



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 26, 2021

Jodi Martinez
3749 Orchard Rd
Peck, MI 48466

RE: License #: AM760072288
Investigation #: 2021A0871009
Martinez AFC Home

Dear Ms. Martinez:

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 (989) 732-8062.

Sincerely,



Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM760072288
Investigation #:	2021A0871009
Complaint Receipt Date:	12/03/2020
Investigation Initiation Date:	12/07/2020
Report Due Date:	02/01/2021
Licensee Name:	Jodi Martinez
Licensee Address:	3749 Orchard Rd Peck, MI 48466
Licensee Telephone #:	(810) 378-5280
Administrator:	Jodi Martinez
Licensee Designee:	N/A
Name of Facility:	Martinez AFC Home
Facility Address:	3749 Orchard Road Peck, MI 48466
Facility Telephone #:	(810) 378-5280
Original Issuance Date:	06/30/1997
License Status:	REGULAR
Effective Date:	07/12/2018
Expiration Date:	07/11/2020
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was abandoned at the hospital. ER staff attempted to discharge Resident A back to his AFC home multiple times.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/03/2020	Special Investigation Intake 2021A0871009
12/07/2020	Special Investigation Initiated - Telephone Telephone call to Licensee Jodi Martinez
12/07/2020	APS Referral Through Central Intake to Sanilac County MDHHS
01/20/2021	Inspection Completed On-site Interviewed Licensee Jodi Martinez and Residents B-K
01/21/2021	Exit Conference Face to face exit conference with Licensee Jodi Martinez
01/25/2021	Contact - Telephone call Telephone call to Resident A's Guardian 1
01/25/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was abandoned at the hospital. ER staff attempted to discharge Resident A back to his AFC home multiple times.

INVESTIGATION:

On December 7, 2020, I telephoned Licensee Jodi Martinez. Licensee Martinez said Resident A “beat up people” and she had to lock the residents in their rooms. Licensee Martinez indicated Resident A went to the hospital on November 18, 2020 and she wrote a 24-hour discharge notice. Licensee Martinez indicated Sanilac County CMH could not find a placement for Resident A. Licensee Martinez stated Resident A hit her staff member in the face and the residents were afraid of him. Licensee Martinez indicated Resident A threatened to “crack my skull” and he chased her around outside for 20 minutes. Licensee Martinez indicated the police were called and it took three police officers to get him down. Licensee Martinez said she locked two of her residents in her car. Licensee Martinez feared for the residents’ safety. Licensee Martinez said Resident A was “physically very aggressive toward me and the residents.”

On November 18, 2020, Licensee Martinez faxed me a copy of the 24-hour discharge notice that she gave to Resident A. It indicates “To Whom it may concern: I Jodi Martinez give emergency discharge to [Resident A] due to substantial risk of: Harm to himself, Harm to other residents, Physical assault, has done bodily harm, destruction of property. I have called guardian, case worker, Resident, Licensing consultant and also sent copy of this letter. Thank you, Jodi Martinez.” It was signed on November 18, 2020.

On January 21, 2021, I conducted an onsite investigation and interviewed Licensee Jodi Martinez. Licensee Martinez indicated Resident A was placed as a “strait AFC resident” when Sanilac CMH placed him in her home in July 2020.

I also interviewed Residents B-K. Resident B said things are good in the home. Resident C stated “he (Resident) was kind of scary, things are better now.” Resident D said, “this is the best home” and gets excellent food. Resident E likes living here, and things are good at the home. Resident F said “things are better now that [Resident A] moved out. It is back to normal now.” Resident F likes Licensee Martinez.

Resident G said he likes living in the home. Resident H said, “things are pretty good here.” Resident I and J were nonverbal and did not provide any information. Resident K said “[Resident A] didn’t treat Jodi very well.” He also stated Resident A “pushed Gail (staff).”

On January 25, 2021, I telephoned Guardian 1. Guardian 1 said she “had no concerns whatsoever” about the care Resident A received while at Martinez AFC. Guardian 1 indicated “Jodi was phenomenal” and that she got Resident A healthy.

Guardian 1 said Licensee Martinez could not control Resident A’s mental health behavior. Guardian 1 said Resident A was removed from a bad situation. Guardian 1 indicated CMH “never had a plan for him” and blames CMH for not having a plan for him. Guardian 1 said Resident A “was putting others at risk.” Guardian 1 hopes that Resident A’s medications can get straightened out and wants to place Resident A back with Licensee Martinez. Guardian 1 said she was also contacted by Adult Protective Services regarding this incident.

APPLICABLE RULE	
R 400.14302	Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.
	<p>(5) A licensee who proposes to discharge a resident for any reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:</p> <p>(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:</p> <p>(i) The resident shall not be discharged until an appropriate setting that meets the resident’s immediate needs is located.</p>
ANALYSIS:	Resident A did not have an appropriate placement when given an emergency 24-hour discharge notice. Hospital staff wanted Resident A to return to Martinez AFC, but Licensee Jodi Martinez refused. I confirm violation of this rule.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

I looked in the file of Martinez AFC to find the *AFC Licensing Division Incident/Accident Report* and not find the *AFC Licensing Division Incident/Accident Report* dated for the hospitalization on November 18, 2020.

On January 26, 2021, I telephoned Licensee Jodi Martinez and asked for the *AFC Licensing Division Incident/Accident Report*. Licensee Martinez could not find one and indicated that Resident A went to mental health and then to the emergency room. Licensee Martinez also stated she did not write one.

On January 26, 2021, I conducted a telephone exit conference with Licensee Jodi Martinez. I advised her there were two rule violations substantiated.

APPLICABLE RULE	
R 400.14311	Investigation and reporting of incidents, accidents, illnesses, absences, and death.
	(1) A licensee shall make a reasonable attempt to contact the resident’s designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident’s designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (c) Incidents that involve any of the following: (ii) Hospitalization.
ANALYSIS:	Martinez AFC file did not have a copy of the hospitalization of Resident A on November 18, 2020. Licensee Jodi Martinez said she did not write one. I confirm violation of this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care medium group home remain unchanged (capacity 1-11).

Kathryn A. Huber

01/26/2021

Kathryn A. Huber
Licensing Consultant

Date

Approved By:

Mary E. Holton

01/26/2021

Mary E Holton
Area Manager

Date