GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 10, 2022

Shawna and Jose Maciel
1051 Collage Avenue
Holland, MI 49423

RE: License #: AS030411649
Investigation #: 2022A0350030
Helping Hands #2

Dear Shawna and Jose Maciel:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS030411649
Investigation #:	2022A0350030
Complaint Receipt Date:	06/07/2022
Investigation Initiation Date:	06/08/2022
Report Due Date:	07/07/2022
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 #2
Facility Address:	1044 College Ave. Holland, MI 49423
Facility Telephone #:	(616) 795-3598
Original Issuance Date:	03/14/2022
License Status:	TEMPORARY
Effective Date:	03/14/2022
Expiration Date:	09/13/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOP-MENTALLY DISABLED, MENTALLY ILL, AGED, ALZHEIMERS,TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was not allowed to bring her clothes into the home because there may have been bed bugs in them, leaving her with not having enough clothing.	No
Resident A does not have her glasses or a walker, and she needs them both.	No
Resident A, as well as the other residents, seem to be overmedicated.	No
Staff make it difficult for Resident A to leave the home.	No
Additional Finding	Yes

III. METHODOLOGY

06/07/2022	Special Investigation Intake 2022A0350030
06/08/2022	Special Investigation Initiated - On Site I spoke with Shawna Maciel, Licensee, and Resident B and Resident C
06/09/2022	Contact made – Telephone call I spoke with Tammy Dykstra, Resident A's Legal Guardian
06/09/2022	Document received – I received an email from Mrs. Dyksta with a clothing receipt attached
06/09/2022	Exit conference – Held with Shawna Maciel, Co-Licensee

ALLEGATION: Resident A was not allowed to bring her clothes into the home because there may have been bed bugs in them, leaving her with not having enough clothing.

INVESTIGATION: On 06/08/2022, I made an onsite inspection and met first with Shawna Maciel, Co-Licensee. I informed Mrs. Maciel of the allegations and she provided explanations to each of them. Her responses are contained in this report. I could not interview Resident A as she was in the hospital. Mrs. Maciel told me that on 06/05, Resident A fell in her room and was sent to the hospital by ambulance. She provided me the Incident Report. Mrs. Maciel told me she and her husband Joe,

heard a thud and went to check on her. They found her on the floor and called 9-1-1. They later learned that she had broken a hip from this incident.

On 06/08/2022, during my discussion with Mrs. Maciel, she informed me that Resident A came to her home from another Adult Foster Care (AFC) home, which was infested with bedbugs at the time, so she did not allow Resident A to bring her clothing supply into her home. Mrs. Maciel said that Resident A's Legal Guardian obtained funding for new clothes for Resident A and she got new clothing. Mrs. Maciel showed me the drawers and closet in Resident A's bedroom, and I observed an ample amount of clothing. Mrs. Maciel also told me that she had more of Resident A's clothing in storage because Resident A has a habit of putting on too many clothing articles at once and soiling herself.

On 06/09/2022, I called and spoke with Tammy Dykstra, Resident A's court-appointed Legal Guardian. Ms. Dykstra informed me that she did not want any of Resident A's clothing going with her to her new residence, Helping Hands #2, because there was an outbreak of bedbugs at the AFC home she left. Ms. Dykstra stated that she bought Resident A $801 of new clothing and said she would send me the invoice. Mrs. Dykstran confirmed what Mrs. Maciel said about Resident A putting on too many clothes at once and soiling herself in them.

On 06/09/2022, I received an email from Mrs. Dyksta with a clothing receipt attached in the amount of $801.36. The invoice had a variety of clothing items listed on it, including pants, blouses, socks, pajamas, etc.

On 06/09/2022, I called and held an exit conference with Shawna Maciel, Co-Licensee. I informed Mrs. Maciel that I was not citing a violation of this rule. Mrs. Maciel thanked me and had no further comment.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A was relocated to Helping Hands #2 from another home that had bedbugs at that time. Shawna Maciel did not allow Resident A's clothing to be brough to Helping Hands #2

	for fear of bedbugs infesting her AFC home. However, Tammy Dykstra purchased $800 worth of new clothing for Resident A, including pants, blouses, socks, and pajamas. I observed the receipt for these clothing items as well as observed an ample supply of clothing in Resident A's drawers and closet. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A does not have her glasses or a walker, and she needs them both.

INVESTIGATION: On 06/08/2022, during my onsite inspection, Mrs. Maciel told me that Resident A does not need prescription glasses, but does use reading glasses. Mrs. Maciel showed me the pair of reading glasses that were in a drawer in Resident A's room. Mrs. Maciel also stated that Resident A uses a walker, but not all the time, and when she doesn't, staff will walk next to or behind her to make sure she doesn't fall. Mrs. Maciel showed me Resident A's walker in her room. Mrs. Maciel reported that Resident A came to this home with this walker, but that she didn't have a script for it because it was filed electronically while Resident A lived at her former residence. I asked Mrs. Maciel to show me Resident A's Health Care Appraisal and she did. It showed that Resident A was diagnosed with Bi-Polar Schizophrenia, HTN (hypertension), Hyperlipidemia, RLS (Parkinson's Dementia II), and Anemia. I also asked for a copy of Resident A's Assessment Plan, and Mrs. Maciel provided it to me. I reviewed it while onsite and observed that the plan showed that Resident A was able to move independently in the community and that she does use a walker.

On 06/09/2022, I called and held an exit conference with Shawna Maciel, Co-Licensee. I informed Mrs. Maciel that I was not citing a violation of this rule. Mrs. Maciel thanked me and had no further comment.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Shawna Maciel, Co-Licensee of this home, informed me that Resident A came to her home with a walker that was prescribed and furnished while she was at her previous AFC home. Mrs. Maciel informed me that Resident A does not wear prescription glasses, but she does use over-the-counter reading glasses. Mrs. Maciel showed me the walker and pair of reading glasses that were in Resident A's room. My findings do not support that this rule was violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A, as well as the other residents, seem to be overmedicated.

INVESTIGATION: On 06/08/2022, I made an onsite inspection and met first with Shawna Maciel, Co-Licensee. I informed Mrs. Maciel of the allegations and she provided explanations to each of them. Her responses are contained in this report. I informed Mrs. Maciel that I wanted to interview a couple of the residents in private, and she arranged for me to do so. I could not interview Resident A as she was in the hospital.

On 06/08/2022, I spoke with Resident B, who stated that she felt her medications were being administered as prescribed and that they were helping her. However, she reported that she may want to have her Depakote dosage increased because she has been feeling irritable and angry lately, although she did not say why.

On 06/08/2022, during my discussion with Mrs. Maciel, she stated that she noticed Resident B being "more anxious lately," and had someone from Visiting Physicians Association (VPA) out to see her yesterday (06/07). The Provider from VPA added Miralax to Resident B's medications and increased her Buspirone. The Provider also withdrew some blood from Resident B for testing. Mrs. Maciel denied overmedicating any of the residents and showed me the Medication Administration Records (MARs). I asked to see a random package of Resident A's medications and then I matched it with the MARs and observed that the pill count was in sync with the MARs. I also scanned the MARs and saw that there were initials in the boxes for this month up until she went into the hospital on 06/05, and an "H" in the boxes since then, which stands for Hospital. Mrs. Maciel informed me that Resident A's medication list was the same as when she was in her previous Adult Foster Care home; there have been no changes since then.

On 06/08/2022, I spoke with Resident C, who stated that he takes medications in the morning and evening, and that he felt he was being given the correct dosages. Resident C reported no changes in how he has been feeling lately, either physically, mentally, or emotionally, and believed the medications were helping him. He said that he "feels good."

While onsite on 06/08/2022, I also observed Resident D, Resident E, and Resident F, and although I did not interview them, they all seemed coherent and alert (I said hello and goodbye to them, and they reciprocated).

On 06/09/2022, I called and spoke with Tammy Dykstra, Resident A's court-appointed Legal Guardian. Mrs. Dykstra informed me that when Resident A went on an outing to visit family members, she did not take a nap as she normally does, and appeared "to be dopey" causing one of her relatives to believe she was being over-medicated.

On 06/09/2022, I called and held an exit conference with Shawna Maciel, Co-Licensee. I informed Mrs. Maciel that I was not citing a violation of this rule. Mrs. Maciel thanked me and had no further comment.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	After reviewing the Medication Administration Records (MARs) and comparing them with the actual medications, I observed that the pill count from a random selection matched what was indicated on the MARs to have been given. Resident B and Resident C stated that they are being provided their medications according to the prescribed dosages. A relative reportedly observed Resident A "to be dopey" on one occasion, thinking she may have been over-medicated. However, it was only due to the fact that Resident A did not have her daily nap when the relative saw her this way, and Resident A was merely tired. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff make it difficult for Resident A to leave the home.

INVESTIGATION: While onsite on 06/08/2022, I spoke with Resident B, who stated that she does not have any family or friends, and therefore does not go anywhere. I asked her if she ever took walks around the block or to the store, and she replied that she used to, but it has been too cold lately. I asked her if she felt free to come and go, and she said she did.

On 06/08/2022, I spoke with Resident C, who stated that he does not have any family or friends that he goes to see; only two sisters who come to see him, and when they do, they just visit him at this home; they don't go anywhere. Resident C informed me that he will go out for a walk occasionally and denied that anyone was making it difficult for him to leave the home.

On 06/08/2022, while onsite, I asked Mrs. Maciel for a copy of Resident A's Assessment Plan, and Mrs. Maciel provided it to me. I reviewed it while onsite and observed that the Plan showed that Resident A was able to move independently in the community. Mrs. Maciel informed me that Resident A recently went to a family member's home to celebrate her birthday and denied that either she or "Joe" make it difficult for Resident A, or any resident, to leave the home.

On 06/09/2022, I called and spoke with Tammy Dykstra, Resident A's court-appointed Legal Guardian, who told me that Mr. and Mrs. Maciel do not inhibit or prohibit Resident A from going places outside of the home. Ms. Dykstra confirmed what Mrs. Maciel told me about Resident A recently going to a relative's house on her birthday.

On 06/09/2022, I called and held an exit conference with Shawna Maciel, Co-Licensee. I informed Mrs. Maciel that I was not citing a violation of this rule. Mrs. Maciel thanked me and had no further comment.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	I could not interview Resident A regarding this allegation as she was in the hospital. However, Mrs. Maciel, Co-Licensee, and Ms Dykstra, Resident A's Legal Guardian, denied that any of the residents are inhibited or prohibited from leaving the home. They each citied a recent outing Resident A had with her family.

	Resident B and Resident C reported that they do not leave the house very often, but said it was because they do not have family or friends whom they would visit. They both stated that if they wanted to leave the home for whatever reason, they knew they could, and that neither Mr. nor Mrs. Maciel would try to prevent them from doing so. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: On 06/08/2022, I spoke with and asked Mrs. Maciel if the residents were allowed to have cell phones and she said she does not allow them to because Resident B was using her own cell phone to call her boyfriend but there was a “No Contact” order issued by the court. Mrs. Maciel decided it was best if no resident had their own cell phone, and that they just use the house phone. Mrs. Maciel informed me that this is not stated in the House Rules, but she does inform potential residents during admission.

On 06/09/2022, I called and spoke with Tammy Dykstra, Resident A’s Legal Guardian. Ms. Dykstra reported that she was also the Legal Guardian of Resident B and was aware that Resident B cannot have a cell phone because she has used it to call her boyfriend but there was an existing court-order for her to have no contact with him. Ms. Dykstra said that she was also aware that Resident A cannot have a cell phone because she uses it to make “hyper-calls,” that is, she will call her attorney “15 times a day” and call banks to get credit cards. I advised Ms. Dykstra to work with Mrs. Maciel in getting these cell phone restrictions put in Resident A and Resident B’s Assessment Plans, and she said she would do so.

On 06/09/2022, I called and held an exit conference with Shawna Maciel, Co-Licensee. I informed Mrs. Maciel that I was citing violation of this rule. Mrs. Maciel reminded me of the reason Resident B doesn’t have a cell phone, and I agreed that it was a valid reason, and advised her to just add the reason, as the one for Resident A, to both of these residents’ Assessment Plans. She said she would and had no further comment.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Mrs. Maciel stated that she does not allow the residents to have their own cell phones because one of them, Resident B, was using her own cell phone to call her boyfriend but there was a "No Contact" order between Resident B and her boyfriend. Mrs. Maciel believed it would be fair, then, if no resident had their own cell phone. They would, however, have 24/7 access to the house phone. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

June 9, 2022

Ian Tschirhart — Date
Licensing Consultant

Approved By:

June 0, 2022

Jerry Hendrick — Date
Area Manager