GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

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

RE: License #: AL820073559
Investigation #: 2022A0119049
Crystal Creek Assisted Living I

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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820073559
Investigation #:	2022A0119049
Complaint Receipt Date:	08/25/2022
Investigation Initiation Date:	08/26/2022
Report Due Date:	10/24/2022
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 I
Facility Address:	8157 Lilley Canton, MI 48187
Facility Telephone #:	(734) 927-7025
Original Issuance Date:	03/30/2001
License **Status:**	REGULAR
Effective Date:	04/03/2022
Expiration Date:	04/02/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff- Diane Brown grabbed Resident A and slammed her head on a chair.	Yes

III. METHODOLOGY

08/25/2022	Special Investigation Intake 2022A0119049
08/25/2022	APS Referral Made
08/26/2022	Special Investigation Initiated - Telephone Licensee Designee/ Administrator -Courtney Carver
08/30/2022	Contact - Telephone call made Staff-Diane Brown and Mark Humphrey
09/07/2022	Inspection Completed On-site Licensee Designee/ Administrator- Courtney Carver, Residents A-B, Staff- Debra Peeden and Quameshia Stewart
09/07/2022	Contact - Telephone call made Resident A's POA- telephone number does not work
10/25/2022	Exit Conference Licensee Designee- Courtney Carver

ALLEGATION:

Staff- Diane Brown grabbed Resident A and slammed her head on a chair.

INVESTIGATION:

On 08/26/2022, I telephoned and interviewed Licensee Designee/ Administrator- Courtney Carver regarding the above allegations. Ms. Carver stated Staff- Diane Brown did have Resident A by the arm and pushed Resident A by the head into a lazy boy chair. Ms. Carver stated Resident A was trying to escape the facility and

hitting Ms. Brown. Ms. Carver stated the incident took place on 08/14/2022 but she was not notified until the following Friday by Resident A's family members.

On 08/30/2022, I telephoned and interviewed Staff-Diane Brown and Mark Humphrey regarding the above allegations. Ms. Brown stated all day Resident A was beating on her. Ms. Brown stated Resident A almost hit her in the face. She stated, "I grabbed [Resident A's] hand and forcefully put [Resident A] down in a chair." Ms. Brown sated she did do it aggressively. Ms. Brown stated, "I did make [Resident A] sit in a chair." She stated Resident A was trying to elope from the facility, which caused her to constantly have to monitor the exit door. Ms. Brown stated she had to constantly block the doors to prevent her from leaving the facility. Ms. Brown stated she extended her arm across the door and verbally told Resident A that she could not leave the facility. Ms. Brown stated Resident A was hitting her arm. Ms. Brown stated it was the end of her shift and she had had enough. Ms. Brown stated Resident A's medications were not helping with her behavior.

Mr. Humphrey stated he heard the door alarm going off constantly throughout the day, which means a resident was trying to elope from the facility. He stated throughout the day he ran to the doors to prevent a resident from eloping and each time, it was Resident A. Mr. Humphrey stated he observed Ms. Brown pull Resident A by the arm, swing her around to sit down in a chair. He stated, "I was not fully paying attention but her actions did not alarm me." Mr. Humphrey stated Resident A did not seem to be in any distress.

On 09/07/2022, I completed an onsite inspection and interviewed Licensee Designee/ Administrator- Courtney Carver, Residents A- B, Staff- Debra Peeden, and Quameshia Stewart regarding the above allegations. Ms. Carver stated she reviewed the building video recording. She stated she observed Ms. Brown grab Resident A by the arm while standing. She stated she observed Ms. Brown then forcefully swing Resident A head first into a leather recliner. Ms. Carver stated Resident A does have behaviors. Ms. Carver stated Ms. Brown did admit to forcefully holding Resident A. Ms. Carver stated Ms. Brown was terminated.

Resident A refused to be interviewed by this writer.

Resident B stated she did observe Ms. Brown swing Resident A around and put her in a chair. Resident B stated Ms. Brown looked mean.

Ms. Peeden and Ms. Stewart denies observing any staffing grabbing or pushing on any residents.

Ms. Stewart stated Ms. Brown has a history of being abusive towards residents.

APPLICABLE RULE	
R 400.15308	**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: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. (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. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner. (e) Withhold food, water, clothing, rest, or toilet use. (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats. (g) Refuse the resident entrance to the home. (h) Isolation of a resident as defined in R400.14102(1)(m). (i) Any electrical shock device.

ANALYSIS:	Licensee Designee/ Administrator- Courtney Carver stated the incident took place on 08/14/2022. Ms. Carver stated she reviewed the building recorded video. She stated she observed Ms. Brown grab Resident A by the arm while standing. She stated she then observed Ms. Brown forcefully swing Resident A head first into a leather recliner. Staff-Diane Brown stated, “I grabbed [Resident A’s] hand and forcefully put [Resident] down in a chair.” Ms. Brown sated she did do it aggressively. Ms. Brown stated, “I did make [Resident A] sit in a chair.” Ms. Brown stated it was end of her shift and she had had enough. Staff- Mark Humphrey stated he observed Ms. Brown pull Resident A by the arm, swing her around to sit down in a chair. Resident B stated she did observe Ms. Brown swing Resident A around and put her in a chair. Resident B stated Ms. Brown looked mean. Ms. Stewart stated Ms. Brown has a history of being abusive towards residents. Therefore, Ms. Brown used a form of physical force with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action, I recommend that the status of the license remains the same.

10/25/2022

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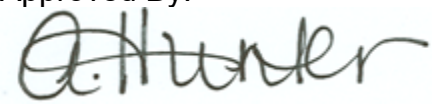
Shatonla Daniel — Date
Licensing Consultant

Approved By:



10/25/2022

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Ardra Hunter — Date
Area Manager