GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2024

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

RE: License #: AS250387054
Investigation #: 2024A0572055
Bentley Manor Assisted Living 2

Dear Melissa Bentley:

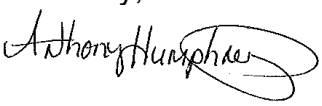
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 #:	AS250387054
Investigation #:	2024A0572055
Complaint Receipt Date:	08/16/2024
Investigation Initiation Date:	08/21/2024
Report Due Date:	10/15/2024
Licensee Name:	Bentley Manor Inc.
Licensee Address:	P.O. Box 460 Clio, MI 48420
Licensee Telephone #:	(801) 547-1763
Administrator:	Melissa Bentley
Licensee Designee:	Melissa Bentley
Name of Facility:	Bentley Manor Assisted Living 2
Facility Address:	4148 W. Wilson Road Clio, MI 48420
Facility Telephone #:	(810) 640-8892
Original Issuance Date:	07/27/2018
License Status:	REGULAR
Effective Date:	01/27/2023
Expiration Date:	01/26/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Concerns of neglect; appropriate measures were not taken when Resident A was choking. IR (Incident Report) differs from what hospital note states as well.	Yes

III. METHODOLOGY

08/16/2024	Special Investigation Intake 2024A0572055
08/21/2024	Special Investigation Initiated - On Site Staff, Janet Hogan; Home Manager, Tiffany Thomas.
08/21/2024	Contact - Face to Face Resident A.
09/09/2024	Contact - Telephone call made Ex-Staff, Crystal Miller.
10/08/2024	Contact - Telephone call made Resident A's Public Guardian.
10/08/2024	Contact - Telephone call made Ex-Staff, Crystal Miller.
10/08/2024	Contact - Document Sent Complainant.
10/08/2024	Contact - Telephone call made Complainant.
10/08/2024	APS Referral An APS referral was made.
10/08/2024	Contact - Document Sent Valley Area Agency on Aging Supervisor
10/08/2024	Contact – Document Received Valley Area Agency on Aging Supervisor
10/09/2024	Contact - Telephone call made

	Home Manager, Tiffany Thomas.
10/09/2024	Contact - Telephone call made Licensee Designee, Melissa Bentley
10/10/2024	Contact - Telephone call made Genesee County MMR Supervisor, Austin Finkbeiner
10/10/2024	Contact - Document Sent Sonia Weber, MMR Records.
10/10/2024	Contact - Document Received Sonia Weber, MMR Records.
10/10/2024	Contact - Telephone call made Sheriff's Department's non-emergency
10/12/2024	Contact - Document Received Dispatch recording.
10/14/2024	Exit Conference Licensee Designee, Melissa Bentley

ALLEGATION:
Concerns of neglect; appropriate measures were not taken when Resident A was choking. IR differs from what hospital note states as well.

INVESTIGATION:
On 08/16/2024, the local licensing office received a complaint for investigation. An APS referral was also made for further investigation.

On 08/21/2024, an unannounced onsite was conducted at Bentley Manor Assisted Living #2, located in Genesee County Michigan. Interviewed were, Staff, Janet Hogan and Home Manager, Tiffany Thomas.

On 08/21/2024, I interviewed Staff, Janet Hogan regarding the allegation. Janet Hogan informed that Staff, Crystal Miller was working the day of 07/27/2024, but is no longer employed with the company due to not having reliable to work. Janet Hogan informed that during the incident, Crystal Miller called her to tell her what happened and that she had called 911 and the ambulance was on the way. One-hour checks were being conducted on Resident A prior to the 911 call. Resident A was responsive when EMS arrived. To her knowledge, Crystal Miller did not perform CPR or Heimlich because Resident A had just vomited and did not appear to be choking. Resident A appeared to be lethargic and struggling to breath, which is why

911 was called. Crystal Miller is certified in CPR and First Aid and in her opinion, Crystal Miller followed protocol.

On 08/21/2024, I interviewed Home Manager, Janet Hogan regarding the allegation. Janet Hogan informed that Resident A was fine on the day of 07/27/2024 and there were visitors there for another resident who had just wished Resident A Happy Birthday as they were leaving. Shortly after, within minutes, Resident A became very lethargic and was kind of slumped over in the chair. According to Crystal Miller, Resident A was still able to respond to questions by nodding head. Resident A already had previous slurred speech due to being a stroke victim, so communication can sometimes be very difficult to understand, but when asked if Resident A was sick, Resident A nodded head, “Yes”. And when asked if Resident A needed to go to the hospital, Resident A again nodded her head, “Yes”. Resident A is currently at a Rehab Center and Crystal Miller recently quite due to not having transportation to work.

On 08/21/2024, I reviewed the Incident Report which indicates that on 07/27/2024 during 2pm checks, staff found Resident A’s wheelchair in between doorway of bedroom/hallway and appeared to be stuck. Staff informed Resident A that the wheelchair was stuck and assisted with pushing Resident A forward. While in the hallway, staff noticed that Resident A’s eyes were glossy and had vomit on self and was having trouble breathing. Resident A was able to respond to question with head nods. The action taken was staff called 911 immediately. Staff will follow all discharge instructions.

On 08/21/2024, I reviewed Crystal Miller’s Employee File and First Aid/CPS was conducted by the American Red Cross and completed on 07/07/2023, within the 2-year validation period.

On 08/21/2024, I spoke with Resident A at a rehabilitation center. Resident A could not speak very clearly, so Resident A wrote some of the answers to my questions on my note pad. Resident A informed that Resident A was eating Subway sandwich and began to choke. Resident A does not remember if CPR or Heimlich was performed and indicated that Resident A did not vomit. Resident A informed that Resident A is able to eat that type of food and does not need any assistance with eating. The crust from the sandwich just got caught in Resident A’s throat. Resident A had a drink but did not take a drink at that time. Resident A informed that staff, checks on Resident A every hour. Resident A believes that this was being done. Resident A does not have any issues with the home and believes that they may of did what they were supposed to do but is not certain because Resident A was passed out. Resident A is ready to go back home and feels safe there.

On 09/09/2024, I made an attempt to contact Ex-Staff, Crystal Miller regarding the allegation.

On 10/08/2024, I made an attempt to contact Resident A’s Public Guardian.

On 10/08/2024, I made another attempt to contact Ex-Staff, Crystal Miller, however the phone number is no longer working.

On 10/08/2024, I contacted Valley Area Agency on Aging Supervisor, Heather Roca regarding the VIPR, which is a report at initial contact with the hospital. Heather Roca informed that the Bentley Manor Assisted Living Incident Report mentions that Resident A's wheels of wheelchair were stuck in a doorway and that Resident A wasn't unresponsive. The biggest concern is that the VIPR records make it seem like the caregiver did not attempt any life saving measures.

On 10/08/2024, I reviewed the VIPR Report which states, "The patient is a 70-year-old male who was found unresponsive in chair by nursing aide, who reported that the patient had been in that state for a few minutes prior to the arrival of the medical team. Upon the arrival, the patient exhibited gurgling, gasping respirations, and a slow pulse rate in the 40s and 50s. Shortly after, the patient displayed ventricular activity on the monitor and lose pulses, leading to the commencement of compressions. Pulses were regained after one to two minutes of CPR.

On 10/09/2024, I spoke with Home Manager, Tiffany Thomas regarding the information in the VIPR Report. Tiffany Thomas informed that this is definitely different from what was reported to her. Tiffany Thomas explained that she was told that Resident A was fine and then within a couple minutes, was slumped over, but was still responding to questions by head nods. Tiffany Thomas does not have an updated phone number for Crystal Miller but will try to get the number from someone who may have it.

On 10/09/2024, I spoke with Licensee Designee, Melissa Bentley regarding the allegation. Melissa Bentley informed that she was not there but from what she was told by her manager, she felt confident that Crystal Miller did the right thing in calling 911 and she was on the phone with them during the crisis. Melissa Bentley believes that although the staff is trained in CPR, sometimes during a crisis situation they may get a little over excited and they may misspeak during the 911 call or at the time of the crisis, the resident could be displaying one behavior but by the time the incident report is written, they are presenting another behavior. Melissa Bentley is unsure what corrective measure would need to be taken if the staff person called 911 after seeing that the resident was exhibiting unusual behaviors that required hospitalization.

On 10/10/2024, I made contact with Genesee County MMR Supervisor, Austin Finkbeiner regarding any reports related to the 911 call on 07/27/2024. Austin Finkbeiner informed that if I wanted dispatch information.

On 10/10/2024, I contacted Sonia Weber regarding any reports related to the 911 call on 07/27/2024. Sonia Weber sent me the MMR Patient Care Report for Resident A and indicated that anything related to Genesee County 911 would need to be

obtained from them. The Dispatch Reason indicates “Breathing Problems”. Below is the timeline of the dispatch call from the Bentley Manor Assisted Living staff:

Call	2:19PM & 0 seconds	07/27/2024
Dispatch Notified	2:19PM & 56 seconds	07/27/2024
Unit notified by Dispatch	2:19PM & 57 seconds	07/27/2024
Dispatch Acknowledged	2:20PM & 24seconds	07/27/2024
Unit En Route	2:20PM & 26 seconds	07/27/2024
Unit Arrived on Scene	2:28PM & 10 seconds	07/27/2024
Arrived at Patient	2:29PM & 32 seconds	07/27/2024
Unit Left Scene	2:49PM & 41 seconds	07/27/2024
Patient Arrived at Destination (Hospital)	3:06PM & 44 seconds	07/27/2024

The report also indicated that Resident A suffered from Cardiac Arrest after the arrival of the EMS. The Cardiac Arrest Etiology was due to Respiratory/Asphyxia and EMS initiated Chest Compressions and Ventilation. The Patient Care Report Narrative states, “MMRAA893 was dispatched lights and sirens to 4148 W Wilson Rd for a 70-year-old male having trouble breathing and alerted mental status. Upon arrival the patient was sitting in a wheelchair in the entrance way of the AFC Home. The caretaker stated the patient had been trying to go through bedroom door and got stuck. The caretaker stated that she had came down the hall a couple minutes after hearing the patient get stuck to find the patient in chair, unresponsive and breathing funny. The patient was unresponsive and has gurgling and gasping aspirations. The patient was breathing at about 12 beats per minute. The patient had vomit on shirt. The patient was wheeled out of the house and to the stretcher.

On 10/10/2024, the Sheriff’s Department’s non-emergency number. I was informed that their Dispatch Notes indicates that a 70-year-old patient was having trouble breathing. The supervisor informed that if any transcripts or audio was needed, I would need to make a FOIA Request.

On 10/12/2024, I received the audio recording of the 911 dispatch call. In the call when the dispatcher asked what was the emergency, Crystal Miller stated, “One of my Consumers is not really responding and he looks like he’s thrown up on himself and sounds like he cannot breathe.”

On 10/14/2024, I conducted an exit conference with Licensee Designee, Melissa Bentley. Melissa Bentley informed me that she has unsuccessfully tried to contact Crystal Miller from all known phone numbers. She does not believe that Crystal Miller would do anything wrong as she is trained in CPR. Melissa Bentley wanted to try to speak with Crystal Miller because she is unsure of the reason why Crystal Miller did not perform CPR but believes that there had to be a reason. Melissa Bentley was informed of the results of this special investigation.

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:	Based on the interviews of Staff, Resident A, MMR, Sheriff's Department's non-emergency and review of several records regarding Resident A, there is substantial evidence to establish a licensing rules violation. Resident A reported having trouble breathing when found stuck in between the doorway of the bedroom. Resident A was not verbally responding. Resident A reported he was choking on a sandwich. Staff observed Resident A gasping for air and failed to initiate CPR. Staff called 911 and paramedics arrived 10 minutes later. CPR was performed by paramedics when Resident A went into cardiac arrest.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 3-6).

10/14/2024

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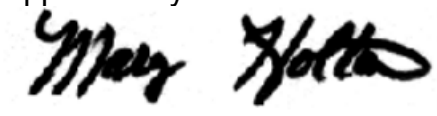
Anthony Humphrey Date
Licensing Consultant

Approved By:



10/14/2024

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Mary E. Holton Date
Area Manager