GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 8, 2021

Corinthia Calhoun
Healing Rivers LLC
6310 Timberview Dr
East Lansing, MI 48823

RE: License #: AS330399006
Investigation #: 2021A0577031
Healing Rivers LLC

Dear Ms. Calhoun:

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330399006
Investigation #:	2021A0577031
Complaint Receipt Date:	05/04/2021
Investigation Initiation Date:	05/04/2021
Report Due Date:	07/03/2021
Licensee Name:	Healing Rivers LLC
Licensee Address:	6310 Timberview Dr East Lansing, MI 48823
Licensee Telephone #:	(517) 214-0646
Licensee Designee:	Corinthia Calhoun
Administrator:	Corinthia Calhoun
Name of Facility:	Healing Rivers LLC
Facility Address:	1210 Stonegate Lane East Lansing, MI 48823
Facility Telephone #:	(517) 721-1418
Original Issuance Date:	01/14/2020
License **Status:**	REGULAR
Effective Date:	07/14/2020
Expiration Date:	07/13/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff yell at residents, are mean, and make residents cry.	Yes
Direct care staff have grabbed Resident C by the shirt.	Yes
Staff are using a gait belt to restrain a resident to the wheelchair.	Yes
Direct care staff member Talisa Ball will withhold food from Resident B as punishment and Resident B is losing weight.	No
In April 2021 Resident B was administered her 4:00pm and 8:00pm doses of Klonopin at the same time.	No
The facility has bed bugs and is not being property treated.	No

III. METHODOLOGY

05/04/2021	Special Investigation Intake 2021A0577031
05/04/2021	Special Investigation Initiated – Letter Email with Dawn Campbell.
05/04/2021	APS Referral with Talaina Cummins
05/05/2021	Contact - Document Received- Intake #179236 was added to current SI for investigation.
05/05/2021	Contact - Telephone call made to Talaina Cummins, APS-Ingham County DHHS Office
05/10/2021	Inspection Completed On-site Interview with residents and physical plant inspection.
05/20/2021	Contact - Telephone call made- Interviewed Complainant.
05/20/2021	Contact - Telephone call made- Interview with Knock It Out Exterminating.
05/21/2021	Contact - Document Received- Intake #179718 was added to current SI for investigation.
05/21/2021	Referral - Recipient Rights to Greg Fox, ORR-Ingham Co.
05/24/2021	Inspection Completed On-site Interview with staff and reviewed documents.

05/25/2021	Contact-Telephone call made- Interview with Anthony Williams, DCS
06/01/2021	Contact-Telephone call made- Interview with Jasmine Sims, DCS.
06/01/2021	Exit Conference with Corinthia Calhoun, LD.

ALLEGATION:

- **Direct care staff yell at residents, are mean, and make residents cry.**
- **Direct care staff have grabbed Resident C by the shirt.**

INVESTIGATION:

On May 04, 2021, and May 05, 2021, the department received two complaints regarding direct care staff Talisa Ball almost hitting an unknown resident with a vehicle on purpose and then laughed about it. On May 10, 2021, I interviewed Complainant who reported the incident with the car did not happen at the facility, nor did it involve a resident of the facility, but was an incident that happened while Talisa Ball was providing care at a person's home for a home care agency. Complainant reported having heard this information from other direct care staff talking at the facility. Complainant stated believing it was necessary for this allegation to be investigated however this allegation is not related to AFC administrative rules pertaining to events at the AFC facility so it will not be investigation. I advised Complainant this was a law enforcement matter.

The complaint received on May 04, 2021, also alleged direct care staff Talisa Ball and Juanita Ball are mean, rude and make residents cry daily.

On May 21, 2021, a third allegation was received and added to current investigation. The complaint alleged Resident C reported to Complainant direct care staff yelling at residents and Resident C was hit twice by two different direct care staff. The complaint stated Resident C later reported two direct care staff grabbed the front of his shirt approximately three months ago. Resident C reported direct care staff did not touch his body or hit him.

On May 10, 2021, Complainant reported Talisa Ball, direct care staff member (DCS), is rude to the residents. Complainant reported Ms. Talisa Ball will say to the residents "sit down and stop", "go back downstairs", and "you will get what I give you for lunch."

On May 10, 2021 I completed an onsite investigation and interviewed Resident A who reported Talisa Ball and Juanita Ball are rude, not nice people and not gentle when providing care. Resident A reported Ms. Talisa Ball and Ms. Juanita Ball will wake the residents up early in the morning and start demanding things such as to

“walk faster or move faster.” Resident A stated, “we are older, it takes our brains and bodies time to work together, we cannot just jump up and go on their demands.” Resident A reported Ms. Talisa Ball and Juanita Ball are not approachable, when asking a question their answers are curt and short. Resident A reported she has not witnessed any direct care staff use physical force on any resident.

On May 10, 2021 Resident F reported Talisa Ball and Juanita Ball are nice to her and now are nice to the other residents. Resident F would not elaborate on what she meant by staff are “nice *now* to other residents.” Resident F denied the allegations of Ms. Juanita Ball and Ms. Talisa Ball grabbing any residents in a forceful way.

On May 10, 2021 Resident E reported DCS Talisa Ball yells at Resident E all the time. Resident E reported Ms. Talisa Ball said “get back downstairs.” Resident E denied the allegations of Ms. Talisa Ball or Ms. Juanita Ball using physical force on any residents.

On May 10, 2021 Resident C reported on two separate incidents DCS Talisa Ball and DCS Juanita Ball grabbed Resident C by the shirt. Resident C reported about three months ago the incident happened when Resident C reported Ms. Juanita Ball grabbed Resident C by the arms of his shirt and made him sit down in the chair. Resident C reported about a month ago Ms. Talisa Ball grabbed Resident C by the shoulders of his shirt. Resident C reported Ms. Talisa Ball and Ms. Juanita Ball are rude to all the residents.

On May 10, 2021 I interviewed Corinthia Calhoun, licensee designee, who reported she has had many conversations with Resident C who never has reported to her or any of her staff of Talisa Ball and Juanita Ball putting their hands on Resident C.

On May 24, 2021 I completed an onsite investigation and interviewed DCS Juanita Ball who denied the allegation of grabbing Resident C's shirt. Ms. Juanita Ball reported Resident C is very independent and does not need any hands-on assistance from staff so there is no need for anyone to physically put their hands on Resident C. Ms. Juanita Ball reported she cannot even think of an incident that would even resemble something of this matter, that Resident C stays to himself. Ms. Juanita Ball stated, "I pretty much get along with everyone, sometimes the residents do not get along with me." Ms. Juanita Ball reported there have been times when she is cooking and a resident wants something done right then and I will say, "give me just a minute and I will be right with you" but this makes them upset. Ms. Juanita Ball reported when Resident A moved into the facility, Resident A wanted her medication at 1:00pm instead of noon like the prescription instructions said so this made Resident A upset at Ms. Juanita Ball. Ms. Juanita Ball denied the allegations of yelling, being mean or rude toward residents, stating, "I do not raise my voice, but I try and redirect."

On May 24, 2021 I interviewed DCS Talisa Ball, DCS who reported she has never grabbed Resident C or any resident by their shirt. Ms. Talisa Ball reported she is not sure where this allegation is coming from or why Resident C would say this. Ms. Talisa Ball denied being mean, rude, or yelling at residents. Ms. Talisa Ball reported Resident B and Resident E will get loud when they are talking or are upset and sometimes, I must talk loud for them to hear you or to get their attention, but I do not yell at them.

On May 24, 2021, I interviewed licensee designee Corinthia Calhoun who reported it has been brought to her attention recently of DCS Talisa Ball and DCS Juanita Ball, DCS being rude or harsh when speaking to residents. Ms. Calhoun reported she has been working with Talisa Ball and Juanita Ball on "their delivery" of what is being said, explaining that what the two direct care staff members are saying is not incorrect rather the manner in which it is said is being misunderstood my residents.

On May 25, 2021 I interviewed DCS Anthony Williams who reported he has not witnessed any forms of physical force being used by any direct care staff. Mr. Williams reported none of the residents have complained or reported to him of a staff using physical force. Mr. Williams reported Resident C has not reported to him of Juanita Ball or Talisa Ball grabbing Resident C's shirt or forcing Resident C to sit in the chair. Mr. Williams stated, "if he ever saw a staff mistreat a resident, I would kick them out of the house and he would call Ms. Calhoun, and possibly call the police." DCS Mr. Williams reported DCS Talisa Ball and DCS Juanita Ball have been spoken to by licensee designee Corinthia Calhoun on how they deliver their message to residents. Mr. Williams reported he has not heard DCS Juanita Ball or DCS Talisa Ball yell at the resident rather he has heard them speak in a more factual or demanding sounding manner. Mr. Williams reported she spoke with licensee designee Ms. Calhoun about his concerns regarding the tone in which DCS Juanita Ball and DCS Talisa Ball and since talking with Ms. Calhoun their approach to the residents have been milder and kinder.

On June 01, 2021, I interviewed DCS Jasime Sims who reported she has not witnessed Juanita Ball and Talisa Ball screaming or yelling but rather talking to residents in a strict tone ofvoice. Ms. Sims reported she has not witnessed any use of physical force from Juanita Ball or Talisa Ball when interacting with residents.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on the information gathered, it has been found Talisa Ball and Juanita Ball do not treat the residents with dignity while providing personal care, to include consideration and respect when speaking to the residents. Resident A, Resident C, Resident E, and Resident F reported direct care staff Talisa Ball and Juanita Ball speak rudely to the residents and are demanding. Ms. Calhoun reported she has been working with Talisa Ball and Juanita ball on their delivery when speaking and interacting with residents because these concerns have been brought to her attention. There was no evidence found to support the allegations of Talisa Ball and Juanita Ball grabbing Resident C's shirt.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Staff are using a gait belt to restrain a resident to the wheelchair.

INVESTIGATION:

On May 05, 2021, the complaint received alleged on May 02, 2021, direct care staff Talisa Ball tied down Resident B to her wheelchair for 30 minutes by using a gait belt because Resident B kept asking to use the bathroom.

On May 24, 2021 I interviewed DCS Talisa Ball who reported per Resident B's guardian's verbal instructions, direct care staff are to strap Resident B to the wheelchair to prevent Resident B from standing up in order for direct care staff can provide care to other residents.

On May 24, 2021, I interviewed DCS Juanita Ball who reported Resident B had physical therapy at the home and was provided a gait belt to assist with mobility during that time. Ms. Juanita Ball reported Resident B will try to get out of her wheelchair all the time so Resident B's guardian advised in writing for direct care staff to use the gait belt to strap Resident B to her wheelchair so Resident B cannot get up when direct care staff are not in the room to assist Resident B.

On May 24, 2021 I interviewed licensee designee Corinthia Calhoun who reported Guardian B1 wrote instructions for direct care staff to follow regarding Resident B's behaviors and how direct care staff should handle those behaviors. Ms. Calhoun provided me with a copy of the instructions which stated the following: "I have given my permission for Healing Rivers to implement using the gait belt to restrain [Resident B] to her wheelchair as needed to complete the daily tasks and to keep [Resident B] from Getting out of the wheelchair by herself which would result in [Resident B] falling."

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**

ANALYSIS:	Based on the information provided during the investigation there is sufficient evidence found that direct care staff Talisa Ball and Juanita Ball as well as licensee designee Corinthia Calhoun used a gait belt to restrict Resident B's movement by strapping Resident B to her wheelchair with the gait belt. Talisa Ball, Juanita Ball, and licensee designee Corinthia Calhoun reported they were provided instructions and given permission from Guardian B1 to restrain Resident B to her wheelchair as needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Talisa Ball, direct care staff will withhold food from Resident B as punishment and Resident B is losing weight.

INVESTIGATION:

The complaint received on May 05, 2021, alleged that DCS Talisa Ball regularly withholds food as a punishment from Resident B. The complaint stated Resident B looks malnourished and keeps losing weight.

On May 10, 2021, I interviewed Complainant who reported DCS Talisa Ball threatens not to feed Resident B until last if she keeps asking to use the bathroom. Complainant reported all the residents get fed their meals, but sometimes they must wait. Complainant reported she is not aware of any residents, including Resident B, who do not get fed. Complainant reported Resident B looks malnourished and she feels like Resident B has gone without meals but does not know this firsthand. Complainant reported not reviewing Resident B's *Resident Weight Record* to see if Resident B was losing weight.

On May 10, 2021 I interviewed Resident A, Resident B, Resident C, Resident D, and Resident E who denied missing any meals or being threatened not to be fed a meal by any direct care staff member. Resident A, Resident B, Resident C, Resident D, and Resident E reported they get breakfast, lunch, and supper, plus snacks in between.

On May 24, 2021, I reviewed and received copies of Resident B's *Resident Weight Record* for the month of May 2021 which documented Resident B being weighed daily and Resident B's weigh fluctuating from 94 pound to 91 pounds. Per the Resident Weight Record, Resident B was weighed in the morning of May 24, 2021 weighing in at 92.8 pounds. I also reviewed the *Residents Weight Charts* of Resident A, Resident C, Resident C and Resident A and did not see any significant weight loss for any resident.

On May 24, 2021 I interviewed DCS Talisa Ball who denied ever threatening to withhold food from residents as a punishment. Ms. Ball stated, "at no time has a resident gone without a meal." Ms. Ball reported she has not made any resident wait to eat as a form of punishment or threatened this to a resident. Ms. Ball reported there was an incident when Resident C wanted hot dogs for lunch, but the facility did not have hot dogs and Resident C was upset. Ms. Ball reported she was working with DCS Heather McKay that day and Ms. McKay felt that if the resident asked for something specific to eat the facility should be able to provide that food. Ms. Ball reported she explained the facility did not have hot dogs available and hot dogs were put on the grocery list and purchased the next day.

On May 24, 2021 I interviewed DCS Juanita Ball who reported no residents have reported to her they have gone without a meal, nor has she heard or seen DCS Talisa Ball threaten this. Ms. Ball reported she has not withheld a meal from residents or threatened to withhold a meal.

On May 25, 2021 I interviewed DCS Anthony Williams who reported he has not heard any direct care staff threaten the residents of withholding their food. Mr. Williams reported none of the residents have ever reported direct care staff members threatening not to feed residents or not feeding residents. Mr. Williams reported he has not withheld food as a punishment nor has he threatened to withhold food as a punishment.

On June 01, 2021, I interviewed DCS Jasime Sims who reported the residents eat in the order as they come to the table or get out of bed. Ms. Sims reported the residents can eat what and when they like. Ms. Sims reported this is how she was trained by Juanita Ball and Talisa Ball. Ms. Sims reported the residents have not reported to her going without meals as a punishment.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.**

ANALYSIS:	Based on the information gathered during the investigation there was no evidence found that direct care staff Talisa Ball withheld food from residents. Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F denied the allegations and reported they all receive breakfast, lunch, and supper, plus snacks. Resident B's weight record was observed on May 24, 2021 and no significant weight loss was observed or documented by the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: In April 2021 Resident B was administered her 4:00pm and 8:00pm doses of Klonopin at the same time.

INVESTIGATION:

On May 05, 20201 the second complaint received alleged in April 2021, an unknown direct care staff member gave Resident B her 4:00pm and 8:00pm medication passes at the same time which included her Klonopin and unknown night pills. The complaint reported the direct care staff member who administered the double dose is still working at the facility.

On May 10, 2021, Complainant reported the medication error she did not witness but heard about from another worker. Complainant reported being told it was DCS Talisa Ball who administered the medications incorrectly. Complainant reported not knowing which day the incident occurred.

On May 24, 2021 during my onsite investigation, I reviewed and received copies of Resident B's *Medication Administration Record* (MAR) for April 2021. Resident B is prescribed Klonopin 1mg, take 1 tablet by mouth three times a day (AM, NOON, PM) (Dsp as: Clonazepam 1mg tab). Resident B's April MAR documented Resident B was administered Klonopin at 8:00am, 12:00pm and 8:00pm. Resident B's April 2021 MAR documented that on April 05, 2021 for Klonopin at 12:00pm the medication was originally initialed by 'TB' then scribbled out and initialed 'JS' under the scribble. Licensee designee Corinthia Calhoun reported the initials 'TB' stand for Talisa Ball and the initials 'JS' are for Jasmine Simms. Licensee designee Corinthia Calhoun stated she did not have any knowledge why Resident B's April 2021 MAR was marked in this manner. The MAR did not have any documentation notes for April 05, 2021. I did not see any discrepancies on the April 2021 MAR and the April 2021 medication bubble packs were disposed of at the time of this investigation so it was not possible to reconcile the medication bubble packs for April 2021 with Resident B's April 2021 MAR.

On May 24, 2021 I interviewed DCS Talisa Ball who reported she worked on Sunday, April 04, 2021 and put her initials in the box for Monday instead of Sunday

when she administered Resident B's noon Klonopin dose. DCS Talisa Ball stated she scribbled out her initials and re-initialed in the correct box once she realized her error. Ms. Ball reported Ms. Simms worked the morning and afternoon of Monday, April 04, 2020 and initialed under the scribble mark when she administered the noon Klonopin dose to Resident B. Ms. Ball reported she is not aware of any medication errors in April 2021.

On May 24, 2021 I interviewed Juanita Ball, DCS who reported she did not make any medication errors during April 2021 and had not heard of any other medication errors being made.

On May 25, 2021 Anthony Williams, DCS reported he does not administer medications at the facility but was told about a situation by DCS Heather McKay of Ms. McKay hearing of a staff administering Resident B's Klonopin incorrectly. Mr. Williams advised Ms. McKay to contact licensee designee Corinthia Calhoun and reported the concerns.

On June 01, 2021 DCS Ms. Sims reported on April 05, 2021, DCS Talisa Ball signed in the wrong spot when administering Resident B's noon dose of Klonopin. Ms. Sims reported she received a call from DCS Talisa Ball on April 04, 2021 notifying DCS Ms. Sims the reason why DCS Talisa ball had scratched out and re-signed her initials in Resident B's April 2021 MAR.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There was insufficient evidence found that Resident B's medication was administered incorrectly. Based the information gathered during the investigation it has been found Resident B's Klonopin was administered per the label instructions of three times a day, AM, Noon, and PM.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility has bed bugs and it is not being property treated.

INVESTIGATION:

On May 04, 2021, a complaint was received reporting the facility has had bed bugs for a while and the facility is not treating the issue properly because they have been using rubbing alcohol and Hot Shot to exterminate the bed bugs.

On May 10, 2021, Complainant reported about a month ago a bed beg was found on the living room couch and the facility is using over the counter sprays and rubbing alcohol to get rid of the bed bugs. Complainant reported they only saw one bed bug. Complainant reported the owner is aware of the bed bug situation.

On May 10, 2021, during my onsite inspection I did not find any live/dead bed bugs or bed bug eggs in the facility. I interviewed Corinthia Calhoun, licensee designee who reported in April 2021 Resident A moved into the facility from a different facility that had bed bugs and Healing Rivers was not aware of this. Ms. Calhoun reported she was notified by direct care staff a bed bug was found on the living room sofa and Ms. Calhoun came to the facility immediately. Ms. Calhoun reported they turned the sofa over and found more bed bugs and the living room furniture was removed immediately from the home, put in the garage, and treated with a bed bug spray called Hot Shot. Ms. Calhoun reported the furniture has since been thrown away. Ms. Calhoun reported they initially sprayed the facility with Hot Shot and if they saw a live bug, they kill it with rubbing alcohol. Ms. Calhoun reported she contacted Knock It Out Exterminating and they came to the facility on May 07, 2021, for treatment and found only one live bed bug, no dead ones, nor did they see any bed bug eggs. Ms. Calhoun reported they do not need to have a second treatment unless a live bug is found.

On May 10, 2021 I interviewed Resident A and Resident C who reported a few weeks ago, they saw one bed bug on the sofa in the living room. Both residents reported the furniture was removed immediately from the home and they have not seen a bed bug since.

On May 20, 2021 I contacted Knock It Out Exterminating and left a message with a returned call and message from Mr. Lennie reporting he was at the facility on May 07, 2021 to provide bed bug treatment and found one live bed bug, no eggs, or signs of any other bed bugs. Mr. Lennie reported the facility was treated with a spray treatment and ensured all bedding was appropriately covered and clothes laundered. Mr. Lennie reported he will be contacting the facility to determine if a second treatment is needed and this would be if the facility has seen any live bed bugs in the past 30 days.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	Based on the information gathered during the investigation it has been found the facilities home furnishings and housekeeping standards presented as comfortable, clean, and orderly. The facility responded appropriately by using an over-the-counter Hot Shot bed bug spray and rubbing alcohol to initially treat the bed bugs, then by removing the furniture in which the bed bugs were found and contacting Knock It Out Exterminating to provide professional treatment at the facility which was completed on May 07, 2021.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended the current status of the license remains unchanged.

Bridget Vermeesch 06/01/2021

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 06/07/2021

Dawn N. Timm Date
Area Manager