GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 05, 2023

Margarito Martinez, Jr.
5565 E. Peck Rd.
Croswell, MI 48422

RE: License #: AL760287996
Investigation #: 2024A0580004
Martinez Manor

Dear Margarito Martinez, Jr.

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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL760287996
Investigation #:	2024A0580004
Complaint Receipt Date:	10/11/2023
Investigation Initiation Date:	10/11/2023
Report Due Date:	12/10/2023
Licensee Name:	Margarito Martinez, Jr.
Licensee Address:	5565 E. Peck Rd. Croswell, MI 48422
Licensee Telephone #:	(810) 679-0226
Administrator:	Margarito Martinez
Licensee Designee:	N/A
Name of Facility:	Martinez Manor
Facility Address:	5565 E. Peck Rd Croswell, MI 48422
Facility Telephone #:	(810) 679-0226
Original Issuance Date:	04/30/2008
License Status:	REGULAR
Effective Date:	12/03/2022
Expiration Date:	12/02/2024
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
On 10/4/2023, Resident A was not accompanied along by staff to her eye appointment.	No
On 10/3/2023, Resident A was prescribed Zithromax, the staff refuses to give her the medication.	No
There are often poor food choices or not food at all. Resident A will often eat cookies because she is very hungry.	Yes
There are bedbugs in the home.	No

III. METHODOLOGY

10/11/2023	Special Investigation Intake 2024A0580004
10/11/2023	Special Investigation Initiated - On Site An onsite inspection was conducted. Contact made with Resident A.
10/11/2023	Contact - Face to Face Contact with the licensee, Margarito Martinez.
10/24/2023	Contact - Telephone call made Call to Mr. Martinez.
10/27/2023	Contact – Document Received Emailed copy of documents requested received.
11/17/2023	APS Referral Call from Lane Smith, APS Sanilac County.
11/21/2023	Contact - Telephone call made Call to Public Guardian A.
12/01/2023	Contact - Telephone call made Spoke with Public Guardian A.
12/01/2023	Contact - Telephone call made Call to exterminator.
12/04/2023	Inspection Completed On-site An onsite inspection was conducted.

12/04/2023	Contact - Face to Face Interviews with Residents A, B, C, and D.
12/04/2023	Exit Conference Exit conference with Margarito Martinez, licensee.

ALLEGATION:

On 10/4/2023, Resident A was not accompanied along by staff to her eye appointment.

INVESTIGATION:

On 10/11/2023, I received a complaint via BCAL Online Complaints.

On 10/11/2023, I conducted an onsite inspection at Martinez Manor. I spoke with Resident A was interviewed while sitting outside on the patio. She stated, “things are good here”.

On 10/27/223, I received an emailed copy of the AFC Assessment Plan for Resident A. It indicates that Resident A does not move independently in the community and must be accompanied by staff. Resident A is assigned a public guardian.

On 11/21/2023, I placed a call to Sanilac County’s assigned public guardian for Resident A. A voice mail message was left requesting a return call.

On 12/01/2023, I spoke with Public Guardian A. She stated that on the day in question her staff did pick Resident A up to accompany for her eye appointment. However, Resident A was reported to be alone outside on the day in question waiting for her ride. Resident A also stated that she had not eaten or had been given her medication. Upon speaking with the licensee, he denied the allegations. Public Guardian A stated that Resident A is able to catch the bus alone to CMH for services.

On 12/04/2023, I conducted an unannounced follow-up onsite inspection at Martinez Manor. Licensee Margarito Martinez stated that staff did not accompany Resident A to the appointment because she was being transported by staff at the public guardian’s office. That appointment was in located in Port Huron, MI. Licensee Margarito Martinez added that when he transports Resident A to her medical appointments, she usually comes out with the instructions given by the physician. Licensee Margarito Martinez stated that Resident A usually does not want anyone to accompany her in the room when seeing the doctor.

APPLICABLE RULE	
R 400.15303	**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:	It was alleged that Resident A was not accompanied along by staff to her eye appointment. Public Guardian A stated that on the day in question her staff did pick Resident A up for her eye appointment. The AFC Assessment Plan for Resident A indicates that Resident A does not move independently in the community and must be accompanied by staff. Resident A is assigned a public guardian. Licensee Margarito Martinez stated that staff did not accompany Resident A to the appointment because she was being transported by staff at the public guardian's office. Based on interviews conducted with the licensee designee and Public Guardian A and a review of the AFC assessment plan for Resident A, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 10/3/2023, Resident A was prescribed Zithromax, the staff refuses to give her the medication.

INVESTIGATION:

On 10/11/2023, I conducted an onsite inspection at Martinez Manor. While onsite I spoke with the licensee Margarito Martinez, He denied the allegations that Resident A is not receiving her medication. He stated that the prescription in question, was delivered via the pharmacy on the evening of 10/02/2023. However, instead of having him or staff sign for them, they placed them on his office desk. Resident A began taking the medication the following morning.

Medication sheets obtained for Resident A for the month of October 2023 indicate that Resident A began taking the medication Azithromycin on 10/03/2023. The order states that Azithromycin, 250mg, take 2 tabs day one, then 1 thereafter, for 4 days. The

medication was administered at 7am 10/03-10/07/2023. The medication sheets for the month of October 2023 also indicate that Resident A was given all her medication for the month, as prescribed.

On 12/01/2023, I spoke with Public Guardian A who stated that Resident A reported to her that she did not receive her medication when it was prescribed on 10/03/2023. When asked, the licensee denied these allegations. She adds that Resident A does sometimes gets confused, so she is unsure if there was some truth to the allegations or not. Resident A is diagnosed with Schizophrenia, Frontotemporal Neuro Cognitive Disorder and alcoholism.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that Resident A was prescribed Zithromax, the staff refuses to give her the medication. Licensee designee Margarito Martinez denied the allegations that Resident A is not receiving her medication. He prescription delivered via the pharmacy on the evening of 10/02/2023. Resident A began taking the medication the following morning. Medication sheets obtained for Resident A for the month of October 2023 indicate that Resident A began taking the medication Azithromycin on 10/03/2023. The order states that Azithromycin, 250mg, take 2 tabs day one, then 1 thereafter, for 4 days. The medication was administered at 7am 10/03-10/07/2023. Public Guardian A who stated that Resident A reported to her that she did not receive her medication when it was prescribed

	on 10/03/2023. She adds that Resident A does sometimes gets confused, so she is unsure if there was some truth to the allegations or not. Based on the interviews conducted with the licensee designee Margarito Martinez, Public Guardian A and a review of the October 2023 medication log for Resident A, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are often poor food choices or not food at all. Resident A will often eat cookies because she is very hungry.

INVESTIGATION:

On 10/11/2023, while onsite, licensee Margarito Martinez denied the allegations that the residents are not being fed properly. He stated that Resident A is a picky eater. While onsite I observed the food supply in the home. The cupboards were fully stocked with canned goods and other non-perishable food items.

On 10/27/2023 I received an emailed copy of the menu for the home. The residents are offered either hot or cold cereal for breakfast, along with fruit, toast, and drink options. These breakfast options do not change and are listed daily throughout the entire menu. For lunch the residents are typically offered sandwich options of Bologna and cheese, grilled cheese and soup, peanut butter and jelly, tuna, salami, turkey or ham and cheese, along with chips, fruit, and juice. Dinner consists of meat options baked chicken, Salisbury steak, meat loaf, lasagna, etc. along with a vegetable, fruit, and drink options. The menu is not dated, however, the menu for the day notes that on one day the residents were served hot or cold cereal for breakfast, along with fruit, toast, and drink options for breakfast, celery, peanut butter and jelly, chips, snack and juice for lunch and spaghetti and meatballs w/rice, corn bread, vegetable applesauce and juice for dinner. Another day offered the same breakfast options, with grilled cheese, soup, fruit, snack, and juice. For dinner the residents were served baked chicken, asparagus, fried potatoes, Jello, and juice.

Based on this menu, residents are not being served the 3-5 daily servings required from the Vegetable group nor their 2-3 daily servings of Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts Group, per the Recommended Dietary Allowances for nutrients.

The weight log for Resident A was obtained. Resident A began the year weighing 143 lbs. in January and February 2023. In March and April 2023, she weighed 144 lbs. In

May and June 2023, she weighed 145lbs. The remaining weights were recorded as July-146 lbs., August-143 lbs., September-141 lbs., and 139lbs., in October 2023.

On 11/17/2023, I spoke with Lane Smith, assigned APS Investigator in Sanilac County He shared that in his investigation, he was able to observe the food supply and what foods are being offered on the menus in in the home. He has also determined that Resident A often declines her food. He indicated that he will not be substantiating the case based on meds, food, and appointments.

On 12/01/2023, Public Guardian A stated that she was concerned when Resident A would express being hungry, which has occurred on more than one occasion. To her knowledge, Resident A has been trying to enjoy the food that is being offered in the home.

On 12/04/2023, while onsite, I observed the freezer contents on the home. I observed packages of chicken, hamburger, and other ample frozen foods.

On 12/04/2023, while onsite, I interviewed Residents A, B C and D. Resident A stated that she gets enough food to eat, however, she does not like the food that is served. Hot or cold cereal is served daily. She is trying to obtain a food voucher. She identified Peanut Butter and Jelly sandwiches as what was being served for lunch.

Resident B stated that she gets enough to eat.

Resident C stated that he does not get full and will often go in own to supplement the things he wants to buy for himself.

Resident D stated that he gets enough food to eat.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.

ANALYSIS:	It was alleged that there are poor food choices or no food at all in the home. Licensee designee, Margarito Martinez, denied the allegations that the residents are not being fed properly. The cupboards were observed were fully stocked with canned goods and other non-perishable food items. The freezer contained ample other frozen foods and meats. The weight log for Resident A was reviewed. The menus reviewed are not meeting the 3-5 daily servings required from the Vegetable group nor the 2-3 daily servings of Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts Group, per the Recommended Dietary Allowances for nutrients. Lane Smith, APS Investigator in Sanilac Co, indicated that he will not be substantiating the case based on meds, food, appointments. Public Guardian A stated that she was concerned when Resident A would express being hungry, which has occurred on more than one occasion. To her knowledge, Resident A has been trying to enjoy the food that is being offered in the home. Resident A stated that she gets enough food to eat, however, she does not like the food that is served. Residents B and D stated that they get enough to eat. Resident C stated that he does not get full and will often go in own to supplement the things he wants to buy for himself. Based on a review of the weight log, for Resident A, menus for the home, interviews with the licensee, Margarito Martinez, Public Guardian A, Lane Smith, APS Investigator, Tuscola County, interviews with Residents A, B, C and D, an observation of the food and menus in them home, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are bed bugs in the home.

INVESTIGATION:

On 10/24/2023, I placed a call to Margarito Martinez. He stated that the home has had bed bugs in the past, a few months back. The home is sprayed monthly. It was last sprayed on Friday, 10/20/2023. He stated that he uses a licensed exterminator, however, he does not have any receipt verification.

On 12/01/2023, Public Guardian A stated that she was made aware that the home has had bed bugs by other AFC homes in the area. Resident A shared with her that all of her things had been removed from her room. She assumes this was when the home was being sprayed. She is unsure if this is a current or former issue.

On 12/01/2023, I placed a call to the exterminator identified for the facility. A voice mail message was left requesting a return call.

On 12/04/2023, while onsite, residents were observed in the rooms, the living room and in the dining area as staff was preparing lunch. They were adequately groomed and appeared to be receiving adequate care. No concerns were noted. While onsite I observed 10 of the residents' beds throughout the home, checking under the mattresses for any signs off bed bugs. None were seen. Residents A, B, C and D all stated that the bugs had been a while ago. Neither had any present bed bug concerns.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	It was alleged that there are bed bug concerns in the home. Licensee Margarito Martinez denied a current bed bug infestation. the home has had bed bugs in the past, a few months back. Public Guardian A stated that she was made aware that the home has had bed bugs. She is unsure if this is a current or former issue.

	While onsite I observed 10 of the resident beds throughout the home, checking under the mattresses for any signs off bed bugs. None were seen. Residents A, B, C and D all stated that the bugs had been a while ago. Neither had any present bed bug concerns. Based on the interviews conducted with the licensee, Margarito Martinez, Public Guardian A and Residents A, B, C, D and an observation of the resident mattresses, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/04/2023, I conducted an exit conference with the licensee, Margarito Martinez. Margarito Martinez was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

Sabrina McGowan December 5, 2023

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton December 5, 2023

Mary E. Holton Date
Area Manager