



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2025

Clyde Kemp
The Helping Hands Place
38 Park Place
Pontiac, MI 48341

RE: License #: AS630245096
Investigation #: 2025A0465024
The Helping Hands Place

Dear Mr. Kemp:

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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Stephanie Gonzalez".

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630245096
Investigation #:	2025A0465024
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/12/2025
Report Due Date:	09/05/2025
Licensee Name:	The Helping Hands Place
Licensee Address:	38 Park Place Pontiac, MI 48341
Licensee Telephone #:	(248) 333-2528
Administrator:	Clyde Kemp & Melissa Ringstaff
Licensee Designee:	Clyde Kemp
Name of Facility:	The Helping Hands Place
Facility Address:	38 Park Place Pontiac, MI 48341
Facility Telephone #:	(248) 333-2528
Original Issuance Date:	05/22/2003
License Status:	REGULAR
Effective Date:	08/18/2024
Expiration Date:	08/17/2026
Capacity:	6
Program Type:	MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The facility did not provide and obtain medical care needed to Resident A for a leg wound and face boil.	No
Additional Findings	Yes

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0465024
07/12/2025	Special Investigation Initiated - Letter Email exchange with Complainant
07/21/2025	Inspection Completed On-site I conducted an onsite investigation at the facility. I completed a walkthrough of the facility, reviewed resident files and interviewed licensee designee and administrator, Clyde Kemp
07/27/2025	Contact - Document Received Facility documents received via email from Mellisa Ringstaff
07/28/2025	Contact - Document Received Facility documents received via email by Clyde Kemp
09/03/2025	Contact - Telephone call made I spoke to Guardian A1 via telephone
09/03/2025	Contact - Telephone call made I spoke to Relative A1 via telephone
09/08/2025	Contact - Telephone call made I spoke to Terry Green, Nurse practitioner for Dr. Mansour
09/11/2025	Contact – Telephone call made I spoke to Guardian B1 via telephone
09/15/2025	Contact - Telephone call made I spoke to Josie Franks, Nurse Practitioner for Trinity Health Wound Care Clinic

09/18/2025	Exit Conference I conducted an exit conference with Clyde Kemp and Melissa Ringstaff, via telephone
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ALLEGATION:

The facility did not provide and obtain medical care needed to Resident A for a leg wound and face boil.

INVESTIGATION:

On 7/7/2025, a complaint was received, alleging that the facility did not provide and obtain medical care needed for Resident A during the time that he resided at the facility. The complaint stated that Resident A was moved out of the facility by Guardian A1 on 7/2/2025, and on this same date Resident A was observed to have a leg wound and a boil on his face. The complaint stated that Guardian A1 was not informed of the wound or face boil, raising concerns about the home's medical care of Resident A.

On 7/12/2025, I spoke to complainant via email exchange. The Complainant confirmed that the information contained in the complaint is accurate.

On 7/21/2025, I conducted an onsite investigation at the facility. The facility specializes in caring for the mentally ill and traumatically brain injured population. At the time of my onsite investigation, there was one resident residing at the facility, Resident B. Due to the medical diagnosis of Resident A and Resident B, I was unable to interview them for this investigation. I completed a walkthrough of the facility, reviewed resident files and interviewed licensee designee and administrator, Clyde Kemp and administrator, Melissa Ringstaff. I observed the home to be clean and well organized. I observed Resident B to be properly dressed and with adequate hygiene.

I reviewed Resident A's record. The *Face Sheet* indicated that Resident A was admitted to the facility on 11/23/2020 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizoaffective Disorder – Chronic and Schizophrenia. The *Assessment Plan for AFC Residents* stated that Resident A required supervision in the community, a history of altered mental status, prompting for completion of self-care tasks, and does not require use of assistive devices. I reviewed the Medical Care Notes for Resident A, which documented that Resident A received primary care from Dr. Faiz Mansour and wound care from Dr. Firas Karmo of Trinity Health Wound Care Clinic. I observed the following documentation in Resident A's record related to wound care and medical care for Resident A:

Trinity Health Wound Care Clinic: Resident A began attending this wound care clinic on 6/25/2024 and consistently attended weekly and/or bi-weekly appointments through 4/22/2025 for a wound on his lower left ankle and left medial ankle. Resident A's record contained *After Visit Summary's* dated 6/13/2024, 6/25/2024, 7/9/2024,

7/30/2024, 8/13/2024, 8/20/2024, 2/11/2025, 3/4/2025, 3/11/2025, 3/18/2025, 3/25/2025, 4/1/2025, 4/8/2025, 4/15/2025, Resident A was successfully discharged from the wound care clinic on 4/22/2025 by Dr. Karmo due to substantial healing of the wounds. Recommendation to continue to wear compression socks as needed.

7/21/2025: Letter from Dr. Faiz Mansour's Office, which stated the following: To Whom It May Concern: The manager at Helping Hands was compliant and consistent in following Resident A's medical appointments.

I spoke to licensee designee and administrator, Clyde Kemp, who stated that he was familiar with Resident A during the time that he resided at the facility. Mr. Kemp stated, "Resident A moved into our facility in 2020. When he moved into our facility, he had a knot on the side of his face that was always present. We never received any medical information this was an issue, and we took Resident A to all of his medical appointments for routine primary care visits and wound care. Resident A received wound care in 2024 through April 2025. According to Dr. Mansour, Resident A had the wound on his legs as a recurring medical condition for years prior to moving into our facility. We provided medical care needed to Resident A and complied with all medical needs including compression socks and ensuring he attended all appointments for wound care." Mr. Kemp denied this complaint is true.

I spoke to administrator, Melissa Ringstaff, who stated that she is familiar with Resident A and provided care to him during the time that he resided at the facility. Ms. Ringstaff stated, "Resident A had a knot on his face when he moved into the facility and this knot/cyst was never noted by his primary doctor or his wound care doctor as needing medical attention. Resident A also never complained of any pain related to it and we did not notice any signs of medical concerns related to it. We did know about the wounds on his legs, and he has those when he moved in. Resident A had a history of leg wounds prior to moving here. We monitored his legs and in June 2024, we had Resident A seen by Dr. Mansour to check his legs because we noticed small wounds. Dr. Mansour monitored Resident A for medical care and referred Resident A to Dr. Karmo for wound care. We took Resident A to the wound care clinic weekly and sometimes bi-weekly depending on what was recommended by the wound care clinic. We always ensured Resident A attended all medical appointments for wound care. We never refused to obtain medical care for Resident A." Ms. Ringstaff denied this complaint is true.

On 9/3/2025, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I have been the guardian for Resident A for 30 years. Resident A has a history of a boil on the side of his face, but it does sometimes require drainage. I was also never informed that he had a wound on his leg. These are things the facility should have notified me of. I was not aware that Resident A was receiving wound care services. The day I picked up Resident A on 7/1/2025 to move him to a new facility, it was discovered that he had a very bad wound on his right leg and a boil on his face. The wound and boil were concerning. I don't believe the facility obtained proper medical care for Resident A." Guardian A1 stated that she believes this allegation is true.

On 9/3/2025, I spoke to Relative A1 via telephone. Relative A1 stated, “Resident A was moved out of the facility on 7/1/2025 and on this day he was observed with a boil on his face and a wound on his right leg. The boil and wound were deep and appeared to be present and untreated for a long time. The facility failed to obtain medical care for Resident A. Guardian A1 was never told of the wound or boil by the facility and this raises concern that they did not provide appropriate medical care to Resident A.” Relative A1 stated that she believes this allegation to be true.

On 9/8/2025, I spoke to Terry Green, Nurse practitioner for Dr. Mansour. Ms. Green stated, “Resident A has been a patient of Dr. Mansour since 2013. We last saw him in our office in July 2025. Resident A was first seen in our office for wound care concerns in March 2024 and Dr. Mansour referred Resident A to Dr. Karmo for wound care shortly after that. Dr. Mansour saw Resident A for follow-up medical care and wound care management. Our medical notes reference that Resident A was attending the wound care clinic consistently for follow-up and dressing changes. The notes stated that Resident A was asked about the wound on his leg and he noted no pain or discomfort. We have no record of a boil on Resident A’s face or any needed medical care for it.”

On 9/11/2025, I spoke to Guardian B1 via telephone. Guardian B1 stated, “The staff at the facility have been absolutely wonderful and have provide great care to Resident B. I have not had any concerns related to medical care for Resident B.” Guardian B1 denied concerns related to complaint.

On 9/15/2025, I spoke to Josie Franks, Nurse Practitioner for Trinity Health Wound Care Clinic. Ms. Franks stated, “Resident A was seen in our clinic and followed by Dr. Karmos. His first appointment at our clinic was 6/25/2024 and his last appointment was on 4/22/2025. Resident A was seen from June 2024 – October 2024 and again from January 2025 – April 2025 for wound care of his legs. He attended his wound care appointments consistently once per week and bi-weekly as required. He was treated for a history of chronic ulcer of ankles/wounds on legs, lymphedema, and edema. There were no concerns noted with Resident A missing his wound care appointments. He was successfully discharged from the wound care clinic on 4/22/2025 by Dr. Karmos with a recommendation to continue to use compression socks as needed.”

APPLICABLE RULE	
R 400.14310	Resident health care.
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	According to the <i>Medical Care Notes</i> and <i>Trinity Health Wound Care Notes</i> , Resident A received primary care from Dr. Faiz Mansour from May 2013 through July 2025 and wound care

	from Dr. Firas Karmo of Trinity Health Wound Care Clinic from June 2024 – April 2025. According to Ms. Green, Resident A consistently attended all primary care appointments with Dr. Mansour, there were no medical concerns related to a face boil, and no concerns noted regarding the care being provided at the facility. According to Mr. Kemp and Ms. Ringstaff, they took Resident A to all needed medical and wound care appointments during the time that he resided at the facility. Mr. Kemp and Ms. Ringstaff stated that they provided all needed medical care to Resident A. Mr. Kemp and Ms. Ringstaff denied this complaint is true. According to Ms. Franks, Resident A was seen at the wound care clinic from 6/25/2024 through 4/22/2025 and attended his wound care appointments consistently once per week and bi-weekly as required. Ms. Franks stated that Resident A was successfully discharged from the wound care clinic on 4/22/2025 by Dr. Karmo due to substantial healing of the wounds. Based in the information above, there is not sufficient information to confirm that the facility failed to provide and obtain medical care needed for Resident A during the time that he resided at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/21/2025, during my onsite investigation at the facility, I reviewed Resident A's record. The *Face Sheet* stated that Resident A was admitted to the facility on 11/23/2020 and has a legal guardian, Guardian A1. When I reviewed Resident A's written assessment plan, I observed that it contained Resident A's signature and the administrator, Melissa Ringstaff's signature. The assessment plan did not contain Guardian A1's signature nor licensee designee, Clyde Kemp's signature. I was unable to locate any written assessment plans that did contain Guardian A1's signature.

On 9/3/2025, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I was never asked to partake in completion of an assessment plan for Resident A, and I never signed any assessment plans for Resident A. I also never received a copy of any of Resident A's assessment plans during the time that he lived at the facility.

On 9/18/2025, I conducted an exit conference with Mr. Kemp via telephone. Mr. Kemp stated, "This is correct. Guardian A1 did not complete or sign Resident A's written assessment plans. I had Resident A sign the assessment plan and I will make sure in the future, the guardians sign the documents." Mr. Kemp acknowledged this allegation is true.

APPLICABLE RULE	
R 400.14301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	According to Mr. Kemp and Guardian A1, Mr. Kemp did not complete a written assessment plan in conjunction with Guardian A1, did not sign the document, and did not obtain Guardian A1's signature on the assessment plan. Based on the information above, the facility did not accurately complete the written assessment plan for Resident A as required per licensing.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 7/21/2025, during my onsite investigation at the facility, I reviewed Resident A's record. The *Face Sheet* stated that Resident A was admitted to the facility on 11/23/2020 and has a legal guardian, Guardian A1. When I reviewed Resident A's care agreement, I observed that it contained Resident A's signature and the administrator, Melissa Ringstaff's signature. The care agreement did not contain Guardian A1's signature nor licensee designee, Clyde Kemp's signature. I was unable to locate any care agreements that did contain Guardian A1's signature.

On 9/3/2025, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I was never asked to partake in completion of a care agreement for Resident A, and I never signed any care agreements for Resident A. I also never received a copy of any of Resident A's care agreements during the time that he lived at the facility. This was a concern for me during the time that Resident A lived at the facility because I never confirmed through an official document the cost for care and when the facility raised the amount, I

was frustrated with the lack of consistency and transparency regarding the monthly cost.”

On 9/18/2025, I conducted an exit conference with Mr. Kemp and Ms. Ringstaff via telephone. Mr. Kemp stated, “Guardian A1 did not complete or sign Resident A’s written assessment plans. I had Resident A sign the assessment plan. I will make sure moving forward that the guardians sign the documents. Thank you for providing me with this information to ensure I do things correctly moving forward.” Mr. Kemp and Ms. Ringstaff are in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14301	Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal. (b) A description of services to be provided and the fee for the service. (c) A description of additional costs in addition to the basic fee that is charged. (d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost. (e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission. (f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule. (g) An agreement by the resident to follow the house rules that are provided to him or her. (h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.

	(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures. (j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315. (k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met. (l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.
ANALYSIS:	According to Mr. Kemp and Guardian A1, Mr. Kemp did not complete a written resident care agreement in conjunction with Guardian A1, did not sign the document, and did not obtain Guardian A1's signature on the care agreement. Based on the information above, the facility did not accurately complete the written resident care agreement for Resident A as required per licensing.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend this special investigation be closed with no change to the status of the license.

Stephanie Gonzalez

9/23/2025

Stephanie Gonzalez
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

09/25/2025

Denise Y. Nunn
Area Manager

Date