/06/22, she got to work just before 10:30pm. She heard Resident A in the bathroom and when she looked, she saw him in the bathroom doorway, in his wheelchair. Ms. Roberts said that it looked like he was sleeping but when she approached him, she discovered that he was having a seizure. Therefore, she wheeled him back toward the office and had staff Caren Weems help her get Resident A onto the floor, with a pillow under his head. Ms. Roberts said that Resident A's seizure behavior vacillated between being quiet and appearing to be sleeping and his body being tense and moving. Ms. Roberts told me that after approximately 25 minutes, she contacted the home manager, Shana Cochran who advised her to contact Resident A's guardian. Ms. Roberts said that she contacted Guardian A1 who said that

she did not want Resident A sent to the hospital “because they would just do what they always do.” Ms. Roberts told me that after talking with Guardian A1, she continued to monitor Resident A and his seizure continued so she eventually contacted 911 and Resident A was transported to the hospital. Ms. Roberts said that Resident A’s seizure began at around 10:30pm and EMT’s arrived approximately 10 minutes after she called them (11:20pm.)

Ms. Roberts confirmed that there was not a seizure protocol in place regarding Resident A. She said that after this incident, staff has been advised that whenever there is an adverse change in a resident’s medical condition, they do not need to contact management or guardians and are to immediately contact 911. Ms. Roberts said that management is in the process of developing and implementing a seizure protocol to ensure that staff knows what to do when a resident has a seizure.

On 05/04/22, I conducted an exit conference with the licensee designee, Melissa Bentley, via telephone. I left her a message stating that I have concluded my investigation and explained which rule violation I am substantiating. I asked her to call me with any questions and told her that once my report is approved, I will send her a copy, requesting a corrective action plan.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 04/06/22 at approximately 10:30pm, Resident A had an active seizure. Staff did not contact 911 until approximately 40 minutes later. EMT’s showed up approximately 10 minutes later at which time Resident A was transported and admitted to the hospital. The home manager, Shana Cochran and staff Gwen Roberts said that prior to this incident, there was not a seizure protocol in place for staff to follow so staff did not know when to contact 911. Ms. Cochran and Ms. Roberts said that Resident A is prone to seizures and his Health Care Appraisal states that he is diagnosed with a seizure disorder. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

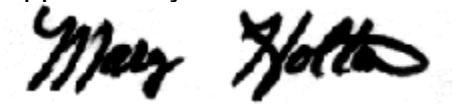
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

May 5, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 5, 2022

Mary E Holton Area Manager	Date