GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 14, 2025

Shawna and Jose Maciel
1051 Collage Avenue
Holland, MI 49423

RE: License #: AS030411649
Investigation #: 2025A1024017
Helping Hands #2

Dear Shawna and Jose 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 was required. On March 10, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS030411649
Investigation #:	2025A1024017
Complaint Receipt Date:	02/18/2025
Investigation Initiation Date:	02/19/2025
Report Due Date:	04/19/2025
Licensee Name:	Shawna and Jose Maciel
Licensee Address:	1051 Collage Avenue Holland, MI 49423
Licensee Telephone #:	(616) 795-3298
Administrator:	Shawna Maciel
Licensee Designee:	Shawna Maciel
Name of Facility:	Helping Hands #2
Facility Address:	1044 College Ave. Holland, MI 49423
Facility Telephone #:	(616) 795-3598
Original Issuance Date:	03/14/2022
License Status:	REGULAR
Effective Date:	09/13/2024
Expiration Date:	09/12/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The house manager's girlfriend is 17 years old and works in the home.	No
Resident A was given her pain medication at the wrong time not as prescribed by a physician.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/18/2025	Special Investigation Intake 2025A1024017
02/18/2025	APS Referral not warranted (CPS referral made)
02/19/2025	Special Investigation Initiated – Telephone with director Libby Huizenga
02/25/2025	Inspection Completed On-site with Shawna Maciel and Marcos Maciel
02/25/2025	Contact - Document Received Resident A's Medication Administration Record (MAR) and picture of medications emailed from licensee designee Shawna Maciel
02/25/2025	Contact - Document Received- Bureau Information Tracking System (BITS) review
03/04/2025	Contact - Telephone call made with Resident A
03/04/2025	Inspection Completed On-site with Residents B, C, and D
03/05/2025	Contact - Document Received-Marcos Maciel TB test results emailed from Shawna Maciel
03/05/2025	Exit Conference with licensee designee Shawna Maciel
03/05/2025	Inspection Completed-BCAL Sub. Compliance
03/05/2025	Corrective Action Plan Requested and Due on 4/9/2025
03/10/2025	Corrective Action Plan Received

03/10/2025	Corrective Action Plan Approved

ALLEGATION: The house manager's girlfriend is 17 years old and works in the home.

INVESTIGATION:

On 2/18/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged the house manager's girlfriend is 17 years old and works in the home.

On 2/19/2025, I conducted an interview with director Libby Huizenga who stated that she is the director of a day program that Resident A attends daily, and Resident A reported to her that there is a 17-year-old working in the home who cooks and clean around the home.

On 2/25/2025, I conducted an onsite investigation at the facility with Shawna Maciel and Marcos Maciel who both stated that Citizen #1 is Marcos Maciel's girlfriend who lives in the home however is not employed as a direct care staff member of the facility and does not provide direct care to any residents. Shawna Maciel and Marcos Maciel also both stated that Citizen #1 has only provided limited services in the home such as cooking and cleaning and is away at school during the day. Marcos Maciel stated he is the home manager of the home and lives in the home also. Shawna Maciel stated she works in the home with Marcos Maciel regularly and Citizen #1 has never been alone with any of the residents.

On 3/4/2025, I conducted an interview with Resident A who stated that she has lived in the home since August of 2024 and believes Citizen #1 also resides in the facility with Marcos Maciel. Resident A stated she does not interact with Citizen #1 however has seen Citizen #1 cook and clean in the home. Resident A stated she does not like that Marcos Maciel takes Citizen #1 on outings with them and she is uncomfortable with this because Citizen #1 is a minor.

On 3/4/2025, I conducted an onsite investigation at the facility with Residents B, C, and D who all stated that they have seen Citizen #1 in the home however do not really know this person. Residents B, C and D also all stated they believe she cooks and clean at the facility however she has not provided any direct care services to them.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(1) Direct care staff shall not be less than 18 years of age and shall be able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents.

ANALYSIS:	Based on my investigation which include interviews with director Libby Huizenga, licensee designee Shawna Maciel, direct care staff member Marcos Maciel, Residents A, B, C, and D there is no evidence to support the allegation that a minor aged person provides direct care to residents. According to Shawna Maciel and Marcos Maciel, Citizen #1 is Marcos Maciel's girlfriend who lives in the home however is not employed as a direct care staff member and only provides cooking and cleaning services in the home. Residents A, B, C and D also all stated that Citizen #1 does not provide any direct care services to residents. Citizen #1 is not a staff member.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was given her pain medication at the wrong time not as prescribed by a physician.

INVESTIGATION:

This complaint also alleged Resident A was given her pain medication at the wrong time and not as prescribed by a physician.

On 2/19/2025, I conducted an interview with director Libby Huizenga who stated that Resident A reported to her that staff gave her a medication during lunch time which she usually takes in the evening therefore Resident A refused to take the medication until evening.

On 2/25/2025, I conducted an onsite investigation at the facility with Shawna Maciel and Marcos Maciel who both stated that Marcos Maciel administers medications to residents regularly and recently Resident A was given her Aspirin medication during the evening time which should have been given to her in the morning therefore Resident A became upset by this. Shawna Maciel stated this medication error was recorded in Resident A's MAR. Shawna Maciel further stated that when Resident A was admitted to the facility she came with over-the -counter Bayer aspirin as part of her belongings and Resident A informed her that she needed to take this medication daily however Resident A did not have a physician script for this medication. Shawna Maciel stated Resident A never obtained a physician script for the Aspirin medication. Despite not having a physician's order, Shawna Maciel stated she continued to give Resident A this medication without physician instructions since Resident A reported to her that she has been taking it prior to her coming to the facility.

On 2/25/2025, I reviewed Resident A's MAR for February 2025 which stated that Resident A takes Aspirin 81 mg once a day and on 2/19/2025 Resident A received this medication at 5pm instead of 8am which was the usual time Resident A had taken this medication during the previous days.

I also reviewed a picture of Resident A's over-the-counter pain medication Bayer Aspirin 81 mg.

On 3/4/2025, I conducted an interview with Resident A who stated that she regularly takes aspirin daily and staff attempted to give her this pain medication at an unusual time therefore Resident A refused to take the medication and waited for a different time in the day to take the medication.

APPLICABLE RULE	
R 400.14312	**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:	Based on my investigation which include interviews with director Libby Huizenga, licensee designee Shawna Maciel, direct care staff member Marcos Maciel, Resident A, and review of Resident A's MAR and medication bottle, there is evidence to support the allegation Resident A was given aspirin medication at a different time than usually administered. Resident A stated that she is regularly given a pain medication by staff members daily. Shawna Maciel stated Resident A has been given an over-the-counter aspirin daily since her admission to the facility however Shawna Maciel has never obtained a physician script for Resident A to take this medication. Resident A has taken medication not prescribed by a physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While at the facility, Shawna Maciel stated that both Marco Maciel and Citizen #1 live in her home and Citizen #1 has been living in her home for over two months. Shawna Maciel stated she was not aware that she needed to report this change to the assigned adult foster care consultant.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.
ANALYSIS:	While at the facility, Shawna Maciel stated that both Marco Maciel and Citizen #1 live in her home and Citizen #1 has been living in her home for over two months. Shawna Maciel stated she was not aware that she needed to report this change. No written notice was given to the department that these new household members were living in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, Shawna Maciel also reported that she does not have health care physicals signed by a licensed physician for the department to review to attest to the physician's knowledge of the physical health of Marcos Maciel and Citizen #1 since they are household members.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.

ANALYSIS:	While at the facility, Shawna Maciel also reported that she does not have health physicals signed by a licensed physician for the department to review to attest to the physician's knowledge of the physical health of Marcos Maciel and Citizen #1 since they are household members.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, Shawna Maciel also reported that she does not have written evidence to show that Citizen #1 has been tested for communicable tuberculosis.

On 3/5/2025, I reviewed written evidence to show that Marcos Maciel was tested for communicable tuberculosis on 11/22/2023 and this disease is not present.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	While at the facility, Shawna Maciel reported that she does not have written evidence to show that Citizen #1 has been tested for communicable tuberculosis.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/5/2025, I conducted an exit conference with license designee Shawna Maciel. I informed Shawna Maciel of my findings and allowed her an opportunity to ask questions and make comments.

On 3/10/2024, I approved an acceptable corrective action plan.

IV. RECOMMENDATION

I received an acceptable corrective action plan therefore I recommend the current license remain unchanged.

4/9/2025

Ondrea Johnson
Licensing Consultant

Date

Approved By:

04/14/2025

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Dawn N. Timm
Area Manager

Date