GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 13, 2023

Shawna and Jose Maciel
1051 Collage Avenue
Holland, MI 49423

RE: License #: AF030396753
Investigation #: 2023A0581022
Helping Hands

Dear Mr. and Mrs. Maciel:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF030396753
Investigation #:	2023A0581022
Complaint Receipt Date:	02/23/2023
Investigation Initiation Date:	02/23/2023
Report Due Date:	04/24/2023
Licensee Name:	Shawna and Jose Maciel
Licensee Address:	1051 Collage Avenue Holland, MI 49423
Licensee Telephone #:	(616) 795-3298
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Helping Hands
Facility Address:	1051 College Ave Holland, MI 49423
Facility Telephone #:	(616) 795-3598
Original Issuance Date:	06/10/2019
License Status:	REGULAR
Effective Date:	12/10/2021
Expiration Date:	12/09/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly given a discharge notice.	No
The licensee is overcharging Resident A for adult foster care payments.	No
Additional Findings	Yes

III. METHODOLOGY

02/23/2023	Special Investigation Intake 2023A0581022
02/23/2023	Special Investigation Initiated - Telephone Interview with Transition Navigator, Ronda Wenger.
03/07/2023	Contact - Telephone call made Interview with Resident A's relative, Relative A1.
03/08/2023	Contact - Telephone call made Interview with Resident A.
03/09/2023	Inspection Completed On-site Interviewed licensee, residents, and obtained documentation.
03/09/2023	Exit conference with licensee, Shawna Maciel.
04/03/2023	Inspection Completed-BCAL Sub. Compliance
04/10/2023	Contact – Document Sent Email to licensee, Shawna Maciel.
04/10/2023	APS Referral Contacted APS specialist, Katheen Woodworth, via email.
04/13/2023	Contact – Telephone call made Interview with licensee, Joe Maciel.
04/13/2023	Contact – Telephone call made Interview with Ms. Maciel.

ALLEGATION:

Resident A was improperly given a discharge notice.

INVESTIGATION:

On 02/23/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident A resided at the facility from May 11, 2022, through December 31, 2022. The complaint alleged the licensee can only discharge a resident from the home for certain reasons, per the licensee's "*Summary of Resident Rights; Discharge and Complaints"* document, which can only for specific reasons and the licensee must follow a specific process in order for the resident to be discharged. The complaint alleged the licensee "loosely" followed this process because the licensees indicated they were unable to meet Resident A's needs because he required a higher level of care than what they could provide and subsequently provided him with a 30-day discharge notice.

Complainant provided documentation along with the complaint including a copy of a *"General Power of Attorney"* document, dated 09/30/2024 identifying Relative A1 as Resident A's Power of Attorney (POA). There was no documentation indicating Resident A had been deemed incapacitated; therefore, enacting the POA.

Complainant included a copy of Resident A's 30-day discharge notice, dated 12/01/2022, which stated, "This is a 30-day notice to move[sic] We are unable to meet your care needs. You need a higher care need then what we can provide[sic]".

Complainant also included a copy of the facility's "House Rules & Policies", which Resident A signed. Part of the policies included addressed 24 hour discharge or emergency discharge notices; however, the entire policy was not included as the numbered 1 and 2 points were missing. Subsequently, I was unable to determine what additional information was included relating to 30 day discharge notices.

Complainant included email correspondence between the licensee, Shawna Maciel, and Relative A1's spouse, Relative A2. Per the email correspondence, the licensee notified Relative A1 on 12/03/2022 about Resident A's discharge notice. In a follow up email, Relative A2 acknowleged the licensee's email, but also asked Mrs. Maciel questions relating to the discharge. Relative A2 asked Mrs. Maciel if Resident A was aware he needed to find another placement, if a social worker was contacted to assist with a new placement, if he'd be able to stay if his behaviors improved, and what would happen if 30 days passed and he didn't have a place to go. Mrs. Maciel responded to Relative A2 on 12/04/2022 stating Resident A was aware of needing to find another placement, that there was no social worker involved due to Resident A not having community mental health involvement, Mrs. Maciel indicated Resident A's behavior hadn't changed and he argues with Mr. Maciel, and finally, she indicated if Resident A didn't find a place to go he would have to go to "the mission".

Relative A2 followed up with another email on 12/04/2022 that she and Relative A1 would be by the following week to visit with Resident A. In a followup email to Mrs. Maciel on 12/20/2022, Relative A2 stated she was checking in to see how Resident A was doing since they visited. Relative A1 also stated she and Relative A2 planned to visit with Resident A at the faciltiy on 12/30/2022. The email correspondence indicated Mrs. Maciel responded to Relative A2 the same day indicating Resident A would still need to move from the faciltiy as he didn't have the funds to stay. Mrs. Maciel indicated in her email that she had Resident A contact Ms. Wenger who indicated to Mrs. Maciel that Relative A1 and Relative A2 were "taking care of his placement" and given them places to call.

Additional email correspondence between Mrs. Maciel and Relative A2 on 12/31/2022 indicated Mrs. Macieltold Relative A2 Resident A would need to leave the next day due to her having an emergency placement that needed his bed. Mrs. Maciel stated in her email that she'd given Resident A a 30 day discharge notice and relayed in her email that either she or Mr. Maciel would take Resident A to the mission or Relative A1 and/or Relative A2 could pick him. Email correspondence from Relative A2 indicated she asked Mrs. Maciel why Resident A was unable to pay. Mrs. Maciel stated in her email to Relative A2 that Resident A didn't ave $2,000 to pay. She indicated in her email that she emailed an agency to assist with additional funds; however, the agency indicated they weren't taking new clients. Relative A2 requested who Mrs. Maciel was working with for "emergency connections", to which Mrs. Maciel indicated she worked with adult protective services.

On 02/23/2023, I initiated the complaint by interviewing, Ronda Wenger, Resident A's former Transition Navigator through Disability Network Lakeshore, via telephone. Ms. Wenger confirmed she worked with Resident A for approximately one year while he was in a nursing home. She stated she worked with him on getting him admitted to the facility, Helping Hands, in May 2022. Ms. Wenger stated Resident A did not have a guardian and often told her he was "capable of being his own person". Ms. Wenger stated Resident A had relatives who wanted to be a part of his AFC placements; however, she indicated Resident A expressed to her that did not want them to be. Ms. Wenger stated she didn't have any concerns with how the facility was operating or with improper discharges.

On 03/07/2023, I interviewed Complainant whose statement to me was consistent with the allegations.

On 03/07/2023, I interviewed Relative A1, via telephone. Relative A1 confirmed he was Resident A's medical and financial POA and not his guardian. Relative A1's statement to me was consistent with the allegations. Relative A1 confirmed he picked Resident A up on 01/01/2023, avoiding Resident A going to the mission.

On 03/08/2023, I interviewed Resident A, via telephone. Resident A confirmed not having a guardian. He also confirmed receiving a 30-day discharge from the licensees on 12/01/2022. He stated the licensees told him he couldn't reside in the facility anymore because he was unable to afford it. He stated he left the facility on 01/01/2023, stayed at a hotel for "awhile" until moving into his current placement.

On 03/09/2023, I conducted an unannounced inspection at the facility. I interviewed licensee, Shawna Maciel. Ms. Maciel's statement to me regarding Resident A's 30-day discharge notice and how he left the facility was consistent with the allegations, Resident A's and Relative A1's statement to me. Mrs. Maciel stated Resident A couldn't pay the monthly AFC payment anymore, but he was also refusing care over the last three months of residing in the facility. She stated Resident A didn't want to use his oxygen machine, was refusing to shower and wouldn't use the bathroom. Mrs. Maciel stated she and Mr. Maciel would prompt Resident A, provide encouragement and reminders; however, his compliance was becoming an issue, which contributed to his discharge notice.

I interviewed Residents B, C, and D, who all stated they resided in the facility with Resident A. None of the residents were able to provide information regarding Resident A's care in the facility. They were unable to report if he was compliant or not. None of the residents stated any concerns with how the licensees were treating them or had treated Resident A while residing in the facility.

I reviewed the licensee's 30-day discharge notice, which was consistent with the discharge notice provided with the complaint.

I reviewed Resident A's *Resident Care Agreement* (RCA), dated 05/11/2022, which indicated a "30 day notice is required in wrighting[*sic*] when moving out".

I reviewed the licensee's "Discharge Policy", which stated the following:

"The licensee will provide a resident and his/her designated representative with a 30day[*sic*] written notice before discharge from the home the written notice. The written notice will state the reason for the discharge. The notice will be sent to both parties. The provision of this subrule do not preclude the licensee from proving other legal notices as required by law.

> The licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists.
>
> 1. Substantial risk, or an occurrence, of self-destructive behavior.

2. Substantial risk to the resident due to the inability of the home to meet the residents needs or assure the safety and well being of other residents of the home.

3. Substantial risk or an occurrence or serious physical assault.

4. Substantial risk, or an occurrence of the destruction of property.

5. In these cases, the licensee will notify the resident, the residents[*sic*] designated representative, the responsible agency, and the Adult Foster Care Consultant not less than a 24hr before discharge. The notice will be in writing and will include all the following information:

6. The reason for the proposed discharge, including the specific nature of the substantial risk.

7. The alternative to discharge that have been attempted by the licensee.

8. The location to which the resident will be discharged, if known.

9. Before the emergency discharge occurs, the licensee will confer with the responsible agency or if the resident dose[*sic*]not have a responsible agency with adult protective service and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or if the resident dose[*sic*] not agree with the licensee that emergency discharge is justified the resident will not be discharged from the home at that time."

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians' instructions; health care appraisal.**
	(12) A licensee shall provide a resident with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency.

ANALYSIS:	Based on my investigation, the licensee provided a 30-day discharge notice to Resident A on 12/01/2022 with the expectation Resident A leave the facility by 12/31/2022. Resident A subsequently left the facility on 01/01/2023. A licensee is only required to state the reason(s) for a 30-day discharge, which was provided by the licensee in the 30-day discharge to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The licensee is overcharging Resident A for adult foster care payments.

INVESTIGATION:

The complaint alleged when Resident A was discharged from the facility "his bank account was depleted." The complaint alleged Resident A had no guardian, but there was concern no one was present when Resident A signed an RCA agreeing to pay $2,000/month to reside in the facility. The complaint alleged licensee, Joe Maciel, told Resident A "Don't worry about it" when referencing the amount Resident A was expected to pay knowing he received less than that in Social Security benefits every month. The complaint alleged it was unknown how Resident A paid the licensee each month; however, the complaint alleged the licensees drove Resident A to the bank to make withdrawals.

Attached to the complaint were Resident A's RCA and bank statements. According to my review of the RCA, which was signed by Resident A and Mrs. Maciel and dated 05/11/2022, Resident A agreed to pay the licensees $2,000/month as the basic fee to reside in the facility.

I reviewed the bank statements provided by Complainant. According to the statements, Resident A made the following withdrawals out of his account:

- 05/10/2022 - $4,423
- 06/03/2022 - $2,000
- 07/01/2022 - $2,000
- 07/29/2022 - $2,000
- 08/22/2022 - $2,000
- 09/16/2022 - $500
- 09/26/2022 - $1,400
- 10/11/2022 - $500
- 11/03/2022 - $1,700
- 12/05/2022 - $1,000

The bank statements indicated Resident A received $1,072 a month in Social Security benefits.

I interviewed Complainant, whose statement to me was consistent with the allegations. Complainant stated Resident A did not have enough money to reside in the facility due to Resident A only receiving approximately $1,100 per month from Social Security benefits.

Transition Navigator, Ms. Wenger, stated Resident A had his own bank account where he had his Social Security funds deposited. Ms. Wenger indicated Resident A would withdraw funds from this account to pay the licensees for rent every month. Ms. Wenger stated when Resident A moved out of the nursing home, he owed the company approximately $3,700, which he paid after being discharged and prior to moving into Helping Hands. She stated she was aware of Resident A also paying the licensees of the facility approximately $647 upon his admission otherwise, she had no information relating to how much Resident A was expected to pay the facility every month for adult foster care payments.

I also interviewed Relative A1, whose statement to me was consistent with the allegations and Complainant's statement to me.

Resident A could not recall what documents he signed when he was admitted to the facility, including the RCA. He recalled being charged $2,000/month to reside in the facility, but stated he only received $1,100/month in Social Security benefits. He stated he had $6,000 in savings when he was admitted into the facility; however, he had no money left when he moved out. Resident A stated the licensees would drive him to the bank, where he'd withdraw the AFC payment, and give to the licensees. He denied the licensees ever requesting he take more money out for them or paying them over $2,000/month. Resident A stated he told Mr. Maciel he did not make $2,000/month, but Mr. Maciel told him, "Don't worry about it."

During my inspection, Mrs. Maciel confirmed Resident A agreed to pay $2,000/month to reside in the facility. She provided me with Resident A's RCA, which was the same RCA provided by Complainant.

Mrs. Maciel provided Resident A's *Resident Funds I* form, which identified Resident A as the person responsible for Resident A's funds. Resident A's signature was on the *Resident Funds I* form, in addition to, licensee Mrs. Maciel's signature.

I reviewed Resident A's *Resident Funds II* form, which indicated the following payments were made to the licensee for "rent" on behalf of Resident A:

- 05/11/2022 - $648
- 06/05/2022 - $2,000
- 07/01/2022 - $2,000

- 08/01/2022 - $2,000
- 09/01/2022 - $2,000
- 10/01/2022 - $2,000
- 11/01/2022 - $1,700

Upon review of the *Resident Funds II* form, there was no indication Resident A was signing the form to indicate he provided the AFC payments to the licensee; however, Ms. Maciel's signature was on each AFC payment transaction acknowledging she received the funds from Resident A.

Mrs. Maciel provided a copy of a cashier's check, dated 05/10/2022, purchased by Resident A and made out to Helping Hands in the amount of $647.50. Mrs. Maciel stated this was the first and only cashier's check Resident A gave to her. She stated the remaining rent was paid to her in cash. She stated she indicated she received the payments by the *Resident Funds II* form.

On 04/13/2023, I interviewed licensee, Joe Maciel, regarding the allegations. Mr. Maciel stated his wife and licensee, Mrs. Maciel, primarily handled all the accounting for the facility. He stated he would transport Resident A to the bank for Resident A to make the withdrawals and pay rent. He stated that while he didn't know the exact amount of funds Resident A would withdraw, he wasn't aware of Resident A taking extra funds out. Mr. Maciel stated Resident A would give the rent money directly to Mrs. Maciel. Mr. Maciel denied ever accepting funds, other than rent, from Resident A. Mr. Maciel stated Resident A did not ever express to him that he was being overcharged to stay in the facility. Mr. Maciel denied ever telling Resident A "don't worry about it" in reference to what he was paying to reside in the facility.

In a follow up interview with Mrs. Maciel, she stated she was not aware of the Social Security benefit amount Resident A was getting deposited in his bank account each month. She stated Resident A would not tell her or Mr. Maciel his financial information. She stated if Resident A had continued to reside in the facility and she became aware of his limited income then she would have adjusted the Adult Foster Care (AFC) payment and RCA to reflect the amount he could have afforded based on his Social Security income.

APPLICABLE RULE	
R 400.1421	**Handling of resident funds and valuables.**
	(10) Charges against the resident's account shall not exceed the agreed price for the services rendered and goods furnished or made available by the home to the resident.

ANALYSIS:	Upon review of Resident A's bank statements, the copy of a cashier's check to the facility, Resident A's *Resident Care Agreement*, and the *Resident Funds II* form, there is no evidence indicating the licensees were over charging Resident A to reside in the facility. Resident A, who was his own guardian while residing in the facility, agreed on 05/11/2022 to pay the licensees $2,000 a month in AFC payments to reside in the facility. There is no indication the licensees were overcharging Resident A to reside in the facility or were accepting more funds than agreed upon.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.1421	**Handling of resident funds and valuables.**
	(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department.
ANALYSIS:	Upon review of Resident A's *Resident Funds II* form, the form was not being completed in all it's entirely by the licensees obtaining Resident A's signature upon acceptance of the AFC payments.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/09/2023 and 04/13/2023, I conducted an exit conference with the licensee, Shawna Maciel, explaining my findings. Mrs. Maciel agreed it was important and necessary to obtain a resident's signature acknowledging they provided her with funds, particularly cash payments.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

04/13/2023

Cathy Cushman — Date
Licensing Consultant

Approved By:

04/17/2023

Dawn N. Timm — Date
Area Manager