GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2023

Melissa Bentley
2099 W Wilson Rd
Clio, MI 48420

RE: License #: AL250015880
Investigation #: 2023A0779016
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 (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
This report contains content of a sexual nature

I. IDENTIFYING INFORMATION

License #:	AL250015880
Investigation #:	2023A0779016
Complaint Receipt Date:	12/28/2022
Investigation Initiation Date:	12/29/2022
Report Due Date:	02/26/2023
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 #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 ALZHEIMERS AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
From 12/15/22 to 12/27/22, Resident A inappropriately sexually touched a female resident on multiple occasions and staff knew of this happening.	Yes

III. METHODOLOGY

12/28/2022	Special Investigation Intake 2023A0779016
12/29/2022	APS Referral Complaint was referred to AFC licensing by APS.
12/29/2022	Special Investigation Initiated - Telephone Spoke to Valley Area Agency on Aging.
01/03/2023	Contact - Telephone call made Spoke to general manager, Angela Work.
01/09/2023	Inspection Completed On-site
01/09/2023	Contact - Telephone call made Interview conducted with staff person, Krystal Bishop.
01/09/2023	Contact – Face to face Spoke to Resident A's legal guardian.
02/06/2023	Contact - Telephone call made Spoke to general manager, Angie Work.
02/07/2023	Exit Conference Held with licensee designee, Melissa Bentley.

ALLEGATION:

From 12/15/22 to 12/27/22, Resident A inappropriately sexually touched a female resident on multiple occasions and staff knew of this happening.

INVESTIGATION:

On 12/29/22, licensing consultant, Derrick Britton, spoke with social worker, Heather Roca, of Valley Area on Aging Agency, who is currently providing services to Resident A. Ms. Roca stated that Resident A has lived at this home since 3/3/21 and that he does not like living there. She reported that Resident A can be verbally aggressive, but that she was not aware of Resident A ever exhibiting sexually inappropriate behavior. Ms. Roca stated that this home did not report these incidents to their agency until 12/27/22. She stated that this home has issued Resident A with a 24-hour discharge notice.

On 1/3/23, a phone interview took place with general manager, Angie Work. She confirmed that they had issued Resident A with a 24-hour discharge notice on 12/28/22. Ms. Work reported that Resident A has had mutual girlfriends while at this home, but that this is the first time that he displayed sexual touching without consent. She stated that several incidents involving Resident A inappropriately touching Resident B took place in common areas of the home and that staff stopped the behavior right away. Ms. Work stated that Resident B suffers from significant cognitive deficiencies and cannot provide consent regarding sexual matters, and she is unable to protect herself. She stated that staff at this home did not report anything about these incidents to management until 12/28/22.

On 1/9/23, an on-site inspection was conducted and Resident A was interviewed. Resident A denied ever touching Resident B inappropriately. He stated that he has no interest in Resident B at all.

During the on-site inspection, Resident B was observed to be clean, well-groomed, and appeared to be doing fine. Due to her cognitive deficiencies, Resident B was not able to be interviewed.

On 1/9/23, home manager, Kelly Quintanilla, stated that between 12/15/22 and 12/25/22, there were four separate incidents where Resident A was observed by staff to be inappropriately touching Resident B. Ms. Quintanilla stated that she observed two of those incidents herself. She stated that on 12/15/22 and 12/25/22, she observed Resident A with his hand between Resident B's legs touching her vaginal area. Ms. Quintanilla reported that all four incidents took place during meals times or group activities in the dining area and that Resident A stopped the behavior as soon as directed by staff to stop. Ms. Quintanilla stated that these are the first known non-consensual inappropriate sexual activity that Resident A has been involved in. She stated that Resident A and Resident B were separated during each incident and staff were trying to keep a closer eye on Resident A. She confirmed that there were no other

interventions put in place to prevent such incidents from happening again after the 12/25/22 incident. She stated that is when staff started having Resident A only sit at tables where there were no females sitting. Ms. Quintanilla confirmed that management was not notified about these incidents taking place until general manager, Ms. Work, was told on 12/28/22. She stated that they then made some moves involving residents' bedrooms and now have male and female residents staying on opposite ends of the facility and that Resident A only eats in the smaller dining room with only other male residents. Ms. Quintanilla stated that it appears that Resident A is now aware of the seriousness of the situation and he has been keeping his distance from all the females.

On 1/9/23, staff person, Lorie Gruno, stated that she witnessed two incidents where Resident A inappropriately touched Resident B. She stated that she observed the incidents when entering the dining room area and immediately redirected Resident A and separated Resident A and Resident B. Ms. Gruno reported that she wrote about the incidents in Resident A's "unusual behavior log book" (UBL) but did not notify supervision of the incidents. Ms. Gruno stated that no other intervention was taken other than to try and keep Resident A and Resident B separated and keeping a closer eye on Resident B.

On 1/9/23, staff person, Krystal Bishop, who stated that she witnessed two incidents of Resident A inappropriately touching Resident B. She stated that she observed these incidents upon entering the dining room area and immediately redirected Resident A and separated Resident A away from Resident B. Ms. Bishop claims that she texted home manager, Ms. Quintanilla, about both incidents. She stated that she was told to keep Resident A and Resident B separated and to keep a closer eye on Resident B.

There were four *AFC Licensing Division-Incident/Accident Reports* (IR's) written, one for each observed incident. They are as follows:

- 12/15/22, staff noticed that Resident A had his hand on Resident B's private area. (This was later clarified to be Resident B's vaginal area). Staff immediately redirected Resident A to keep his hands to himself and to never touch a female inappropriately. Corrective measures listed on the IR was to separate Resident A and Resident B and to keep a closer watch on Resident A.
- 12/22/22, Resident A was caught by staff to be touching Resident B's breast. Resident A saw staff enter the dining room, stopped what he was doing and proceeded to go to his room. Corrective measures listed was that staff had a conversation with Resident A regarding the consequences of touching a female without their permission or consent.
- 12/24/22, Upon entering the dining room, staff saw Resident A approach Resident B and put his hand on her breast and attempt to put his hand down her pants. When Resident A noticed staff presence, he backed away from Resident B. Corrective measures were that staff again instructed Resident A to keep his hands to himself and to stay away from the females in the home. Staff would continue to monitor the situation closely.

- 12/25/22, staff saw Resident A sitting next to Resident B and he had his hands between Resident B's legs. Staff separated Resident A and Resident B. Corrective measures listed were to not allow Resident A to sit at any table where female residents are.

Resident A's *Assessment Plan for AFC Residents* states that Resident A is not mobile and utilizes a wheelchair. The plan indicates that he requires only minimal assistance from staff in order to complete all his activities of daily living (ADL's). It does indicate that Resident A is able to control his sexual behavior.

On 1/9/23, a conversation took place with a representative of the Family Service Agency, who is Resident A's legal guardian. She stated that she is not aware of Resident A having a history of inappropriate sexual behavior. She stated that they are looking for a new home for Resident A to move to.

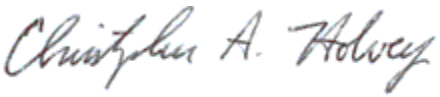
On 2/6/23, general manager, Ms. Work, stated that Resident A did not display any further inappropriate sexual behavior in this home and that Resident B is doing well. She stated that Resident A moved out of this home on 1/23/23.

APPLICABLE RULE	
R 400.15305	**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:	It was confirmed that between 12/15/22 and 12/25/22, staff observed Resident A on several separate occasions to have inappropriately touched Resident B. Due to her cognitive deficiencies, Resident B is not able to consent to any sexual activity and is not able to protect herself. Other than separating Resident A and Resident B at the time of each incident and staff attempting to keep a closer eye on Resident A, there were no interventions put into place to protect Resident B from Resident A's inappropriate sexual behavior until 12/25/22. This resulted in three additional incidents, after the initial incident on 12/15/22, where Resident A inappropriately sexually touched Resident B. There was sufficient evidence found to prove that Resident B was not provided adequate protection and/or safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/7/23, an exit conference was held with licensee, Melissa Bentley. She was informed that a written corrective action plan was required to address the above licensing rule violation.

IV. RECOMMENDATION

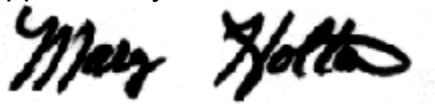
Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.



2/8/2023

Christopher Holvey Date
Licensing Consultant

Approved By:



2/8/2023

Mary E Holton Date
Area Manager