GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2024

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

RE: License #: AS330399006
Investigation #: 2024A1033037
Healing Rivers LLC

Dear Ms. Calhoun:

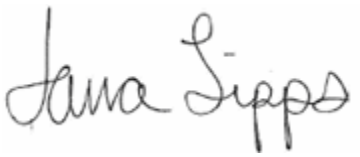
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330399006
Investigation #:	2024A1033037
Complaint Receipt Date:	04/12/2024
Investigation Initiation Date:	04/15/2024
Report Due Date:	06/11/2024
Licensee Name:	Healing Rivers LLC
Licensee Address:	6310 Timberview Dr East Lansing, MI 48823
Licensee Telephone #:	(517) 214-0646
Administrator:	Corinthia Calhoun, Designee
Licensee Designee:	Corinthia Calhoun, Designee
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 has been slapped and degraded by direct care staff.	No
Additional Findings	Yes

III. METHODOLOGY

04/12/2024	Special Investigation Intake 2024A1033037
04/15/2024	Special Investigation Initiated – Telephone call. Interview with Complainant.
04/25/2024	Inspection Completed On-site- Interviews conducted with Resident C, D, E, direct care staff, Jasmine Sims, Jamie Grinston, and licensee designee, Corinthia Calhoun. Initiated review of Resident A's resident record.
05/13/2024	Contact - Telephone received- Interview with Guardian A1, via telephone.
05/13/2024	Contact – Telephone call made- Interview with Sierra Richardson, registered nurse with Heart to Heart Hospice.
05/13/2024	Contact – Telephone call made- Interview with licensee designee, Corinthia Calhoun, via telephone.
05/13/2024	Exit Conference via telephone with licensee designee, Corinthia Calhoun.

ALLEGATION: Resident A has been slapped and degraded by direct care staff.

INVESTIGATION:

On 4/12/24 I received an online complaint regarding the Healing Rivers LLC, adult foster care facility (the facility). The complaint alleged that Resident B observed Resident A being slapped by direct care staff members when they were waking him up on an unspecified date. On 4/15/24 I interviewed Complainant, via telephone. Complainant reported receiving the information in the allegation from Resident B. Complainant reported that Resident B confided that he observed direct care staff at the facility slapping Resident A to wake him up while he was sleeping. He reported that Resident B did not specify a date of the occurrence. Complainant reported Resident B denied direct care staff had ever been physically or verbally abusive toward him.

Complainant reported visiting the facility on different occasions and has not had any concerns about direct care staff physically harming any of the residents.

On 4/25/24 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff, Jasmine Sims on this date. Ms. Sims reported that the facility is currently caring for six residents, three female residents and three male residents. She reported that Resident A has difficulty with communication and only answers in “yes” or “no” answers, which do not always make sense to the questions being asked of him. Ms. Sims reported direct care staff must assist Resident A with his personal care, toileting, feeding (she noted he is able to hold “finger foods”), standing, and on some days, ambulating. She reported Resident A is a fall risk. Ms. Sims reported she has never observed anyone slap Resident A. She reported that she is unaware of any direct care staff member who would be slapping Resident A. Ms. Sims reported that she has no concerns about Resident A’s care and current direct care staff are able to meet his care needs.

On 4/25/24, during on-site investigation, I interviewed Resident C. Resident C reported that she has resided at the facility for about 1.5 years. She reported “the staff are great”. Resident C reported that she has never observed a direct care staff member physically slapping or in any other way harming Resident A.

On 4/25/24 during on-site investigation, I interviewed Resident D. Resident D reported that he keeps to himself in his resident bedroom most of the day. He reported he goes out to the common areas for meals with the other residents. Resident D reported direct care staff are “rough on [Resident A]”. When asked to articulate what he meant by this, Resident D had a very difficult time explaining this statement nor did Resident D name any specific direct care staff members involved. When asked, “Do you feel safe with the direct care staff?”, Resident D reported, “Yeah, I guess so.” Resident D could not give any concrete examples of what his statement meant about the staff get “rough on [Resident A]” meant.

On 4/25/24, during on-site investigation, I interviewed Resident E. Resident E reported that she has never observed a direct care staff member hit or slap any of the residents at the facility. Resident E reported she has no stated concerns about the direct care staff at this time.

On 4/25/24, during on-site investigation, I interviewed direct care staff, Jamie Grinston. Ms. Grinston reported that Resident A receives hospice care through the Heart to Heart Hospice program. She reported that Resident A requires total care with his activities of daily living. She reported hospice staff provide for Resident A’s showers, but direct care staff assist with personal care, toileting, and feeding. She reported that Resident A does not communicate in complete sentences and usually answers with “yes” or “no” responses which do not always correspond correctly to the questions being asked of him. Ms. Grinston reported that Resident A is a fall risk and requires stand by assist with ambulation. Ms. Grinston reported that she has no knowledge of any direct care staff member slapping Resident A at any time.

On 4/25/24, during on-site investigation, I interviewed licensee designee, Corinthia Calhoun, regarding the allegation. Ms. Calhoun reported Resident A admitted to the facility on 4/8/23. She reported Resident A requires assistance with activities of daily living which include, feeding him, personal care assistance, and assistance with ambulation. She reported Resident A can be a fall risk. Ms. Calhoun reported she has no knowledge of any of the direct care staff slapping Resident A or physically harming him in any manner.

On 5/13/24 I interviewed Guardian A1, via telephone. Guardian A1 reported that she makes a visit to the facility at least one time per week as she has multiple wards who reside at this facility. Guardian A1 reported that she has never had any concern about any direct care staff member being physically abusive with any of the residents at the facility. She reported that Resident A receives hospice services and she receives regular updates from the Heart to Heart Hospice registered nurse, Sierra Richardson. She reported that Ms. Richardson as recent as last week provided an update to Guardian A1 on Resident A's care and had no stated concerns about potential abuse/neglect from any direct care staff member toward Resident A. Guardian A1 reported that over the past couple of years she has had about seven clients at this facility and she has never had a concern about the care these clients have received. She reported that several of her clients are verbal and have the capability of reporting concerns and have not reported any concerns to her about the direct care staff at this facility.

On 5/13/24 I interviewed Ms. Richardson, via telephone. Ms. Richardson reported that she is new to the facility providing hospice services . She reported that she visits Resident A about one time per week for regular hospice nursing visits. Ms. Richardson reported that Resident A’s health is continuing to decline. She reported that Resident A has days when it is unsafe for him to walk and she has ordered him a wheelchair to have at the facility for these times. She reported direct care staff seem resistant to use the wheelchair and report that they have been able to assist Resident A with ambulating with a stand by assist and do not need the wheelchair at this time. She reported that it has not been discussed whether this facility is capable of admitting residents who require the use of a wheelchair. She reported direct care staff just continue to state that they do not feel Resident A requires a wheelchair at this time. Ms. Richardson reported that since she only assesses Resident A one time per week it is difficult to determine what his functional level is when she is not present at the facility. She reported that she has observed Resident A to be unsafe while ambulating and has utilized the wheelchair while she is at the facility providing for his care on at least one occasion. Ms. Richardson reported that she has never observed any of the direct care staff slapping Resident A or physically harming him in any manner.

During the on-site investigation on 4/25/24 I reviewed the following documents:

- *Health Care Appraisal*, for Resident A, dated 4/8/23. On this document, under section, *12. Mobility/Ambulatory Status*, it reads, “Fully Ambulatory”.

- *Assessment Plan for AFC Residents,* for Resident A, dated 12/28/23. On page two, under section, *II. Self Care Skill Assessment*, subsection, *G. Walking/Mobility*, it indicated, “yes” Resident A needs help with walking/mobility. There are no further narrative notes to determine what type of help Resident A requires in this area. Under subsection, *J. Use of Assistive Devices*, the assessment indicates, “no”. Under section, *III. Health Care Assessment*, subsection, *D. Special Equipment Used (wheel chair, walker, cane, etc.)* this area is marked, “yes”, but there is not a narrative description of what equipment is being referenced in this section.

On 5/13/24 I interviewed Ms. Calhoun, via telephone. Ms. Calhoun reported that Resident A does not have any special equipment at the facility. She reported that she believes the marking of “yes” on the *Assessment Plan for AFC Residents* form under the subsection, *D. Special Equipment Used (wheel chair, walker, cane, etc.)* was an error. She reported that Resident A has never required the use of special equipment. She further reported that Resident A has been declining but he is still a standby assist from direct care staff with ambulation.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon interview with Complainant, Ms. Sims, Ms. Grinston, Ms. Calhoun, Resident C, D, & E, Guardian A1, & Ms. Richardson, it can be determined that there was not adequate evidence found to determine that the direct care staff have slapped or otherwise physically assaulted Resident A. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 4/25/24 I conducted an unannounced on-site investigation at the facility. I interviewed Resident C and Resident E in their shared resident bedroom. I observed three beds in this resident bedroom. I inquired about the third bed. Both, Resident C and Resident E confirmed that there are three residents who share this resident bedroom and that the third bed belongs to Resident F.

On 5/13/24 I reviewed the Original Licensing Study Report for this facility, dated 1/14/20, and completed by licensing consultant, Dawn Campbell. On page 3 of this report, under section, A. Physical Description of Facility, it lists the three licensed bedrooms for the facility. It lists each bedroom as being licensed for two residents per bedroom. There was not a bedroom listed that was licensed for three residents.

On 5/13/24 I interviewed Ms. Calhoun via telephone. Ms. Calhoun reported that there has always been three residents in this resident bedroom and that when the original licensing inspection was conducted with Ms. Campbell that there were three beds in this bedroom on that date. She reported that she had a verbal conversation with Ms. Campbell about having three residents occupy this bedroom. Ms. Calhoun reported that she had always been under the impression that three residents could occupy this space.

APPLICABLE RULE	
R 400.14409	**Bedroom space; "usable floor space" defined.**
	(4) A maximum of 2 beds shall be allowed in any multioccupancy bedroom, except as provided in subrule (5) of this rule.
ANALYSIS:	Based upon my observations during the on-site investigation on 4/25/24 and the interviews with Resident C, Resident E, and Ms. Calhoun, as well as review of the Original Licensing Study Report for the facility, it can be established that the licensee designee was knowingly allowing three residents to occupy shared space in a multioccupancy resident bedroom that was originally licensed for occupancy of two residents. A violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/13/24 I conducted an exit conference with Ms. Calhoun, via telephone. I discussed the violation of Rule 409(4) being cited on this report and the need for a corrective action plan. Ms. Calhoun verbalized understanding of this violation and reported she had no further questions.

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

5/13/24

Jana Lipps Date
Licensing Consultant

Approved By:

05/14/2024

Dawn N. Timm Date
Area Manager