GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 3, 2025

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

RE: License #: AM250291561
Investigation #: 2025A0569019
Bentley Assisted Living

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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AM250291561 |
| | |
| **Investigation #:** | 2025A0569019 |
| | |
| **Complaint Receipt Date:** | 01/28/2025 |
| | |
| **Investigation Initiation Date:** | 01/29/2025 |
| | |
| **Report Due Date:** | 03/29/2025 |
| | |
| **Licensee Name:** | Bentley Manor Inc. |
| | |
| **Licensee Address:** | P.O. Box 460<br>Clio, MI 48420 |
| | |
| **Licensee Telephone #:** | (810) 547-1763 |
| | |
| **Administrator:** | Melissa Bentley |
| | |
| **Licensee Designee:** | Melissa Bentley |
| | |
| **Name of Facility:** | Bentley Assisted Living |
| | |
| **Facility Address:** | 6252 W Mt Morris Rd<br>Mt Morris, MI 48458 |
| | |
| **Facility Telephone #:** | (810) 686-6976 |
| | |
| **Original Issuance Date:** | 01/13/2010 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/15/2024 |
| | |
| **Expiration Date:** | 07/14/2026 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| **Staff did not properly supervise Resident A on 1/23/2025.** | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 01/28/2025 | Special Investigation Intake<br>2025A0569019 |
| 01/29/2025 | APS Referral<br>Referral to APS. |
| 01/29/2025 | Special Investigation Initiated - Letter<br>Email to ORR. |
| 02/26/2025 | Inspection Completed On-site |
| 02/26/2025 | Contact - Face to Face<br>Interview with Resident A at current placement. |
| 02/26/2025 | Inspection Completed-BCAL Sub. Compliance |
| 02/27/2025 | Contact - Telephone call made<br>Attempted contact with Cassidy Convis, staff person. Left voicemail requesting return phone call. |
| 02/27/2025 | Contact - Telephone call made<br>Attempted contact with Patricia Swift, staff person. Left voicemail requesting return phone call. |
| 02/27/2025 | Exit Conference<br>Exit conference with Melissa Bentley, licensee designee, and Angela Work, administrator. |
| 03/03/2025 | Contact - Telephone call made<br>Attempted contact with Cassidy Convis, staff person. Left voicemail requesting return phone call. |
| 03/03/2025 | Contact - Telephone call made<br>Attempted contact with Patricia Swift, staff person. Left voicemail requesting return phone call. |

## ALLEGATION:

**Staff did not properly supervise Resident A on 1/23/2025.**

## INVESTIGATION:

This complaint was received via LARA-BCHS-complaints@michigan.gov. The complainant reported that Resident A has a history of choking on food. The complainant reported that Resident A's assessment requires staff to remain present with Resident A while he is eating to prevent Resident A from choking on food. The complainant reported that on 1/23/2025, staff left Resident A unsupervised, and Resident A choked on his food. The complainant reported that staff then performed the Heimlich procedure on Resident A and called 911.

An unannounced inspection of this facility was conducted on 02/26/2025. Resident A was discharged from this facility on 01/27/2025. Resident A's file was reviewed. Resident A's written assessment documents in section IIA. that Resident A requires staff closely monitor him while Resident A is eating at all times. The assessment and health care appraisal document that Resident A has not been prescribed a special or modified diet. Resident A's file contains an incident report (IR) dated 1/23/2025. The IR documents that Resident A was eating a sandwich in the dining room at 6:00pm. The IR documents that staff left Resident A unattended in the dining room when staff took dishes to the kitchen area to put the dishes in the sink. The IR documents that staff returned to the dining room and Resident A was waiving his hand and indicated that he was choking on the food. The IR documents that staff immediately initiated the Heimlich procedure on Resident A and called 911. The IR documents that, after several minutes, Resident A did cough up the food that he was choking on. The IR documents that paramedics then arrived at the facility and provided medical attention and treatment. The corrective measure documented in the IR is that staff will closely monitor Resident A when eating, and a follow up appointment was scheduled with Resident A's physician.

Resident A was interviewed at his current placement on 2/26/2025. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A has recently had a stroke, and has difficulty verbalizing, but was able to answer questions. Resident A stated that he does remember choking on food while residing at the Bentley Manor facility. Resident A stated that he does not remember if staff were in the dining room when he began choking, but that staff immediately helped him by administering the Heimlich procedure. Resident A stated that he was able to cough up the food that he was choking on, and paramedics then arrived to assess him. Resident A stated that he was fine and did not want to go to the hospital with the paramedics. Resident A stated that he was not injured from this incident. Resident a stated that staff always assisted him when he resided at the Bentley Manor facility.

Monique Martinez, staff person, stated on 2/26/2025 that she was working when Resident A choked on his food. Staff Martinez stated that she was assisting another resident in their bedroom when she heard a commotion from the dining room. Staff Martinez stated that Patricia Swift, staff person, had been in the dining room serving Residents their dinner. Staff Martinez stated that she observed Resident A waving his hands and was choking on his food. Staff Martinez stated that she immediately started applying the Heimlich procedure to Resident A and called for another staff to call 911. Staff Martinez stated that after about 5 minutes, Resident A did cough up the food that he was choking on. Staff Martinez stated that paramedics then arrived and provided medical attention and assessment. Staff Martinez stated that Resident A was not injured from this incident. Staff Martinez stated that Resident A has a history of choking on his food, and staff are supposed to remain in the dining room monitoring Resident A at all times while he is eating.

Attempted contacts with Cassidy Convis, staff person, and Patricia Swift, staff person, were made. Staff Convis and Staff Swift have not responded to voicemails requesting a return phone call.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14303** | **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:** | The complainant reported that Resident A was left unsupervised while eating on 1/23/25 and choked on his food. The complainant reported that Resident A is supposed to be supervised at all times while eating. Resident A's written assessment documents that Resident A must be closely monitored by staff while eating. The incident was documented in an IR and confirmed by statements from staff. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

An exit conference was conducted on 02/27/2025 with Melissa Bentley, licensee designee. The findings in this report were reviewed and a corrective action plan was requested.

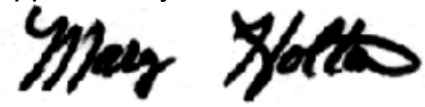
## IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

03/03/2025

Kent W Gieselman — Date
Licensing Consultant

Approved By:



03/03/2025

Mary E. Holton — Date
Area Manager