



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2026

Corinthia Calhoun
Healing Rivers LLC
1210 Stonegate Ln.
East Lansing, MI 48823

RE: License #: AS330399006
Investigation #: 2026A1029040
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 licensee designee 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. 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,

A handwritten signature in black ink that reads "Jennifer Browning".

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AS330399006
Investigation #:	2026A1029040
Complaint Receipt Date:	05/04/2026
Investigation Initiation Date:	05/06/2026
Report Due Date:	07/03/2026
Licensee Name:	Healing Rivers LLC
Licensee Address:	1210 Stonegate Ln., 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:	07/14/2024
Expiration Date:	07/13/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 05/01/2026 Resident A wandered away from Healing Rivers and the direct care staff members did not notice that she was gone until law enforcement contacted them.	Yes
Resident A is not allowed to have visitors at Healing Rivers.	No

III. METHODOLOGY

05/04/2026	Special Investigation Intake 2026A1029040
05/06/2026	APS Referral not required. Already assigned to APS, Penny Howard
05/06/2026	Special Investigation Initiated - Email to Penny Howard
05/13/2026	Inspection Completed On-site – face to face with Resident A, Jasmine Sims, Juanita Ball at Healing Rivers LLC
05/14/2026	Contact - Document Received- Additional complaint from denied APS referral.
05/15/2026	Contact - Telephone call made to Guardian A1 / Tri County Guardianship Services - left message
05/15/2026	Contact - Telephone call made to direct care staff member Jasmine Sims
05/15/2026	Contact - Email sent to APS policy mailbox
05/20/2026	Contact - Telephone call received - Text from Guardian A1
05/22/2026	Contact - Face to Face with Jasmine Sims, Resident B, and Resident C at Healing Rivers
05/27/2026	Contact - Telephone call made to licensee designee Corinthia Calhoun
06/11/2026	Exit conference with licensee designee Corinthia Calhoun

ALLEGATION: On 05/01/2026 Resident A wandered away from Healing Rivers and the direct care staff members did not notice that she was gone until law enforcement contacted them.

INVESTIGATION:

On 05/04/2026, a complaint was received through the Bureau of Community and Health Systems online complaint system alleging that, on 05/01/2026, Resident A wandered away from Healing Rivers LLC. The direct care staff member Ms. Sims reportedly did not realize she was missing until they were contacted by law enforcement. According to the allegations, Resident A had traveled approximately half a mile from Healing Rivers LLC and entered a bank and when the bank tellers were unable to get her to speak, they contacted law enforcement, who responded at approximately 3:50 PM and they contacted nearby AFC homes to determine Resident A's residence. When direct care staff member Ms. Sims at Healing Rivers she was unable to provide her baseline mentation and did not know how long she had been away from the home. Following the incident, Resident A was transported to Sparrow Hospital due to an elevated heart rate and altered mental status. Adult Protective Services (APS) investigator Penny Howard was also assigned to review these concerns.

On 05/06/2026, I received an email from APS worker Ms. Howard informing me that her APS case had been closed and substantiated for neglect. Ms. Howard reported that Resident A is diagnosed with developmental delay, hypertension, and diabetes. Ms. Howard stated in her previous residence, she had not received her prescribed thyroid medication for approximately one year. Tri County Guardianship Services became her guardian about a month ago when the previous guardian could no longer fulfill the responsibilities and learned during a recent medical appointment that the thyroid prescription had not been refilled.

According to Ms. Howard, the lack of thyroid medication, combined with a urinary tract infection, contributed to Resident A becoming agitated and eloping from the AFC home undetected when another resident (who is permitted to leave unsupervised) left the facility. Ms. Howard stated the APS case was substantiated for neglect but Resident A is now receiving all prescribed medications, reports being content in her placement, and stated she likes staff and does not plan to leave without supervision. Ms. Howard stated APS has no further involvement, and the current guardian was notified of the case closure.

On 05/13/2026, I conducted an unannounced onsite investigation and interviewed direct care staff member Jasmine Sims. Ms. Sims reported that she was the only direct care staff member on duty when Resident A left the facility. She stated she was cleaning the back bedrooms at the time and had checked on Resident A beforehand, observing her lying in bed with her back toward the door. Ms. Sims did not recall the exact time of this check and noted that resident checks are not documented, stating she keeps track of them "in my head."

Ms. Sims stated Resident A had not previously attempted to leave the facility, and staff were not aware she might do so. After the incident, door alarms were installed to alert direct care staff members when doors are opened. Ms. Sims reported that law enforcement contacted her when Resident A was located at a nearby bank. Resident A was later taken to the hospital for an evaluation and subsequently returned to Healing Rivers.

Ms. Sims emailed me the *AFC Incident / Accident Report* (from 05/01/2026-no time noted) which included the following documentation:

Explain what happened:

I went to assist another client after [Resident A]'s bedroom to do a room check. As I was helping the other client [Resident A] had gotten out of the house. I didn't realize she was gone until the police called.

Action taken by staff:

I notified everyone that needed to be notified.

Correct Measures:

The AFC put a door alarm. We upscaled our room checks from every 2 hours to an hour since the incident.

I reviewed Resident A's *Assessment Plan for AFC Residents* which includes documentation that she doesn't move independently in the community and needs assistance.

On 05/13/2026, I interviewed direct care staff member Juanita Ball. Ms. Ball stated she was not on duty when Resident A left the facility and was surprised by the incident, noting that Resident A is not typically someone who "walks away." Ms. Ball reported that Resident A's recent urinary tract infection had caused confusion and changes in her behavior. Ms. Ball stated Resident A also has a thyroid condition and had not received her thyroid medication for some time prior to her placement at Healing Rivers. Ms. Ball stated that the combination of these conditions likely contributed to Resident A's confusion at the time of the incident. Ms. Ball explained that the facility has since installed alarms that chime whenever someone enters or exits the home and they have been monitoring Resident A more closely now that they are aware she may attempt to leave.

Neither Ms. Ball nor Ms. Sims knew which bank Resident A went to, though Ms. Ball believed it was "Bank of America" on the same side of the street as the facility. After leaving Healing Rivers, I observed a First National Bank of America nearby on the same side of the street. According to Google Maps, it is approximately 0.8 miles from the facility, or roughly a 17-minute walk.

On 05/13/2026, I attempted to interview Resident A. She was unable to recall leaving the facility or being located at the bank. Resident A stated she has "never left," and when asked if she went for a walk, she responded, "no way" and pointed toward the road. She could not provide further details.

On 05/22/2026, I conducted an unannounced onsite investigation at Healing Rivers and interviewed Resident B and Resident C. Both residents stated they were present when Resident A left but did not know she had exited the building. Residents B and C also stated that an alarm now sounds whenever the door is opened, which I also verified during the onsite visit.

On 05/22/2026, Ms. Sims reported that Resident A has not attempted to leave again, though she sometimes stands near the door and the direct care staff members redirect her to other activities when this occurs.

On 05/27/2026, I interviewed licensee designee Corinthia Calhoun. Ms. Calhoun stated that according to Resident A's records from her previous apartment, Resident A was able to visit local stores and there was no indication that she could not come and go from the community. Ms. Calhoun contacted Resident A's doctor regarding the behavioral changes and was informed they could be related to dementia or an undetected UTI. Ms. Calhoun stated the doctor later confirmed Resident A had a severe UTI, which could explain her sudden change in behavior. Ms. Calhoun stated that Resident A's *Assessment Plan for AFC Residents* indicated she could come and go in the community. Ms. Calhoun stated she confirmed Ms. Sims was in the back of the house assisting another resident when Resident A left. Ms. Calhoun stated that new door alarms have been installed since the incident and even though Community Mental Health initially told her door alarms were not permitted, licensing confirmed they are allowed, so the alarms will remain in place for safety. Ms. Calhoun reported that residents are checked every two hours, with additional checks occurring throughout the evening from 5 PM onward. Ms. Calhoun stated that during the day, most residents spend time in the common areas or dining room.

This incident constitutes a repeat violation of rule 400.14303(2), previously cited in Special Investigation 2025A0622041 dated 06/05/2025. The prior investigation involved a resident found wandering unsupervised near Saginaw and Stonegate Road, close to Healing Rivers LLC. In that case, law enforcement responded to the home and spoke with Ms. Ball, who was unaware the resident had left the facility. Following the 2025 violation, Ms. Calhoun submitted a *Corrective Action Plan* on 06/05/2025. The plan included the following immediate actions: revising the admission policy; implementing immediate reassessment and discharge protocols; retraining staff on elopement prevention, documentation practices, and early identification of discrepancies in resident capabilities; improving documentation and communication procedures; and installing facility safety measures, including head counts and door alarms.

On 06/11/2026 I completed an exit conference with licensee designee Ms. Calhoun. Ms. Calhoun was informed this was a repeat violation and she stated she would retrain the direct care staff members again and she is glad the door alarm is now installed. Ms. Calhoun stated there have been no further incidents of Resident A trying to leave the facility.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	According to <i>Assessment Plan for AFC Residents</i> Resident A doesn't move independently in the community and needs assistance. On 05/01/2026 Resident A was able to leave the facility unnoticed walking almost one mile to a bank where the bank employees contacted law enforcement. Ms. Calhoun has since added alarms to the doors and increased checks for Resident A. Ms. Sims, Ms. Calhoun, and Ms. Ball all stated Resident A had a thyroid condition and urinary tract infection that changed her demeanor and caused confusion which resulted in her leaving undetected.
CONCLUSION:	REPEAT VIOLATION ESTABLISHED [SIR # 2025A0622041 DATED 06/05/2025. CAP COMPLETED.]

ALLEGATION: Resident A is not allowed to have visitors at Healing Rivers.

INVESTIGATION:

On 05/14/2026 an additional complaint was received stating Resident A is not able to have visitors at Healing Rivers and if her family calls the home, they will be informed she is at the doctor or is not available, and she hasn't been to church in the last 2-3 weeks.

On 05/15/2026, I interviewed direct care staff member Ms. Sims. She stated that Resident A's family previously visited regularly, but Guardian A1 stopped visitation because the family became "disrespectful" toward direct care staff members, arguing about who held guardianship, and causing Resident A to become agitated. According to Ms. Sims, guardianship recently transferred to Tri County Guardianship Services, and the family has not visited for several weeks. Ms. Sims reported that Guardian A1 also directed direct care staff members to stop taking Resident A to church until further notice. She stated that although the family used to call Resident A's cell phone, they have recently begun calling the house phone. Ms. Sims reported that three relatives had called within the past three days and she allowed Resident A to speak with them. Ms. Sims stated the family has called them names and used profanity during interactions.

On 05/18/2026, I received a text message from Guardian A1 confirming she initiated the no-contact order. Guardian A1 stated she has only issued such an order once in 25

years. She expressed concern that if Resident A were evicted from Healing Rivers, she would be unable to afford a comparable facility. Guardian A1 stated the family wants guardianship but she has repeatedly told them to stop fighting with the direct care staff members.

On 05/22/2026, I completed an unannounced onsite investigation and interviewed Resident B and Resident C. Both residents stated they are allowed to have visitors and no one has prevented them from receiving visits or going on outings. Resident C reported that she frequently attends church, goes to the library, and uses public transportation independently.

On 05/27/2026, I interviewed licensee designee Ms. Calhoun. She stated that Resident A's family would come to the home, throw trash on the premises, yell at direct care staff members and poke at them. She noted that Resident A often returned from family visits with increased behavioral issues. Ms. Calhoun stated she could not modify visitation rules due to directives from Guardian A1. She reported that although she attempted to allow family visitation in pairs while supervising, the family continued to swear at direct care staff members and disrupt the home environment. Ms. Calhoun stated she believed there were financial motivations behind some of the family's behavior, noting they requested Resident A's food stamp card and had not paid her room and board fees. She reported that Resident A visited with the family during her first month at the AFC, but Guardian A1 later suspended their visits. Ms. Calhoun also stated that one family member followed Ms. Sims home and threatened her, resulting in a police report being filed.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (I) Receive visitors at a reasonable time. Exceptions or visitor restrictions must be covered in the resident's assessment plan. Special consideration must be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.
ANALYSIS:	Resident A received visitors after moving into Healing Rivers however they were verbally disrespectful to the Healing Rivers direct care staff members which would also agitate Resident A. Guardian A1 started a no contact order until this situation is resolved.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning

Jennifer Browning
Licensing Consultant

06/11/2026

Date

Approved By:

Dawn Timm

06/12/2026

Dawn N. Timm
Area Manager

Date