GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 15, 2023

Shawna and Jose Maciel
1051 Collage Avenue
Holland, MI 49423

RE: License #: AF030396753
Investigation #: 2023A0581017
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 #:	2023A0581017
Complaint Receipt Date:	01/18/2023
Investigation Initiation Date:	01/18/2023
Report Due Date:	03/19/2023
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?
The licensees did not fix Resident A's Continuous Positive Airway Pressure (CPAP) machine.	No
The licensees are mentally and physically abusive to Resident A.	No
Additional findings.	Yes

III. METHODOLOGY

01/18/2023	Special Investigation Intake 2023A0581017
01/18/2023	APS Referral APS received the allegations and is investigating. No referral necessary.
01/18/2023	Special Investigation Initiated - Telephone Interview with APS, Kathleen Woodworth.
01/18/2023	Contact - Telephone call made Left message with Guardian A1
01/18/2023	Contact - Document Sent Email to Guardian A1
01/19/2023	Contact – Telephone call received Interview with Guardian A1.
01/30/2023	Inspection Completed On-site
02/27/2023	Contact – Document Sent Requested police reports concerning Resident A.
02/27/2023	Contact – Document Sent Email to Ms. Woodworth.
02/27/2023	Contact – Telephone call made Interview with Resident A's psychiatric nurse, Kim Brinx, through Corso Care Home Health.
02/27/2023	Contact – Document Sent Email to licensee, Shawna Maciel.

ALLEGATION:

The licensees did not fix Resident A's Continuous Positive Airway Pressure (CPAP) machine.

INVESTIGATION:

On 01/18/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged the licensees, Shawna and Joe Maciel, were responsible for fixing Resident A's Continuous Positive Airway Pressure (CPAP) machine, but had not done so; therefore, Resident A was not getting any sleep. The complaint alleged it was unclear what the current condition of Resident A's CPAP machine was right now.

On 01/19/2023, I interviewed Guardian A1 who stated she did not indicate any concerns with Resident A's CPAP machine being broken and/or it not being addressed by the licensees.

On 01/30/2023, I conducted an unannounced onsite inspection. The licensee, Shawna Maciel, confirmed Resident A had a CPAP machine. She showed me Resident A's CPAP machine, which the licensee was storing in the facility garage due to Resident A being admitted to the hospital. She stated Resident A had gone to the doctor in September or October 2022 for a checkup regarding the CPAP machine. She indicated there had been no issues during the doctor's visit despite Resident A recently indicating it was broken or not fitting his face correctly. She stated she had been getting parts for the CPAP machine like new filters and hoses. Ms. Maciel showed me the newly obtained CPAP parts (e.g., headgear, frame system, cushions, filters, and hoses, etc.), which indicated they had been ordered and shipped to the facility on 01/18/2023.

During the inspection, I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan), dated 06/01/2022; however, Resident A's CPAP machine was not listed as an assistive device on the assessment plan.

I did not interview Resident A during the investigation due to him being hospitalized, but I interviewed Resident B, C, D, and E; however, none of them had any information regarding Resident A's CPAP machine being used by Resident A or it being broken and the licensees not fixing it.

On 02/27/2023, I interviewed Resident A's psychiatric nurse, Kim Brinx, through Corso Care Home Health. Mr. Brinx stated he observed Resident A's CPAP machine in Resident A's bedroom when he visited the facility approximately weekly, but Resident A indicated he did not want to use it.

On 02/27/2023, the licensee, Ms. Maciel confirmed via email Resident A's CPAP was not indicated in his assessment plan. She stated it was not in his assessment

plan because he was not admitted into the facility with it. She indicated in her email it took approximately one month before she got the CPAP machine after Resident A's relative brought it in. She stated in her email to me that it was indicated to her Resident A had been utilizing the CPAP for approximately 10 years.

On 02/27/2023, Ms. Maciel forwarded me an after-visit summary from Resident A's doctor visit, dated 09/16/2023, regarding his CPAP machine. According to this after visit summary, Resident A was provided with the following instructions:

- Continue to use PAP therapy nightly. Strive for at least four hours nightly.
- Do not drive or operate equipment if drowsy.
- Use good sleep hygiene and strive to get 7-8 hours of sleep nightly.
- Bring equipment to each office visit.
- Obtain new masking supplies on a regular basis.
- Call if any questions or concerns with PAP or with sleep.
- Contact Airway Oxygen to obtain new masking supplies.

The documentation indicated Resident A should follow-up in approximately one year. It also provided recommendations for how often the parts on his CPAP machine should be replaced.

On 02/28/2023, Adult Protective Services specialist, Kathleen Woodworth, stated in her email to me that Guardian A1 denied Resident A's CPAP machine was ever broken.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician with regard to such items as medications, special diets, and other resident health care needs that can be provided in the home.

ANALYSIS:	Based on my investigation, which included interviews with the licensee, Shawna Maciel, Guardian A1, and Corso Care Home Health psychiatric nurse Kim Brinx, APS specialist Kathleen Woodworth, my observations of Resident A's CPAP machine and its respective parts, and my review of the medical after visit summary, dated 09/16/2023, the licensees were following the instructions of Resident A's physician in regard to his CPAP machine. The licensees took Resident A to his yearly CPAP machine review on 09/16/2023 and obtained new parts for the machine, which were with Resident A's belongings at the facility. Subsequently, there is no evidence indicating the licensees failed to fix or replace Resident A's CPAP machine, as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.1408	**Resident care; licensee responsibilities.**
	(1) A licensee shall provide basic self-care and habilitation training in accordance with the resident's written assessment plan.
	"Assessment Plan" means a written statement prepared in cooperation with a responsible agency or person that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services taking into account the preferences and competency of the individual.
ANALYSIS:	A resident's specific habilitation training and self-care needs are to be documented in the written assessment plan. Specific licensee responsibilities include helping the resident learn to do, what he or she can do, and doing for a resident what he or she cannot do. Resident A required the use of a CPAP machine to help him breathe and sleep at night; however, the CPAP machine was not indicated on Resident A's assessment plan, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The licensees are mentally and physically abusive to Resident A.

INVESTIGATION:

The complaint also alleged Resident A was experiencing mental abuse by the facility's licensees, Shawna and Jose Maciel. The complaint alleged Mr. and Mrs. Maciel get Resident A "riled up to get a reaction out of him and humiliate him." The complaint alleged Mr. and Mrs. Maciel tell Resident A he is "like a five-year-old" and they tell him to quit fixating on things. The complaint also alleged Mr. Maciel told Resident A to "kill himself." The complaint alleged Mr. and Mrs. Maciel threatened and even hit Resident A with a baseball bat; however, there were no marks or injuries to Resident A. The complaint alleged Mr. and Mrs. Maciel have guns in the home, which Resident A feels threatened by because he's observed them on the facility's countertops, but the complaint also indicated Mr. and Mrs. Maciel are licensed to carry concealed weapons.

On 01/18/2023, I interviewed APS specialist, Ms. Woodworth, via telephone. Ms. Woodworth stated Resident A's guardian, Guardian A1, was aware of Resident A's recent incidences leading him to be admitted to the local hospital. Ms. Woodworth stated Guardian A1 took away Resident A's phone due to him having inappropriate contact with minors while using the phone. Ms. Woodworth stated the facility's licensee, Shawna Maciel, indicated to her Resident A had been getting "agitated" so she had been in contact with his psychiatric nurse to have his medications adjusted. Ms. Woodworth stated on or around 01/16/2023, Resident A ran away from the facility to a gas station in the middle of the night. She stated he was then taken to the hospital; however, he was discharged back to the facility. She stated when he arrived back to the facility he ran away again. She stated he was subsequently admitted to the Emergency Room (ER) the second time because Resident A was complaining of chest pain. Ms. Woodworth stated Resident A appeared to be experiencing delusions about the injuries and abuse by the licensees. Ms. Woodworth stated the licensee issued Resident A a 24-hour discharge notice due to Resident A being a danger to himself.

On 01/19/2023, I interviewed Guardian A1 via telephone. Guardian A1 stated she had no concerns with the licensees mistreating Resident A, or mentally and/or physically abusing him.

On 01/30/2023, I conducted an unannounced onsite investigation at the facility. I was unable to interview Resident A as he was still in the hospital. The licensees, Shawna and Joel Maciel, were both present during my investigation. Both Mr. and Mrs. Maciel denied mentally or physically assaulting or abusing Resident A. Mr. Maciel denied ever using a bat to assault Resident A or threaten him. They also denied talking down to him or talking inappropriately to him. Mr. and Mrs. Maciel stated they have their concealed carry permits, which Ms. Maciel showed me;

however, they stated their guns are kept in a safe in their private space. During my investigation, I did not observe any guns or weapons on the facility's countertops or out in the open within the facility. Both Mr. and Mrs. Maciel stated their son has airsoft guns that resemble a rifle and pistol, which he's brought over to shoot targets in the backyard; however, they denied their son every using these airsoft guns to intimidate Resident A or any of the other residents. Mr. and Mrs. Maciel indicated Resident A could have seen one of the airsoft guns and believed it to be a real gun.

I interviewed Resident B, C, D, and E. None of the residents indicated any concerns with how Mr. and Mrs. Maciel treated them. Resident B and C both stated they had never seen Mr. and Mrs. Maciel mistreat Resident A by calling him names, talking down to him, assaulting him or intimidating him with guns. Resident D and E stated they had just moved to the facility within the last week and had no knowledge of Resident A.

On 02/28/2023, I confirmed APS specialist Ms. Woodworth was also not substantiating the licensee for any abuse or neglect. She indicated in her email to me that when she interviewed Resident A he was made "outlandish statements". She stated in her email that Resident A made statements to her indicating he had broken ribs from being beaten with a bat; however, she was informed by the nursing staff at the hospital these statements were not true. She also indicated in her email to me that she also had no way to prove he was being mentally abused by the licensees.

On 03/27/2023, I interviewed Kim Brinx, psychiatric nurse through Corso Care Home Health. Mr. Brinx stated he worked with Resident A approximately four months and saw him approximately weekly. He indicated his case with Resident A had been closed for approximately six weeks due to Resident A getting admitted to the hospital. He stated Resident A "was a difficult case" due to his behaviors, which included being self-injurious and volatile. He stated Resident A would become agitated, engage in negative self-talk, and would express he wanted to live on his own. Mr. Brinx did not have any concerns with the licensees not communicating with him or not providing adequate care to Resident A. He stated he had no concerns either of Mr. or Mrs. Maciel being mentally or physically abusive towards Resident A or mistreating him while he resided at the facility. Mr. Brinx indicated Resident A was a "poor historian" and not reliable. He had no concerns the licensees were using guns to intimidate Resident A.

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(1) A licensee shall not mistreat or permit the mistreatment of a resident by responsible persons or other occupants of the home. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm.

ANALYSIS:	There is no evidence the licensees, Shawna and Joe Maciel, mistreated Resident A by physically assaulting him or hitting him with a bat. Additionally, despite the licensees having concealed carry permits, there is no evidence they ever used a gun to intimidate Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.1412	**Resident behavior management; prohibitions.**
	(2) A licensee, responsible person, or any person living in the home shall not use any of the following methods of handling a resident for discipline purposes: **(e) Mental or emotional cruelty, including subjecting a resident to verbal abuse, making derogatory remarks about the resident or members of his or her family or making malicious threats.**
ANALYSIS:	There is no evidence the licensees, Shawna and Joe Maciel, were mentally or emotionally cruel to Resident A by talking down to him or belittling him.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 02/28/2023, I conducted an exit conference with the licensee, Shawn Maciel, via email informing her Resident A's CPAP should have been indicated in his assessment.

IV. RECOMMENDATION

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

03/07/2023

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Cathy Cushman Date
Licensing Consultant

Approved By:

03/15/2023

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Dawn N. Timm Date
Area Manager