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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2021

Angela Martinez
1321 Juhl Rd.
Marlette, MI 48453

RE: License #: AM760317941
Investigation #: 2021A0871040
Martinez Retirement Home

Dear Mrs. 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AM760317941
Investigation #:	2021A0871040
Complaint Receipt Date:	08/30/2021
Investigation Initiation Date:	09/01/2021
Report Due Date:	10/29/2021
Licensee Name:	Angela Martinez
Licensee Address:	1321 Juhl Rd. Marlette, MI 48453
Licensee Telephone #:	(810) 648-2175
Administrator:	Angela Martinez
Licensee:	Angela Martinez
Name of Facility:	Martinez Retirement Home
Facility Address:	127 Lincoln Sandusky, MI 48471
Facility Telephone #:	(810) 648-4744
Original Issuance Date:	03/15/2013
License **Status:**	REGULAR
Effective Date:	05/20/2021
Expiration Date:	05/19/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

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II. ALLEGATION(S)

	Violation Established?
Staff are refusing to provide meals to Resident A.	No
Staff are throwing Resident A's belongings out.	No
Additional Findings	Yes

III. METHODOLOGY

08/30/2021	Special Investigation Intake 2021A0871040
08/30/2021	APS Referral Denied to Sanilac County MDHHS
09/01/2021	Special Investigation Initiated - On Site Interviewed Home Manager Michelle Hughes
09/01/2021	Contact - Telephone call made Telephone call to Guardian 1
09/10/2021	Contact - Telephone call received Telephone call from Resident A
09/16/2021	Contact - Telephone call made Telephone call to Guardian 1
09/29/2021	Exit Conference Telephone exit conference with Licensee Angela Martinez
09/29/2021	Contact – Telephone call made Telephone call to Manager Michelle Hughes

ALLEGATION:

Staff are refusing to provide meals to Resident A.

INVESTIGATION:

On September 1, 2021, I conducted an unannounced onsite investigation and interviewed Manager Michelle Hughes. Manager Hughes indicated that Resident A leaves the facility and does not tell staff. Manager Hughes said Resident A lets her breakfast "sit for hours" and breakfast is served before Resident A leaves the facility. Manager Hughes reported that on August 31, 2021, Resident A was served breakfast, but she left. Resident A returned with food from a nearby Speedy-Q.

On September 22, 2021, I conducted an unannounced onsite investigation and interviewed Staff Mariah Rollette. Ms. Rollette advised "there is plenty of food here" and I observed the food in the facility. The cupboards were full of large cans of vegetables and sauces. The freezer was full of frozen foods and meats. There are two refrigerators in the basement, and I observed 10 dozen eggs, gallons of milk and other food in the refrigerators in the basement. There is also 1 ½ freezers that were full. Also located in the basement is a pantry that was stocked with canned foods and potatoes.

On September 1, 2021, I telephoned Resident A's Guardian 1. Guardian 1 said Resident A is "fixated on being pregnant. When a pregnancy test is performed and she is told it is negative, Resident A "gets mad." Guardian 1 indicated Resident A is "very attention seeking." Guardian 1 said CMH asked staff to document when Resident A is coming and going. Guardian 1 said Resident A leaves the facility and does not notify staff. Guardian 1 said she does not tell staff that she is not going to be there for dinner. Guardian 1 indicated "she is not starving by any means." Guardian 1 said the other day she picked Resident A up from work and took her to McDonald's. Guardian 1 reported that it took Resident A 1 ½ hours to eat her burger and fries. Guardian 1 said if she was starving, she would not have taken that long to eat her meal. Guardian 1 said she will tell people that she is starving and has not been fed in three days but can eat at the facility. Guardian 1 reported that Resident A could take a packed lunch to work but she does not ask staff to pack a lunch for her.

Manager Hughes provided me with a copy of the meals that she missed for the month of August 2021. Resident A missed 19 breakfasts, lunch, and dinner meals in the month of August 2021. Resident A was LOA overnight for three days and two days she was at work and missed dinner. Manager Hughes said Resident A was with a family member that lives in Carsonville, Michigan when she was LOA.

Manager Hughes also provided me with a copy of Resident A's *Assessment Plan for AFC Residents."* It indicates 'Moves Independently in Community – yes.' It is signed and dated by Guardian 1 and Licensee Angela Martinez on May 6, 2021. I observed the menu at the facility . The menu appeared to provide three nutritious meals per day and followed the recommended dietary allowances.

On September 1 and September 22, 2021, I observed the menus for the month of August and September 2021. The menus appeared to provide three nutritious meals per day and followed the recommended dietary allowances.

On September 22, 2021, I observed Resident A's weight record from March through September 2021. It indicates the following:

Date:	Weight:
04/01/2021	148
05/01/2021	143
06/01/2021	150
07/01/2021	155
08/01/2021	154
09/01/2021	155

On September 22, 2021, I interviewed Residents B-E. Resident B said he gets enough to eat, and a meal has never been denied to him. Resident C said he "always gets enough to eat" and the staff have never denied serving him a meal. Resident D stated "the food is good" and she gets enough to eat. Resident D has never been denied a meal. Resident E also said she gets enough to eat, and the food is good. Resident E said she has never been denied a meal.

On September 22, 2021, at the onsite investigation, I Staff Mariah Rollette said when Resident A would leave the facility, she knew that she would go to work and then over to her boyfriends. Staff Rollette said Resident A "would just walk out the door" but she had an idea of where she was going. Ms. Rollette stated she would ask her if she would be home for dinner and she would usually say "no." Ms. Rollette stated Resident A would come back later and get upset if dinner was done. Ms. Rollette reported that Guardian 1 advised not to push Resident A for information because "she would explode."

On September 27, 2021, I interviewed Manager Hughes via telephone. Manager Hughes reported that Resident A would walk out, and she would go to work and with her boyfriend. Manager Hughes said Resident A was supposed to call to let them know if she would be home for dinner, but she never would. Resident A's Guardian 1 told her that she was trying to get Resident A to follow rules as she would be moving into an apartment and had to follow rules there. Guardian 1 told Manager Hughes she was trying to teach Resident A responsibility.

On September 10, 2021, I interviewed Resident A via telephone. Resident A said she "is having problems with feeding." Resident A reported the facility does not make any food and she did not have any dinner. Resident A indicated "they hardly make breakfast" and she is not getting a whole lot to eat. Resident A said she eats and what she does not want, she "tosses the rest." Resident A said she did have dinner yesterday and it was good.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Manager Hughes said Resident A leaves before eating her food and does not tell staff. Guardian 1 said Resident A is not starving and leaves before telling staff. Guardian 1 stated Resident A chooses not to eat at the facility. There is no evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are throwing Resident A's belongings out.

INVESTIGATION:

On September 1, 2021, Manager Hughes said she was unaware of anyone throwing Resident A's belongings out. Manager Hughes showed me Resident A's room and it was quite messy. Manager Hughes said Resident A is told to clean her room but chooses not to.

On September 1, 2021, Guardian 1 reported that she was not aware of staff throwing anything out. Guardian 1 said Resident A "leaves her stuff all over the place." Resident A has never told Guardian 1 that staff threw anything away. Guardian 1 reported that Resident A brings bags of stuff from the thrift store and the facility does not want it in the house because of bed bugs. Guardian 1 indicated Resident A "goes digging in dumpsters and brings stuff home." Guardian 1 said License Angela Martinez told Resident A to leave it outside because of bed bugs. Guardian 1 stated Resident A should not be digging through dumpsters and is unaware of staff throwing her belongings away.

On September 10, 2021, when I asked Resident A about what the facility has thrown out, she replied “they threw my wedding dress and a bunch of other stuff out.” Resident A could not provide any other items that the staff threw out.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.**
ANALYSIS:	Guardian 1 was unaware of staff throwing any personal belongings of Resident A away. Guardian 1 reported that Resident A dumpster digs, and Licensee Angela Martinez does not want it in her home because of bed bugs. Manager Hughes denied that staff threw anything of Resident A’s out. There is no evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On September 1, 2021, Manager Hughes showed me Resident A’s room and it was quite messy. Manager Hughes said Resident A is told to clean her room but chooses not to.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On September 1, 2021, Resident A’s bedroom was messy with clothes scattered all over the floor. I confirm violation of this rule
CONCLUSION:	**VIOLATION ESTABLISHED**

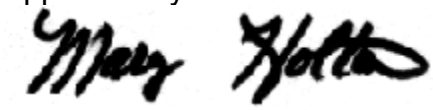
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend continuation of the current status of the license of this AFC adult medium group home (capacity 7-12).

09/29/2021

Kathryn A. Huber Date
Licensing Consultant

Approved By:



09/29/2021

Mary E Holton Date
Area Manager