



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

October 18, 2018

Margarito Martinez
5565 E. Peck Rd.
Crosswell, MI 48422

RE: License #: AL760287996
Investigation #: 2018A0871049
Martinez Manor

Dear Mr. 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 #:	AL760287996
Investigation #:	2018A0871049
Complaint Receipt Date:	09/04/2018
Investigation Initiation Date:	09/07/2018
Report Due Date:	11/03/2018
Licensee Name:	Margarito Martinez, Jr.
Licensee Address:	5565 E. Peck Rd. Croswell, MI 48422
Licensee Telephone #:	(810) 633-9227
Administrator:	Margarito Martinez, Jr.
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:	12/03/2016
Expiration Date:	12/02/2018
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On September 2, 2018, Resident A was physically grabbed by staff and put into another room where she was not allowed contact with anyone.	Yes
Resident A was not given her evening snack.	Yes

III. METHODOLOGY

09/04/2018	Special Investigation Intake 2018A0871049
09/04/2018	APS Referral Denied to Sanilac County MDHHS
09/07/2018	Special Investigation Initiated - On Site Interviewed Licensee Margarito Martinez, Residents B-C
09/07/2018	Contact - Face to Face Interviewed Resident A at Day Program
10/18/2018	Inspection Completed-BCAL Sub. Compliance
10/18/2018	Exit Conference Telephone contact with Licensee Margarito Martinez

ALLEGATION:

- On September 2, 2018, Resident A was physically grabbed by staff and put into another room and was not allowed to have contact with anyone.
- Resident A was not given her evening snack.

INVESTIGATION:

On September 7, 2018, I conducted an unannounced onsite investigation and interviewed Licensee Margarito Martinez. Mr. Martinez indicated Resident A and

Resident B were complaining about something and that Resident A “was constantly watching [Resident B].” Ms. Martinez said Resident A “kept going on and on” and he told her this “can’t keep going on and told her to go to another room.” Mr. Martinez said Resident A “wouldn’t leave it alone.” Mr. Martinez again said, “she wouldn’t leave it alone.” Mr. Martinez told Resident A to “go to the living room” and that she could have a snack after everyone else had their snack. Mr. Martinez said, “she pushed into me and I put my hand on her arm.” Everyone got done with their snack and Resident A did not get a snack. Mr. Martinez said Resident A “likes to mock [Resident B]” over another resident. Resident A and Resident B are constantly bickering, and Resident A said “fine, I won’t have my snack.” Mr. Martinez said this is an ongoing thing and he did put his hand on her because she pushed into him.

Resident B said Resident A “tells me off all the time.” Resident B said she never witnessed Mr. Martinez push or grab Resident A and has never witnessed him push anybody else. Resident B said Mr. Martinez tells Resident A to behave.

On September 7, 2018, I interviewed Resident A at day program. Resident A said Resident B “likes to cause trouble with me.” Resident A said “he (Mr. Martinez) would not let me have a snack.” She was in her room and opened the door 3-4 times and asked if she could get a snack. Resident A said Mr. Martinez “grabbed my arms and pulled me into the living room.” Mr. Martinez told her “you stay here until I get ready to call you.” Resident A said she did not get a snack that night and that she was crying.

On October 18, 2018, I conducted a telephone exit conference with Licensee Margarito Martinez.

APPLICABLE RULE	
R 400.15308	Resident behavior interventions prohibitions.
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Licensee Margarito Martinez used physical force when he put his hand on Resident A’s arm. Resident A said Mr. Martinez grabbed her. I confirm violation of this rule.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.15308	Resident behavior interventions prohibitions.
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (e) Withhold food, water, clothing, rest, or toilet use.
ANALYSIS:	Licensee Margarito Martinez and Resident A both said she did not get her evening snack. 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 large group home remain unchanged (capacity 1-15).

Kathryn A. Huber

10/18/2018

Kathryn A. Huber
Licensing Consultant

Date

Approved By:

Mary E. Holton

10/18/2018

Mary E Holton
Area Manager

Date