



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 10, 2026

Anna Hunt
The Cottages At Martin Lake, LLC
9293 W 32nd Street
Fremont, MI 49412

RE: License #: AS620398378
Investigation #: 2026A0340021
The Cottages At Martin Lake

Dear Ms. Hunt:

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 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 (616) 356-0100.

Sincerely,



Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS620398378
Investigation #:	2026A0340021
Complaint Receipt Date:	01/27/2026
Investigation Initiation Date:	01/27/2026
Report Due Date:	03/28/2026
Licensee Name:	The Cottages At Martin Lake, LLC
Licensee Address:	9293 W 32nd Street Fremont, MI 49412
Licensee Telephone #:	(231) 307-4567
Administrator:	Anna Hunt
Licensee Designee:	Anna Hunt
Name of Facility:	The Cottages At Martin Lake
Facility Address:	3088 S Van Wagoner Ave Fremont, MI 49412
Facility Telephone #:	(231) 307-4567
Original Issuance Date:	06/12/2019
License Status:	REGULAR
Effective Date:	05/29/2024
Expiration Date:	05/28/2026
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A missed his heart medication when he previously resided at the Cottages at Martin Lake.	Yes
Resident A did not receive a shower.	No

III. METHODOLOGY

01/27/2026	Special Investigation Intake 2026A0340021
01/27/2026	APS Referral complaint received from Adult Protective Service (APS)
01/27/2026	Contact – Letter sent MDHHS – Adult Services – Policy Re: referral source ID
01/27/2026	Special Investigation Initiated - Telephone Anna Hunt
02/01/2026	Contact - Document Received requested from Ms. Hunt
03/03/2026	Contact – Telephone Call Made Ms. Hunt
03/3/2026	Exit Conference Ms. Hunt

ALLEGATION: Resident A missed his heart medication when he resided at the Cottages at Martin Lake.

INVESTIGATION: On January 27, 2026, a complaint was filed with the BCHS Online Complaints by Adult Protective Services (APS). It stated that Resident A lived at The Cottages at Martin Lake more than five months ago. When he lived at the home there was “a day or so” when he did not receive his heart medication. It further states that Licensee Anna Hunt informed Resident A that his medication had not come in and that was why he did not receive it. However, Resident A does not believe this to be true.

On January 27, 2026, I contacted Licensee Anna Hunt. I requested documentation of Resident A’s Health Care Appraisal, Assessment Plan and Medication Administration Record (MAR) from his time residing in the home. She reminded me

this was the same person she had previously reported to me regarding an incident in which Resident A had increased behaviors, becoming violent toward staff and interfering in the care of other residents. Resident A had been sent to the ER for a medication evaluation and became upset with Ms. Hunt for sending him to the hospital. Resident A moved out of the home on August 16, 2025.

On February 2, 2026, I received and reviewed the requested documents. Resident A's Health Care Appraisal was completed by Dr. Vadlamudi, MD, on 2/10/25. Resident A is diagnosed with congestive heart failure atrial flutter, paroxysmal tachycardia hypotension, morbid obesity, and sleep apnea.

Resident A's Assessment Plan was signed by Anna Hunt on 2/27/25. There was nothing remarkable in his Assessment Plan.

I reviewed Resident A's MAR for the months prior to his moving out. On June 29, 2025, it was documented that Resident A did not receive his Carvedilol at 5:09 pm, which is heart medication. The "No Pass Reason" was "out of med". Other medications noted as not being passed that month were as follows:

6/3/25 8:13 am Tamsulosin
6/4/25 8:01 am Tamsulosin
6/5/25 7:10 am Tamsulosin
6/10/25 7:44 am Escitalopram
6/11/25 8:15am Escitalopram
6/29/25 7:08 pm Atovastatin

On March 4, 2026, I contacted Licensee Anna Hunt. I asked Ms. Hunt about being out of Resident A's medication. First, she stated her staff were marking "out of med" when they meant to "click" "resident refused" instead. I then pointed out to Ms. Hunt that there was an additional note documented that stated, "waiting on refill". She did not have knowledge of what had occurred for Resident A's Carvedilol to have run out. There was no documentation from the pharmacy or communication with the doctor or pharmacy regarding that or other medications being unavailable.

I discussed with Ms. Hunt the need for communications with the pharmacy and doctor to be documented if a resident runs out of a medication. Ms. Hunt understood this and stated she would keep that record moving forward.

I asked for and received the Incident Report (IR) regarding this issue involving Resident A which Ms. Hunt sent and I reviewed. The IR was completed by Ms. Hunt on 8/1/25. It stated Resident A had been angry and refusing care. His behavior had become physically violent toward staff, hitting staff Echo, as well as interfering with the care of another resident. Resident A was attempting to take another resident's medication, telling the other resident not to take it, he was talking about dying, so Ms. Hunt called 911 and Resident A was taken to Gerber Hospital for an evaluation on this date.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	<p>The allegation was made that Resident A did not receive his prescribed heart medication.</p> <p>Resident A's MAR indicates in June 2025 when he resided in the home that he did not receive his heart medication called Carvedilol due to the home being out of the medication. There were additional incidents in which Resident A did not receive other prescribed medications due to the home being out of those medications as well. There is no documentation regarding why the medication ran out, nor that the doctor or the pharmacy had been contacted regarding any of the incidents.</p> <p>Ms. Hunt did not recall the medication running out. She stated staff do not document communication with the pharmacy or doctor to indicate what was done if the medication was not refilled.</p> <p>Resident A has not resided in the home since August 2025.</p> <p>There is a preponderance of evidence to support the allegation that Resident A did not receive his prescribed medication.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A did not receive a shower.

INVESTIGATION: On January 27, 2026, a complaint was filed with the BCHS Online Complaints by Adult Protective Services (APS). It stated that Resident A previously resided at The Cottages at Martin Lake but had moved out five months ago. When he lived at the home he did not receive regular showers. The date or timeframe of when this happened was not provided.

On January 27, 2026, I contacted Licensee Anna Hunt and requested Resident A's Assessment Plan.

On February 2, 2026, I received and reviewed the requested documents. Resident A's Assessment Plan was signed by Anna Hunt on 2/27/26. Under "Bathing" it states "needs set up assist".

Ms. Hunt had also included his “Care Plan” which charts his Activities of Daily Living (ADL’s). For the month of June 2025, Resident A showered on the 2, 5, 9, 12, 16, 19, 23, 26, and 30. During the month of July 2025, Resident A was showered on the 3, 10, 14, 17, 21, 24, 28, and 31. For the month of August 2025, which was the last month Resident A resided at the Cottages, it documents that Resident A showered August 5, 7, 11 and 14. Resident A moved out of the home after this date.

On March 3, 2026, I spoke with Ms. Hunt. I asked her what it meant that staff “set up” for Resident A’s showers. She clarified that the assist Resident A received was for staff to bring things which he needed to the bathroom and get things “ready” for his shower. He was able to shower himself independently.

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing
	(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily: (a) Bathing or showering, or both.
ANALYSIS:	<p>The allegation was made that while Resident A was living at the Cottages, there was a week that he did not receive a shower. No timeframe was provided and Resident A has not lived at The Cottages since last summer.</p> <p>Resident A’s Assessment Plan stated that he did not require assistance with showering other than staff bringing things to the bathroom and set it up for him.</p> <p>The ADL log for showering showed that Resident A did have regular showers.</p> <p>There is no evidence to support the allegations.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

On March 3, 2026, I conducted an exit conference with Designee Anna Hunt. We discussed the allegations and the citation found. A request for a Corrective Action Plan was made, which Ms. Hunt agreed to send. She had no further questions.

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change to the current license status.

Rebecca Piccard

March 10, 2026

Rebecca Piccard
Licensing Consultant

Date

Approved By:

Jerry Hendrick

March 10, 2026

Jerry Hendrick
Area Manager

Date