STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS

SHELLY EDGERTON
DIRECTOR

October 11, 2017

Kristen Martell
1627 Plas SW
Wyoming, MI 49519

License #: AS410299024
SIR #: 2017A0583016

Dear Ms. Martell:

Enclosed is a copy of an AMENDED ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT TO REVOKE YOUR LICENSE to operate an adult foster care small group home, alleging that you have violated the Adult Foster Care Facility Licensing Act. In accordance with MCL 24.292 of the Administrative Procedures Act of 1969, this ORDER has been forwarded to the Michigan Administrative Hearing System to provide you with a prompt hearing.

Sincerely,

Jay Calewarts, Division Director
Adult Foster Care, HFA and Camps Licensing Division
Bureau of Community and Health Systems

Enclosures

Cc: Jerry Hendrick, Area Manager
Ray Howd, Office of Attorney General

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS

In the matter of

License #: AS410299024
SIR #: 2017A0583016

Kristen Martell

_____/

AMENDED ORDER OF SUMMARY SUSPENSION
AND NOTICE OF INTENT TO REVOKE LICENSE

The Michigan Department of Licensing and Regulatory Affairs, by Jay Calewarts, Division Director, Adult Foster Care and Camps Licensing Division, Bureau of Community and Health Systems, orders the summary suspension and provides amended notice of the intent to revoke the license of Licensee, Kristen Martell, to operate an adult foster care small group home pursuant to the authority of the Adult Foster Care Facility Licensing Act, 1979 PA 218, as amended, MCL 400.701 et seq., for the following reasons:

1. On or about July 28, 2009, Licensee was issued a license to operate an adult foster care small group home with a licensed capacity of six at 1405 Forrester Drive SE, Grand Rapids, Michigan 49508.
2. Prior to the issuance of the license, and during subsequent modifications of the statutes and rules, Licensee received copies of the Adult Foster Care Facility Licensing Act and the licensing rule book for

adult foster care small group homes. The Act and rule book are posted and available for download at www.michigan.gov/lara.

3. Licensee failed to assure Resident A protection from financial exploitation by withdrawing funds from Resident A's bank account that exceeded the cost for care services specified in the resident care agreement, as evidenced by the following:

    a. Resident A receives social security benefits totaling $892.50 each month. Per the resident care agreement dated February 1, 2017, Resident A agreed to pay Licensee $848.50 per month for rent and care services plus an additional $44 per month for internet service expense.

    b. Between February 1, 2017, and June 30, 2017, Licensee withdrew a total of $5,924.42 from Resident A's bank account via debit card, exceeding the agreed upon amount for rent, care, and internet expenses by $1,441.42.

    c. On September 19, 2017, Ms. Zylstra completed an on-site inspection at the facility and interviewed Licensee. Licensee provided Ms. Zylstra with copies of Resident A's bank statements and admitted to making all of the debit withdrawals from the account from February 2017 through June 2017.

    d. On October 4, 2017, Grand Rapids Police Detective Eric Gizzie informed Ms. Zylstra that an arrest warrant for Embezzlement From A Vulnerable Adult would be issued for Licensee on October 5, 2017.

4. Licensee lacks the financial capability to operate the home to adequately provide for the residents, as evidenced by the following:
    a. Between February 2017 and June 2017, Licensee made unauthorized withdrawals from Resident A's bank account totaling $1,441.42.
    b. On September 19, 2017, during an interview with Ms. Zylstra, Licensee stated that she was "behind on her property taxes" and owed approximately $22,000. Licensee stated that she plans to borrow money from family members so she can pay the taxes by February 2018. Ms. Zylstra contacted the Kent County Treasurer's Office, and a representative confirmed that Licensee owed $22,077.93 in property taxes.
    c. On October 4, 2017, a DTE Energy representative informed Ms. Zylstra that Licensee has an outstanding balance of $1,504.72 for natural gas service that is due on October 21, 2017. The representative also indicated that there was a "force move out" on the account, which requires DTE Energy to turn gas service off until the balance is paid in full plus a security deposit.
    d. On October 6, 2017, Licensee was arrested and charged with Felony Embezzlement From A Vulnerable Adult More Than $1000 But Less Than $20000.
5. Licensee failed to administer medication to Resident C as prescribed by his physician, as evidenced by the following:

a. Resident A was admitted to the facility on August 30, 2017, with prescribed Ativan to be administered three times a day.

b. On September 19, 2017, Resident C received a new prescription for Ativan after a psychiatric appointment with Dr. Handlin.

c. On September 27 and October 2, 2017, Resident C was taken to St. Mary's Emergency Department for agitation. Resident C's blood was tested on September 28, 2017, and results came back negative for benzodiazepines, or Ativan.

d. On October 3, 2017, Ms. Zylstra, accompanied by Network 180 Recipient Rights Worker Melissa Gekeler, conducted an on-site inspection and interviewed Licensee. Licensee stated that on September 2, 2017, Resident C ran out of Ativan and that it was not refilled until September 19, 2017. Licensee stated that she administered Resident C's Ativan three times a day as prescribed after September 19, 2017. Ms. Zylstra reviewed Resident C's medication administration record. Resident C's medication log sheet dated September 18, 2017, through October 17, 2017, did not list Ativan as a prescribed medication and, therefore, did not show it as being administered. Licensee was unable to provide medication records that indicate Ativan was administered to Resident C during this time.

6. Licensee failed to complete a criminal history check prior to employing Robert Robertson at the facility and failed to provide any of the required trainings, as evidenced by the following:

a. On September 15, 2017, Ms. Zylstra, accompanied by Detective Gizzie, Adult Protective Services Worker Kortney Post, and Recipient Rights Worker Lori Boeskool, conducted an on-site inspection at the facility. Licensee told Ms. Zylstra that Robert Robertson sometimes stays overnight at the facility and showed her the area in the basement where he sleeps. She admitted that she has left him alone to care for residents for "very short periods of time." She admitted that she did not complete a criminal background check on Mr. Robertson prior to him caring for residents and that he has not received any of the necessary trainings required for a direct care worker, including first aid, CPR, reporting requirements, resident rights, and safety and fire protection training.

b. On September 15, 2017, during interviews with Ms. Zylstra and Ms. Boeskool, both Resident B and Resident C stated that Mr. Robertson lives at the facility and supervises residents when Licensee was not there.

c. On October 3, 2017, Ms. Zylstra and Ms. Gekeler interviewed Licensee, and she confirmed that Mr. Robertson continues to reside at the facility and provide care for residents when she is absent. She acknowledged that she still has not completed a criminal background check on Mr. Robertson and that he has not received any of the necessary trainings required to be a direct care worker.

7. Direct Care Worker Robert Robertson administered medication to residents without being trained in medication administration, as evidenced by the following:
    a. During separate interviews on October 3, 2017, both Resident A and Resident C told Ms. Zylstra that Mr. Robertson has administered medications to them.
    b. On October 3, 2017, Licensee acknowledged to Ms. Zylstra that she puts the residents' medications in medication cups and has Mr. Robertson administer the medications to residents. Licensee admitted that Mr. Robertson has not completed medication administration training.
8. Licensee failed to obtain written evidence that Direct Care Worker Robert Robertson has been tested for communicable tuberculosis prior to his caring for residents and living in the home. During the on-site inspections at the facility, Licensee admitted to Ms. Zylstra that Mr. Robertson spends the night at the facility and cares for residents when she is absent. Licensee acknowledged that she did not obtain evidence that Mr. Robertson had been test for communicable tuberculosis prior to his presence in the home.
9. Licensee is not suitable to meet the physical, emotional, social, and intellectual needs of residents. On October 6, 2017, Licensee was arrested and charged with Felony Embezzlement From A Vulnerable Adult More Than $1000 But Less Than $20000.

10. This AMENDED ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT TO REVOKE replaces the previous ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT TO REVOKE issued on October 6, 2017.

COUNT I

The conduct of Licensee, as set forth in paragraphs 3(a) through 3(d) above, evidences a willful and substantial violation of:

R 400.14315

(10) A licensee, administrator, direct care staff, other employee, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.

COUNT II

The conduct of Licensee, as set forth in paragraphs 4(a) through 4(d) above, evidences a willful and substantial violation of:

R 400.14201

(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.

COUNT III

The conduct of Licensee, as set forth in paragraphs 5(a) through 5(d) above, evidences a willful and substantial violation of:

R 400.14312

(2) Medication shall be given, taken, or applied pursuant to label instructions.

COUNT IV

The conduct of Licensee, as set forth in paragraphs 6(a) through 6(c) above, evidences a willful and substantial violation of:

MCL 400.734b

(2) Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents after April 1, 2006 until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5).

COUNT V

The conduct of Licensee, as set forth in paragraphs 3(a) through 3(d) above, evidences a willful and substantial violation of:

R 400.14305

(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.

COUNT VI

The conduct of Licensee, as set forth in paragraphs 6(a) through 6(c) above, evidences a willful and substantial violation of:

R 400.14204

(3) A licensee or administrator shall provide in-service training or make training available through other sources to

direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:

(a) Reporting requirements.
(b) First aid.
(c) Cardiopulmonary resuscitation.
(d) Personal care, supervision, and protection.
(e) Resident rights.
(f) Safety and fire prevention.
(g) Prevention and containment of communicable diseases.

COUNT VII

The conduct of Licensee, as set forth in paragraph 8 above, evidences a willful and substantial violation of:

R 400.14205

(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.

COUNT VIII

The conduct of Licensee, as set forth in paragraphs 7(a) and 7(b) above, evidences a willful and substantial violation of:

R 400.14312

(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or

she shall comply with all of the following provisions:

(a) Be trained in the proper handling and administration of medication.

COUNT IX

The conduct of Licensee, as set forth in paragraph 9 above, evidences a willful and substantial violation of:

R 400.14201

(9) A licensee and the administrator shall possess all of the following qualifications:

(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.

DUE TO THE serious nature of the above violations and the potential risk they represents to vulnerable adults in Licensee's care, emergency action is required. Therefore the provision of MCL 24.292 of the Administrative Procedures Act of 1969, as amended, is invoked. Licensee is hereby notified that the license to operate an adult foster care small group home is summarily suspended.

EFFECTIVE 6:00 p.m., on October 6, 2017, Licensee is ordered not to operate an adult foster care small group home at 1405 Forrester Drive SE, Grand Rapids, Michigan 49508 or at any other location or address. Licensee is not to receive adults for care after that time or date. Licensee is responsible for informing case managers or guardians of adults in care that the license has been suspended and that Licensee can no longer provide care.

HOWEVER, BECAUSE THE Department has summarily suspended the license, an administrative hearing will be promptly scheduled before an administrative law judge. Licensee MUST NOTIFY the Department and the Michigan Administrative Hearings System (MAHS) in writing within seven calendar days after receipt of this Notice if Licensee wishes to appeal the summary suspension and attend the administrative hearing. The written request must be submitted via MAIL or FAX to:

Michigan Administrative Hearings System
611 West Ottawa Street, 2nd Floor
P.O. Box 30695
Lansing, Michigan 48909
Phone: 517-335-2484
FAX: 517-335-6088

MCL 24.272 of the Administrative Procedures Act of 1969 permits the Department to proceed with the hearing even if Licensee does not appear. Licensee may be represented by an attorney at the hearing at his or her own expense.

DATED: 10-11-17

Jay Calewarts, Division Director
Adult Foster Care and Camps Licensing Division
Bureau of Community and Health Systems

This is the last and final page of the AMENDED ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT in the matter of Kristen Martell, AS410299024, consisting of 11 pages, this page included.

JEK