GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2023

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

RE: License #: AS330399006
Investigation #: 2023A0578032
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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330399006
Investigation #:	2023A0578032
Complaint Receipt Date:	04/10/2023
Investigation Initiation Date:	04/11/2023
Report Due Date:	06/09/2023
Licensee Name:	Healing Rivers LLC
Licensee Address:	6310 Timberview Dr, East Lansing, MI 48823
Licensee Telephone #:	(517) 214-0646
Administrator:	Corinthia Calhoun
Licensee Designee:	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:	07/14/2022
Expiration Date:	07/13/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell and hurt her arm. Direct care staff did not seek immediate medical attention. It was later determined Resident A had a fractured shoulder.	No
Additional Findings	Yes

III. METHODOLOGY

04/10/2023	Special Investigation Intake 2023A0578032
04/10/2023	APS Referral Completed.
04/11/2023	Special Investigation Completed On-site.- Interview with licensee designee, Ms. Corinthia Calhoun and direct care staff Jasmine Sims. Interview with Resident A.
04/11/2023	Contact-Document Reviewed- *AFC Licensing Division Incident / Accident Report* related to the allegations, dated 03/13/2023
04/11/2023	Contact-Document Reviewed- *Assessment Plan* from Lansing Urgent Care, dated 03/14/2023.
04/11/2023	Contact-Document Reviewed- *Assessment Plan for AFC Residents* for Resident A, dated 03/30/2022.
05/04/2023	Contact-Telephone- Confirmation of handrails installed from Ms. Corinthia Calhoun.
05/22/2023	Contact-Telephone- Interview with Relative A1.
05/24/2023	Exit Conference with licensee designee Ms. Corinthia Calhoun.

ALLEGATION:

Resident A fell and hurt her arm. Direct care staff did not seek immediate medical attention. It was later determined Resident A had a fractured shoulder.

INVESTIGATION:

On 04/10/2023, I received this anonymous complaint through the BCHS On-line Complaint System. Complainant reported that on 03/15/2023, Resident A fell outside of this facility and hurt her arm. Complainant acknowledged Resident A refused to

be taken to urgent care, but Complainant alleged licensee designee Ms. Corinthia Calhoun and direct care staff at this facility did not take Resident A to receive immediate medical care. Complainant added that on 03/17/2023, Resident A complained of her arm hurting and direct care staff at this facility finally took Resident A to Sparrow Hospital, where Resident A was provided with medical care for pain in her elbow. On 03/22/2023, Resident A was observed with bruising from the top of Resident A's shoulder to her ribs. Complainant alleged Resident A's shoulder was x-rayed on 03/23/2023 and Resident A was determined to have a fracture in her shoulder on 03/24/2023.

On 04/11/2023, I completed an unannounced investigation on-site at this facility and interviewed licensee designee, Ms. Corinthia Calhoun regarding the allegation. Ms. Calhoun acknowledged that Resident A had fallen outside and in front of the facility, while Resident B was present. Ms. Calhoun reported this fall occurred on 0313/2023. Ms. Calhoun reported that Resident A will often not wear shoes, and if Resident A does wear shoes, she will often not tie her shoelaces. Ms. Calhoun reported that on the day of the allegation, Resident A has gone outside of the facility to smoke and when she attempted to re-enter the facility, Resident A lifted her foot but missed the step and fell. Ms. Calhoun reported that she was in her office when the incident occurred. Ms. Calhoun reported she and another direct care staff member went out to provide Resident A with assistance after being informed of Resident A's fall by Resident B. Ms. Calhoun reported when she first observed Resident A after this fall, Resident A was on her knees while Resident B informed her that Resident A had "missed a step." Ms. Calhoun reported Resident A was asked if she wanted to go the emergency room to receive medical care and Resident A refused. Ms. Calhoun reported she had offered to provide Resident A with transportation to the hospital on at least one additional occasion, but Resident A continued to refuse. Ms. Calhoun reported Resident A is her own guardian and did not want to go to the hospital.

Ms. Calhoun reported that she reviewed the incident with the case manager for Resident A, who clarified that Ms. Calhoun had a responsibility to take Resident A to be seen at the hospital, despite Resident A continuing to refuse. Ms. Calhoun reported Resident A was taken to Sparrow Hospital on 03/15/2023 regarding pain in her elbow. Ms. Calhoun reported Resident A was assessed for injuries at Sparrow Hospital and had her elbow x-rayed and was returned to the facility. Ms. Calhoun reported when Resident A was examined at urgent care on 03/23/2023, another x-ray was completed of the bruised shoulder area of Resident A and it was determined that Resident A had a fracture in her shoulder. Ms. Calhoun clarified that Resident A had stopped complaining of pain in her arm and had never complained of pain in her shoulder. Ms. Calhoun reported Resident A was prescribed Ibuprofen 600MG and the use of an arm sling which Resident A refuses to use. Ms. Calhoun reported that Resident A will use this arm and sleep on her right side without any reports of pain.

While at the facility, I interviewed Resident A regarding the allegation. Resident A reported living at this facility for over three months. Resident A acknowledged having

pain in her right arm more than two weeks ago but clarified that she had seen a physician regarding this pain. Resident A reported after seeing this physician she was prescribed Tylenol to treat the pain in her arm. Resident A denied being in any current pain. Resident A acknowledged falling and reported this fall occurred in her bedroom and she had an injury to her shoulder as a result. Resident A acknowledged being provided with medical care when she needs it and reported that she has never missed any of her physician appointments. Resident A acknowledged that if she needed immediate medical attention, direct care staff at this facility would provide it.

While at the facility, I interviewed Resident B regarding the allegations. Resident B reported living at this facility for over three months. Resident B acknowledged being outside and observing Resident A when Resident A fell on 03/13/2023. Resident B reported Resident A went to put her foot on the step when she missed the step and "went down." Resident B reported that she then provided Resident A with assistance. Resident B denied knowing any details of any injury Resident A received because of the fall. Resident B denied having any additional concerns.

While at the facility, I interviewed direct care staff Jasmine Sims regarding the allegation. Ms. Sims reported working at this facility for over a year. Ms. Sims acknowledged that Resident B had informed staff Resident A had fallen outside the front of the facility and direct care staff provided assistance to Resident A. Ms. Sims acknowledged that Resident A was observed with no visible injuries and did not want to be transported to the hospital. Ms. Sims acknowledged Resident A was later examined at Sparrow Hospital regarding some pain in her elbow, but that Resident A's shoulder was not examined. Ms. Sims acknowledged that after being observed with bruising and having additional x-rays completed on Resident A's shoulder, it was determined that Resident A's shoulder had been fractured. Ms. Sims confirmed Resident A was only prescribed pain medication and the use of a sling to address this injury. Ms. Sims clarified Resident A did not verbalize any kind of complaint of pain prior to being examined at Sparrow Hospital. Ms. Sims noted Resident A often sleeps on her right side at night and never demonstrated any discomfort or pain.

On 04/11/2023, I reviewed the *Assessment Plan* from Lansing Urgent Care, dated 03/14/2023 and related to the allegations. The *Assessment Plan* from Lansing Urgent Care documented that Resident A had "uncomplicated pain in the right shoulder" and an "unspecified sprain of the right elbow." The aftercare instructions from the *Assessment Plan* from Lansing Urgent Care included keeping the elbow iced and elevated and taking Tylenol medication as needed.

On 04/11/2023, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 03/30/2022. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A moves independently in the community and requires no assistance with walking or mobility.

On 04/11/2023, I reviewed the *AFC Licensing Division Incident / Accident Report* related to the allegations, dated 03/13/2023 and completed by direct care staff Juanita Ball. The *AFC Licensing Division Incident / Accident Report* documented that as Resident A was coming up the steps to come inside the facility, Resident A missed her step and fell on the porch. The *AFC Licensing Division Incident / Accident Report* documented that Resident B entered the facility to notify direct care staff that Resident A had fallen. The *AFC Licensing Division Incident / Accident Report* documented that Ms. Ball and Ms. Calhoun immediately provided Resident A with assistance and assessed for injuries. The *AFC Licensing Division Incident / Accident Report* documented that Resident A only reported pain in her cheek but refused emergency medical services or to be taken to the hospital. The *AFC Licensing Division Incident / Accident Report* documented that Ms. Ball observed Resident A's shoes to be halfway off her feet. The *AFC Licensing Division Incident / Accident* Report documented that Ms. Ball inspected Resident A and found no redness or cuts or bruises and treated Resident A's cheek with rubbing alcohol.

On 05/22/2023, I interviewed Relative A1 regarding the allegations. Relative A1 reported that Resident A is "gravely disabled" and had been having disagreements with some of the other residents but had no concerns for the level of care provided to Resident A at this facility. Relative A1 acknowledged that Resident A has fallen at this facility and explained that Resident A's pain tolerance was "very high" and would not be surprised if Resident A did not want to go the hospital on the day of the incident. Relative A1 confirmed that Resident A had only reported pain in her elbow and was examined by Sparrow Hospital where they had missed that Resident A had a fracture in her shoulder. Relative A1 acknowledged Resident A was provided with pain medication and an arm sling for treatment for this fracture but clarified that Resident A may eventually require shoulder replacement surgery. Relative A1 clarified that Resident A may have Vascular Dementia, which may be responsible for the repeated falls that Resident A has experienced. Relative A1 expressed that her only dissatisfaction was with community mental health as they did not provide her with any information relating to Resident A's falls even though Relative A1 is in the process of obtaining guardianship for Resident A. Relative A1 reported her dissatisfaction with community mental health in this area has led her to moving Resident A to another facility.

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:	Based upon my investigation, which consisted of interviews with direct care staff Jasmine Sims, licensee designee Corinthia Calhoun, Resident A, Resident B and Relative A1 there is not enough evidence that direct care staff at this facility did not obtain needed care immediately for Resident A after Resident A had fallen on 03/13/2023.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 04/11/2023, I examined the front entrance of the facility where it was reported Resident A had fallen on 03/15/2023. I noted an elevated concrete porch enclosed on the right and left side by the front wall of the facility. I noted the top of this concrete porch was 12” above the grade of the front sidewalk with one step in transition between the sidewalk and porch. I observed no handrails on each side of this step or a handrail enclosing this elevated porch. I reviewed my findings with Ms. Corinthia Calhoun while on-site.

On 05/25/2023. Ms. Corinthia Calhoun reported handrails had been installed on the open sides of the step and front porch of this facility.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(8) Stairways shall have sturdy and securely fastened handrails. The handrails shall be not less than 30, nor more than 34, inches above the upper surface of the tread. All exterior and interior stairways and ramps shall have handrails on the open sides. All porches and decks that are 8 inches or more above grade shall also have handrails on the open sides.
ANALYSIS:	During my investigation on-site at this facility, the porch at this facility was more than 8 inches above grade, with an exterior stairway with no handrails on the open sides of the porch or stairway.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

05/26/2023

Eli DeLeon Date
Licensing Consultant

Approved By:

05/31/2023

Dawn N. Timm Date
Area Manager