GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2021

Courtney Carver
Crystal Creek Assisted Lvng Inc
8121 Lilley
Canton, MI 48187

RE: License #: AL820264717
Investigation #: 2021A0778038
Crystal Creek Assisted Living 2

Dear Ms. Carver:

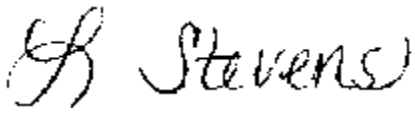
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0380.

Sincerely,



LaKeitha Stevens, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3055

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820264717
Investigation #:	2021A0778038
Complaint Receipt Date:	09/23/2021
Investigation Initiation Date:	09/24/2021
Report Due Date:	11/22/2021
Licensee Name:	Crystal Creek Assisted Lvng Inc
Licensee Address:	8121 Lilley Canton, MI 48187
Licensee Telephone #:	(734) 927-7025
Administrator:	Courtney Carver
Licensee Designee:	Courtney Carver
Name of Facility:	Crystal Creek Assisted Living 2
Facility Address:	8101 Lilley Canton Township, MI 48187
Facility Telephone #:	(734) 927-7025
Original Issuance Date:	03/31/2006
License Status:	REGULAR
Effective Date:	03/28/2021
Expiration Date:	03/27/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The hospital sent Resident A back to the home with an IV still in his arm and the facility contacted EMS for its removal. Staff was not skilled to remove it.	No
Resident A was sent to the hospital for abdominal pain on 9/13/2021 without notifying his guardian.	Yes

III. METHODOLOGY

09/23/2021	Special Investigation Intake 2021A0778038
09/24/2021	Special Investigation Initiated - Telephone
09/24/2021	Contact - Telephone call made Telephone call made to Courtney Carver of Crystal Creek
09/24/2021	Contact - Document Sent Email sent to consultant Edith Richardson
09/29/2021	Contact - Document Received Received denied APS documentation
09/29/2021	Contact - Telephone call made Telephone calls were made to traveling nurse Diana Jones. I left a message to call me back.
10/12/2021	Contact - Telephone call made Telephone call made to Nurse Jones, left message to call me back.
11/04/2021	Contact - Telephone call made Telephone call made to licensee designee regarding Nurse Jones

11/04/2021	Contact - Telephone call made Telephone call made to staff Nina Smith
11/04/2021	Contact - Telephone call received Telephone call from Nurse Jones
11/05/2021	Exit Conference Telephone exit conference attempted with Courtney Carver, licensee designee. I left a detailed message and requested a call back with any questions or concerns.

ALLEGATION: The hospital sent Resident A back to the home with an IV still in his arm and the facility contacted EMS for its removal. Staff was not skilled to remove it.

INVESTIGATION: On 09/24/2021, I completed a telephone interview with the complainant. She stated Resident A was transported to the hospital and his guardian was not notified. She stated he was returned to the facility with an IV and none of the staff were skilled in the removal process of the IV.

On 09/24/2021, I completed a telephone interview with Courtney Carver, licensee designee. Ms. Carver stated she was informed the guardian was not notified of Resident A's hospitalization. In addition, she stated Resident A was accidentally returned from the hospital with an IV attached. Ms. Carver stated this was an error of the hospital. I asked for the staff and nurse on duty and their contact information.

On 11/04/2021, I completed a telephone interview with staff Nina Smith. Ms. Smith stated she was on duty when Resident A was returned to the facility via ambulance. She stated she noticed Resident A had an IV and called Nurse Diana Jones for guidance. According to Ms. Smith, she was directed to call the hospital and inform them of the error. Ms. Smith stated she did as directed and the ambulance with EMTs returned, placed Resident A in back of the truck, removed the IV and returned him to the facility. Ms. Smith stated she is not trained in the removal of IVs and was not going to attempt removal.

On 11/04/2021, I completed a telephone interview with Nurse Diana Jones. Ms. Jones is a traveling nurse for the facility. Ms. Jones stated she was notified by staff Resident A was returned to the facility with an IV. She stated staff are not experienced in the removal of an IV and she was not present. Therefore, she

instructed them to contact the hospital and inform them of the error. Ms. Jones stated the hospital mistakenly kept the IV attached and the removal was for them to complete.

APPLICABLE RULE	
R 400.15305	**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:	There is no evidence Resident A's personal needs, protection and safety were not adhered too. Resident A was returned with an IV still attached. Staff contacted the discharging hospital. The hospital sent and ambulance and EMTs to remove the IV.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was sent to the hospital for abdominal pain on 9/13/2021 without notifying his guardian.

INVESTIGATION: On 09/24/2021, the complainant indicated Resident A's guardian was not informed of his hospitalization.

On 09/24/2021, I sent an email to Edith Richardson, the consultant for this facility and inquired if she received an incident report regarding Resident A's hospitalization. Mrs. Richardson stated an incident report was not received.

On 09/24/2021, I called Courtney Carver, licensee designee. She indicated Resident A's guardian was not notified.

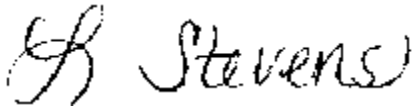
On 11/05/2021, I attempted a telephone exit conference with Mrs. Carver. I left a detailed message regarding the findings of this complaint. Ms. Carver was informed this allegation would be substantiated for failure to submit incident reports and notifications to all required persons.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a

	written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Courtney Carver, licensee designee failed to notify Resident A's guardian and all required entities of his hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

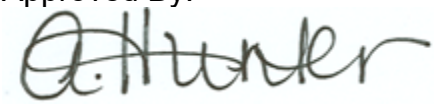
Contingent upon receipt of an acceptable corrective action plan I recommend the status of the license remain unchanged.



11/9/2021

LaKeitha Stevens Date
Licensing Consultant

Approved By:



11/16/2021

Ardra Hunter Date
Area Manager