GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 15, 2019

Bradford Martell
Endless Compassion, LLC
1324 Rosewood Ave. SE
Grand Rapids, MI 49506

RE: License #: AS410370829
Investigation #: 2019A0583013
Embracing Life II

Dear Mr. Martell:

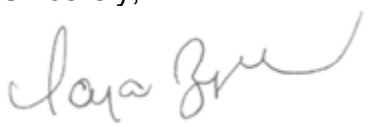
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410370829
Investigation #:	2019A0583013
Complaint Receipt Date:	12/27/2018
Investigation Initiation Date:	01/02/2019
Report Due Date:	01/26/2019
Licensee Name:	Endless Compassion, LLC
Licensee Address:	1324 Rosewood Ave. SE, Grand Rapids, MI 49506
Licensee Telephone #:	(616) 402-0477
Administrator:	Bradford Martell
Licensee Designee:	Bradford Martell
Name of Facility:	Embracing Life II
Facility Address:	445 Rosemary St. SE, Grand Rapids, MI 49507
Facility Telephone #:	(616) 608-7460
Original Issuance Date:	01/28/2015
License **Status:**	REGULAR
Effective Date:	07/28/2017
Expiration Date:	07/27/2019
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
The facility does not provide adequate supervision of Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/27/2018	Special Investigation Intake 2019A0583013
01/02/2019	Special Investigation Initiated - Letter Adult Protective Services Staff, Lacey Lott
01/02/2019	APS Referral
01/02/2019	Inspection Completed On-site Staff Mackenzee Sturm, Resident A
01/02/2019	Contact - Telephone call Licensee Designee, Bradford Martell
01/02/2019	Contact - Telephone call made Legal Guardian, Carol Hockeborn
01/02/2019	Contact - Document Licensee Designee, Bradford Martell
01/03/2019	Contact - Document Licensee Designee, Bradford Martell
01/04/2019	Contact - Document Licensee Designee, Bradford Martell
01/04/2019	Contact – Document GRPD incident 10-090668
01/08/2019	Contact – Face to Face Resident A
01/14/2019	Exit Conference Licensee Designee Bradford Martell

ALLEGATION: The facility does not provide adequate supervision of Resident A.

INVESTIGATION: On 12/27/2018 I received allegations from BCAL online alleging Resident A was not properly supervised by Licensee Bradford Martell. The complaint alleges Resident A has ADHD, bipolar disorder, depression and a seizure disorder and on multiple occasions, Resident A has left the group home to meet unidentified individuals and have sexual relationships with them. Recently, Mr. Martell purchased Resident A a bus ticket to travel to Kalamazoo Mi to meet an unidentified male she met online. Allegations state the unknown male held Resident A "hostage" and she was not allowed to leave.

On 01/02/2019 I received an email from Adult Protective Services Investigator Lacey Lott. Ms. Lott stated she is assigned the allegations for investigation.

On 01/02/2019 I completed and unannounced onsite investigation at the facility. I interviewed Staff Mackenzee Sturm privately and attempted to interview Resident A.

Ms. Sturm stated she did not work the weekend Resident A left the facility and does not have specific information regarding the allegations. Ms. Sturm stated she did work 12/9/2018 which is the day Resident A returned to the facility. Ms. Sturm stated Mr. Martell picked Resident A up from the bus station in Grand Rapids 12/9/2018 and drove her to the facility. Ms. Sturm stated Resident A went to bed immediately upon returning to the facility and stated she did not want to discuss the incident. Ms. Sturm stated Resident A has a history of connecting with individuals online and then meeting them in person. Ms. Sturm stated staff have discussed the dangers of meeting individuals online with Resident A however Resident A is able and allowed to move freely in the community. Ms. Sturm stated Resident A's legal guardian is Carol Hockeborn and she has informed staff to try to verbally dissuade Resident A from meeting individuals online and in person, however staff cannot restrict Resident A from doing so.

I attempted to interview Resident A privately at the facility. Resident A informed me that she would not discuss details regarding the incident.

On 01/02/2019 I interviewed Licensee Designee Bradford Martell via telephone. Mr. Martell stated Resident A is allowed to move independently in the community. Mr. Martell stated Ms. Hockeborn has instructed staff to discourage Resident A from meeting individuals in person that she has met online, however staff cannot restrict her from doing so. Mr. Martell stated Resident A recently met a male named "KJ" online and requested to meet him in Kalamazoo for the day. Mr. Martell stated he purchased a round trip bus ticket for Resident A to travel to Kalamazoo to meet "KJ" on 12/1/2018 at noon and return the same day at approximately 10:00 pm. Mr. Martell stated he only knew the male's name was "KJ" and Resident A would not disclose "KJ's" address to him. Mr. Martell stated he dropped Resident A off at the Grand Rapids bus station at approximately noon on 12/1/2018 and subsequently

received a telephone call from Resident A at 9:30 pm the same day stating Resident A would not be returning to the facility. Mr. Martell stated Resident A reported she was getting married and would not return to the facility, although Mr. Martell attempted to dissuade Resident A from not returning to the facility. Mr. Martell stated the following morning (12/2/2018) he telephoned Resident A's legal guardian, Ms. Hockeborn, and informed Ms. Hockeborn that Resident A refused to return to the facility. Mr. Martell stated he filed a report with law enforcement 12/3/2018 identifying Resident A did not return to the facility. Mr. Martell stated he also filed an Incident Report with Licensing and Regulatory Affairs. Mr. Martell stated Resident A was gone over a week but telephoned him about five times while she was in Kalamazoo and never reported she was in danger. Mr. Martell stated during some of the telephone conversations Resident A stated she was "ready to come home" however Mr. Martell did not arrange for Resident A to return to the facility until speaking with one of the inhabitants of the home in Kalamazoo whom stated Resident A needed to leave or would be kicked out. Mr. Martell stated he purchased Resident A a bus ticket back to Grand Rapids and he picked her up from the bus station but he was unsure of the date this occurred and would need to check. Mr. Martell stated since returning from Kalamazoo, Resident A has not made any statements which would indicate that she had been mistreated while in Kalamazoo. Mr. Martell stated Resident A has a history of "attention seeking" behaviors and he would question her reliability regarding any statements pertaining to being abused while in Kalamazoo. Mr. Martell stated he did not feel it was his responsibility to arrange transportation for Resident A from Kalamazoo back to Grand Rapids, but he did so because he cares about Resident A's wellbeing.

On 01/02/2019 I reviewed the facility file which indicated an Incident Report was not received from the facility.

On 01/02/2019 I received via email a copy of Resident A's Assessment Plan for AFC Residents and Incident Report from Licensee Designee, Bradford Martell.

I reviewed Resident A's Assessment Plan for AFC Residents signed by Ms. Hockeborn 02/18/2018 which indicates Resident A can move independently in the community and that staff "need to request where she is going and when she will return".

I reviewed the Incident Report signed 12/2/2018. The Incident Report stated the Bureau was notified of the incident 12/2/2018 and law enforcement was notified of the incident 12/2/2018.

On 01/02/2019 I interviewed Resident A's legal guardian, Carol Hockeborn via telephone. Ms. Hockeborn stated Resident A has a history of being a "runner" and will often meet unknown men she has connected with online. Ms. Hockeborn stated Resident A will sometimes leave the facility she is residing in without legal "permission" and hitchhike to meet unknown men. For this reason she has asked facility staff to attempt to verbally dissuade Resident A from leaving but

acknowledged that staff cannot force Resident A not to leave. Ms. Hockeborn stated that Mr. Martell "should have told me before he bought the ticket" for Resident A to travel to Kalamazoo, "but I probably would have said yes anyway". Ms. Hockeborn stated she received a text from Mr. Martell on 12/2/2018 stating Resident A did not return to the facility. Ms. Hockeborn stated she is happy with the level of care provided at the facility and Resident A can move independently through the community.

On 01/04/2019 I received an email from Licensee Designee, Bradford Martell, stating Resident A "left" the facility "on 12/1 and returned on 12/9".

On 01/04/2019 I received and reviewed of copy of GRPD incident report # 18-090668. The incident report states Mr. Martell filed a missing person report for Resident A on 12/03/2018 and contacted law enforcement 12/10/2018 to report Resident A returned to the facility 12/09/2018.

On 01/08/2019 I completed an onsite investigation at the facility and interviewed Resident A privately. Resident A stated she met a man named "KJ" online and asked Mr. Martell to help her visit KJ in Kalamazoo. Resident A stated Mr. Martell purchased her a round trip bus ticket to Kalamazoo and dropped her off at the bus station in Grand Rapids on 12/1/2018 with her 4pm and 8pm medications. Resident A stated she is competent to take her medications while absent from the facility. Resident A stated she was scheduled to stay in Kalamazoo with "KJ" for the day of 12/1/2018 and return via bus the same evening. Resident A stated she telephoned Mr. Martell 12/1/2018 and informed him she would not be returning to the facility. Resident A stated while she was absent from the facility she was physically and sexually assaulted by "KJ" at his home in Kalamazoo. Resident A stated she spoke via telephone with Mr. Martell throughout her time away from the facility and at one point informed Mr. Martell she wanted to come back to the facility. Resident A stated Mr. Martell told her he would not be coming to get her, and she needed to call him back when she was "calm". Resident A stated on 12/9/2018 Mr. Martell did arrange for her to come back to the facility via the bus and he picked her up at the Grand Rapids bus station. Resident A stated she did not inform Mr. Martell of the abuse she sustained while in Kalamazoo. Resident A stated she can move independently through the community.

On 01/11/2019 I completed an Exit Conference with Licensee Designee Bradford Martell via telephone and informed him of the findings. Mr. Martell stated he does not agree with the findings. Mr. Martell stated he asked Resident A the name of the male she would be meeting in Kalamazoo and Resident A would only inform him that the male's name was "KJ". Mr. Martell stated he asked Resident A for "KJ's" address before allowing her to travel to Kalamazoo however she did not know the address and could not provide it to Mr. Martell.

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:	Resident A's Assessment Plan For AFC Residents stated Resident A can move independently in the community however she must "request where she is going and when she will return". Mr. Martell purchased a bus ticket for Resident A to travel to Kalamazoo to meet an unknown male on 12/1/2019 and was expected to return to the facility the same day. Resident A refused to return to the facility on 12/1/2019 as planned. Mr. Martell stated he only knew the unknown male's name was "KJ" and Mr. Martell did not know the address Resident A was scheduled to visit in Kalamazoo. There is a preponderance of evidence to substantiate violation of R 400.14303 (2). Resident A's Assessment Plan states she may move independently in the community however the Assessment Plan also indicates staff must request where Resident A is visiting and when she will return. Mr. Martell purchased a bus ticket for Resident A to travel via bus to meet a male named "KJ" at an unknown address in Kalamazoo, Mi. Resident A's guardian was not informed Resident A was visiting an unknown male in Kalamazoo at an unknown address until Resident A failed to return to the facility. Resident A's Assessment Plan was not followed as written and signed by her legal guardian.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff documented the administration of Resident A's medications on 12/2/2018 and 12/8/2018 although Resident A left the facility 12/1/2018 and returned to the facility 12/9/2018.

INVESTIGATION: On 01/02/2019 I received scanned copies via email of Resident A's Medication Administration Record covering 12/1/2018 through 12/31/2018 from Licensee Designee Bradford Martell. Mr. Martell stated the following in the email:

"Looks like we gave (Resident A) her 4 p.m. and 8 p.m. meds to take along with her knowing she would be back that evening at around 10 pm. With her Guardians guidance we determined that she was to not be sent with any additional meds and

the necessity to do so wasn't appropriate considering she was going to be home that night."

I reviewed the documentation which indicates Resident A was administered the following medications:

Carbamazepine 200 mg on 12/2/2018 at 8:00 am and 12/8/2018 at 8:00 am
Cetirizine 10 mg on 12/2/2018 at 8:00 am and 12/8/2018 at 8:00 am
Fluticasone Propionate 12/02/2018 at 8:00 am 12/8/2018 at 8:00 am
Hydroxyzine Pamoate 25 mg 12/2/2018 at 8:00 am
Metronidazole 500 mg 12/2/2018 at 8:00 am and 12/8/2018 at 8:00 am
Polyethylene Glycol 12/2/2018 at 8:00 am
Qvar 12/2/2018 at 8:00 am and 12/8/2018 at 8:00 am
Sulfamethoxa 800 mg 12/2/2018 at 8:00 am and 12/8/2018 at 8:00 am
Symbicort 12/2/2018 at 8:00 am and 12/8/2018 at 8:00 am
Topiramate 50 mg 12/2/2018 at 8:00 am and 12/8/2018 at 8:00 am

On 01/04/2019 I received an email from Licensee Designee, Bradford Martell stating Resident A "left" the facility "on 12/1 and returned on 12/9".

On 01/11/2019 I completed an Exit Conference with Licensee Designee Bradford Martell via telephone and informed him of the findings. He stated he does not agree with the rule violation because there is an "explanation" behind Resident A's MAR indicating Resident A was given medication by staff when she was not residing at the facility. Mr. Martell stated on 12/02/2018 and 12/08/2018 staff marked in Resident A's MAR that Resident A was given her medication before verifying she was not home. Mr. Martell stated staff discarded the medications when they realized Resident A was not at the facility although they did record that she was given the medication in the MAR. Mr. Martell stated he would submit a Corrective Action Plan despite not agreeing with the rule violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A left the facility on 12/1/2018 and returned on 12/9/2018. Resident A's Medication Administration log incorrectly indicates Resident A was administered medications by facility staff while Resident A was not present at the facility. There is a preponderance of evidence to substantiate a violation of R 400.14312 because staff did not administer Resident A's

	medications while she was not present at the facility making the MAR incorrect.
CONCLUSION:	**VIOLATION ESTABLISHED**

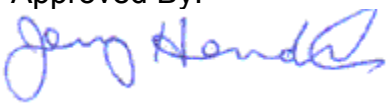
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

01/15/2019

Toya Zylstra Date
Licensing Consultant

Approved By:



01/15/2019

Jerry Hendrick Date
Area Manager