GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 13, 2022

Melissa Bentley
2099 W Wilson Rd
Clio, MI 48420

RE: License #: AM250015879
Investigation #: 2023A0572003
Bentley Manor #7

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 (517) 643-7960.

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 #:	AM250015879
Investigation #:	2023A0572003
Complaint Receipt Date:	10/18/2022
Investigation Initiation Date:	10/21/2022
Report Due Date:	12/17/2022
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 #7
Facility Address:	1099 W Vienna Road Clio, MI 48420
Facility Telephone #:	(810) 687-7157
Original Issuance Date:	09/01/1995
License Status:	REGULAR
Effective Date:	04/16/2022
Expiration Date:	04/15/2024
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 10/01/2022 after a resident went on an outing with staff, resident returned to the facility and ingested a whole bottle of Tylenol (150 pills) and was hospitalized. It is unknown how/when/where the resident obtained the OTC (Over The Counter) medication.	Yes

III. METHODOLOGY

10/18/2022	Special Investigation Intake 2023A0572003
10/21/2022	Special Investigation Initiated - Letter Complainant.
10/21/2022	Contact - Telephone call received Complainant.
11/29/2022	Inspection Completed On-site Home Manager, April Stanley; Staff, Brittany Lindsey, and Resident A.
11/29/2022	Contact - Telephone call made Recipient Rights, Kim Nguyen.
11/30/2022	Inspection Completed-BCAL Sub. Compliance
11/30/2022	Contact - Telephone call made Administrator, Angela Work
12/01/2022	Contact - Telephone call made Licensee, Melissa Bentley
12/01/2022	Contact - Telephone call made Case Manager, Nichole Thorton
12/09/2022	Contact - Telephone call made Nicole Ferris
12/12/2022	Contact - Face to face Staff, Brittany Lindsey

12/12/2022	Contact – Face to face. Resident A
12/12/2022	Contact – Document Received Administrator, Angela Work
12/12/2022	APS Referral APS Referral made.
12/12/2022	Exit Conference Licensee, Melissa Bentley

ALLEGATION:
On 10/01/2022 after a resident went on an outing with staff, resident returned to the facility and ingested a whole bottle of Tylenol (150 pills) and was hospitalized. It is unknown how/when/where the resident obtained the OTC medication.

INVESTIGATION:
On 10/18/2022, the local licensing office received a complaint for investigation. Recipient Rights conducted their investigation. A referral was made to Adult Protective Services (APS).

On 11/29/2022, an unannounced onsite was made at Bentley Manor #7, located in Genesee County Michigan. Interviewed were Home Manager, April Stanley, Staff, Brittany Lindsey, and Resident A.

On 11/29/2022, Home Manager April Stanley was interviewed regarding the allegation. She informed that Resident A ingested what she believes to be 100 pills from a bottle of generic Tylenol. She believes that Resident A got them when she was on an outing at the Dollar Tree without anyone knowing it. Resident A was sick the next day on 09/29/2022, as she puked her medications. Ms. Stanley attempted to get her vitals and take her temperature, but Resident A refused. Resident A allowed her to give her a Covid test and that came back negative. Ms. Stanley assumed that Resident A had influenza. Staff closely monitored her, and she appeared to be getting better. Resident A was taken to the hospital when staff called her and indicated that Resident A was slurring her words. Resident A never indicated what happened until the Doctor said that he had the results from the lab. Resident A then indicated that she had purchased the medications and hid them in her closet. After Resident A was released from ICU, and then transferred to the psych unit. Resident A was having liver failure due to the overdose. Resident A denied trying to take her life, but Ms. Stanley believes that she was because this has not been her first attempt. Resident A has made other attempts at another placement.

On 11/29/2022, Staff Brittany Lindsey informed that the residents went on an outing on Wednesday, 09/28/2022, and the next morning she puked her meds. Resident A laid in the bed all day and did not hardly eat. On Friday, she was feeling a little bit better as she was eating a little bit and she watched a movie. She couldn't finish the movie and wanted to go to bed early. The next day, a former staff member called her and said that Resident A was acting strange and wasn't making any sense. She told him to call 911. The former staff later found an empty bottle of Generic Tylenol in her closet. The bottle says that it contains 100 tablets. It was found that Resident A's liver was starting to shut down as a result of the overdose. Resident A had not shown any sign of suicidal ideation as she was very bubbly and happy leading up to the incident. Ms. Lindsey is unsure when Resident A got ahold of the Tylenol but assumes that it was during the Wednesday evening outing. Due to this incident, whenever Resident A leaves the home and comes back, she must be searched, and they must conduct 20-minute checks. If Resident A is in the restroom for longer than 10 minutes, she usually will knock on the door to make sure that she is okay. Ms. Lindsey informed that Resident A has been very compliant with these changes. Resident A has a history of suicidal attempts at a previous facility. At a previous home, she tied a cord around her neck and put a scarf around it. Resident A has a history of seizures, so her plan was when she passed out, the staff would think that she was having a seizure.

On 11/29/2022, I interviewed Resident A regarding the allegation. She informed that during an outing at the Dollar Store, she purchased a bottle of generic Tylenol. She purchased them because she was tired of having seizures and headaches. She informed that everyone thinks that she was attempting to take her life, but she wasn't this time. She was sent to the psych ward afterwards and that really upset her. She admits to taking the entire bottle in one day. She didn't think anything would happen because she did this before at another facility and nothing happened. She admits that she was attempting to take her life that time, but not this time. During this incident, she purchased the Tylenol and hid it in her backpack and hid the backpack in her closet. She then took the 100 pills while in the bathroom without anyone knowing. She didn't let the staff know what she did until the doctor came into her hospital room and said that they had her lab results. Because of the incident, staff are now checking on her more often and they must check her pockets and purse before she leaves the home and when she returns. She does not have a problem with this and believes that the staff care about her and are trying to keep her safe.

On 11/29/2022, I reviewed Resident A's Medication Sheet. Her medications appeared to be accurate. Resident A's psychotropic medications were discontinued after her alleged suicide attempt.

On 11/29/2022, I reviewed Resident A's Service Plan. It indicates that Increased staff supervision in the form of line-of-sight supervision while consumer is using electrical cords, scarves, belts, rope, string/yarn. Additionally, line of sight supervision while consumer is using potential sharps such as, but not limited to:

knives, tools, glass, and other objects with sharp metal edges, due to consumer's recent suicide attempts (03/11/2022 & 04/28/2022) and extensive history of past self-harm and suicide attempts. Search and seizure of personal property of unapproved items if there is good cause for evidence/suspicion that Resident A has obtained restricted items and is keeping them in her room for the purpose of later engaging in Self-Injurious Behaviors.

On 11/29/2022, I interviewed Administrator, Angela Work regarding the allegation. She informed that she is aware of Resident A taking the 100 tablets of Tylenol. She believes that they were following the Service Plan for Resident A. Staff were only allowed to check Resident A's belongings if they had reasonable cause and to her understanding, staff did not have reasonable cause to check her person. When asked about the plan to conduct 20-minute checks on Resident A, she informed that GHS never provided the facility with a form to document 20-minute checks, so they documented the normal 1-hour check per their policy, but they were conducting visual checks on Resident A at least every 20 minutes because she spent most of her time in the common areas of the home. After this latest incident, Ms. Work decided to create their own 20-minute monitoring log because there was no way to prove that they were conducting 20-minute checks on Resident A.

On 11/29/2022, I spoke with Recipient Rights, Kim Nguyen. I informed her that in speaking with Resident A, she had indicated that she had taken several pills before at previous facility and was attempting to commit suicide at that time. Ms. Nguyen informed that she does not recall unless she is talking about when she tried to take a bunch of vitamins, but she was caught before she could take the entire bottle. Resident A could be confused between the medications and the vitamins.

On 12/01/2022, I reviewed the Incident Report. It indicates that Resident A was feeling sick and slurring her words on 10/01/2022. The Guardian and Home Manager were contacted, and Resident A was taken to the hospital after her health was assessed. Staff will continue to monitor Resident A closely and notify the Guardian of any reoccurrences.

On 12/01/2022, I contacted Resident A's Case Manager, Nichole Thorton. She informed that she was aware of the latest incident involving Resident A overdosing on the Tylenol. Resident A has a history of suicide attempts at a previous facility. After an incident in her previous home, staff were to check her belongings for sharps, ropes, cords, etc., if they had probable cause to believe that she was suicidal. Due to this incident, staff are now to check for any unapproved and harmful items prior to her leaving the home and when she returns. They are also instructed to make 20-minute checks on Resident A throughout the day.

On 12/09/2022, I interviewed Staff, Nicole Ferris regarding the allegation. She informed that they took the Residents to the Dollar Tree on 09/28/2022. She always watches what the Resident purchases and does not allow for them to purchase any type of medications or throat lozenges. There were two staff and five residents, and

they were altogether. She does not recall Resident A going into another aisle. She believes that Resident A may have stolen the medication but isn't certain. She also is not sure if Resident A stole or purchased the medication during that outing because she does not believe that the Dollar Tree sells a pill bottle that has 100 tablets.

On 12/12/2022, I went to two Dollar Tree Stores to identify the medication. One of which was the store that they had their outing at. Neither store carried a 100-tablet bottle of generic Tylenol. I took pictures of all the medications at the Dollar Tree Store.

On 12/12/2022, I made an unannounced visit to Bentley Manor #7 and spoke with Resident A. She informed that she purchased the Generic Tylenol at the Dollar Tree, and it had a red label at the top. She indicated that the pictures of the medications I took at the Dollar Tree were not the ones that she purchased. When asked how she was able to purchase without anyone knowing, she informed that she picked up the pills and mixed it with other items that she was going to purchase. Staff and residents went to the van while she was at the counter making her purchase. She always waits for them to leave because they know that she doesn't like for anyone to see her PIN Number.

On 12/12/2022, I spoke with Staff Brittany Lindsay regarding the pill bottle. She said the Administrator may still have a picture of the pill bottle. She described it as a 100 tablet of Generic Tylenol with a red label at the top. She informed that they went on an outing last week, and she made sure that Resident A was right by her side while in the store and she assisted her with finding what she wanted. She gave her some room so she can put in her PIN Number because she doesn't like for anyone to be around her when she's entering her PIN, but she was right there while she was being rung up. When they went to the Dollar Tree, she tried to find the pill bottle but couldn't find it.

On 12/12/2022, contact was made with Administrator, Angela Work. I asked for her to send me a picture of the medication bottle and she sent it to me via email. It was the "Ready In Case" brand in red and is compared to the 500mg Extra Strength Tylenol. This brand is carried by the Dollar Tree Stores.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Resident A overdosed on 100 tablets of Generic Tylenol, which was causing her liver to fail. It had been identified by some stuff and Resident A that the incident occurred the evening in which the residents went on an outing at the Dollar Tree Store. Resident A informed that she had not stolen but had purchased the medication by mixing it in with the other items that she was about to purchase. She went to the counter last, and staff and the other residents went to the van while she was completing her purchase.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/13/2022, an Exit Conference was held with Licensee Designee, Melissa Bentley regarding the results of the special investigation.

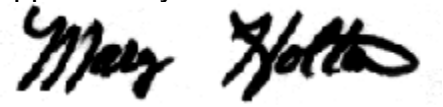
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this medium size group home pending the receipt of an acceptable corrective action plan.

12/13/2022

Anthony Humphrey Date
Licensing Consultant

Approved By:



12/13/2022

Mary E. Holton Date
Area Manager