GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 21, 2022

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

RE: License #: AL820073559
Investigation #: 2023A0101001
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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820073559
Investigation #:	2023A0101001
Complaint Receipt Date:	09/29/2022
Investigation Initiation Date:	10/04/2022
Report Due Date:	11/28/2022
Licensee Name:	Crystal Creek Assisted Lvng Inc
Licensee Address:	8121 Lilley Canton, MI 48187
Licensee Telephone #:	(734) 927-7025
Administrator:	Courtney Carver, Designee
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?
Resident A fell on the floor in the facility on 09/13/2022, and again on 09/14/2022. Resident A was not assessed, and she did not receive medical care. After the fall on 09/14/2022, Resident A was screaming and complaining of leg pain. There was a noticeable bruise on her left hip. On 09/17/2022, the hospice nurse came out to the facility, and determined Resident A's hip was fractured.	No
On 09/13/2022, Resident A fell on the floor in the facility and the fall was not reported.	No
Additional Findings	Yes

III. METHODOLOGY

09/29/2022	Special Investigation Intake 2023A0101001
09/29/2022	Referral received from APS
10/04/2022	Special Investigation Initiated - Telephone Licensee Designee Courtney Carver
10/04/2022	Contact - Document Received incident reports & hospice file
10/05/2022	Contact - Document Received additional hospice file
11/04/2022	Inspection Completed On-site
11/04/2022	Contact - Telephone call received Courtney Carver who was not onsite
11/17/2022	Contact - Telephone call made Relative 1
11/17/2022	Contact - Telephone call made The Care Team Hospice's Nurse Rachael Melligner

11/17/2022	Exit Conference with Ms. Carver

ALLEGATION: Resident A fell on the floor in the facility on 09/13/2022, and again on 09/14/2022. Resident A was not assessed, and she did not receive medical care. After the fall on 09/14/2022, Resident A was screaming and complaining of leg pain. There was a noticeable bruise on her left hip. On 09/17/2022, the hospice nurse came out to the facility, and determined Resident A's hip was fractured.

INVESTIGATION: On 10/04/2022, I received and reviewed Resident A's hospice file and the incident reports regarding Resident A falling. Resident A was one hundred two-years-old. Resident A was terminally ill and was a patient of The Care Team Hospice. According to the hospice file Resident A was at the end stage of life and the treatment plan was to provide "end stage of life care and comfort." Staff was to administer morphine and Ativan every four hours. According to the Medical Examiner's Report the cause of death was terminal disease, heart disease with heart failure. The Medical Examiner's Report also indicates there was no underlying conditions caused by drug overdose or trauma. "(i.e., FRACTURES, HEAD INJURY, ETC)"

According to the incident reports, Resident A fell on 09/13/2022, and on 09/14/2022, both falls were reported to the hospice nurse and an assessment was performed after each fall. The incident report for the fall on 09/13/2022, indicates Resident A fell off the toilet. Resident A denied any pain and a range of motion (ROM) assessment was performed. According to the Very Well Health's website range of motion (ROM) is a measure of a joint or muscle's ability to complete all of the movements it is capable of. However, the second fall showed a bruise on Resident A's left hip.

On 11/04/2022, I spoke with the Licensee Designee, Courtney Carver. Ms. Carver stated when Resident A fell on 09/14/2022, the hospice nurse was called, and she was instructed to perform a ROM assessment. After completing the ROM assessment, she was instructed to transfer Resident A to her chair and then to her bed. The hospice nurse informed Ms. Carver she would be out on 09/17/2022. Ms. Carver further stated the pain Resident A displayed was her "normal baseline pain." Ms. Carver stated Resident A had back pain.

I spoke with The Care Team Hospice's Nurse Rachael Milligner on 11/17/2022. Ms. Milligner stated she visited Resident A on 09/17/2022, and Resident A was not in pain. Ms. Milligner stated it was never determined Resident A's hip was fractured because an x-ray was never performed. However, there was a concern from some of the facility's staff that Resident A needed medical care because they assumed Resident A's hip was fractured. Ms. Milligner stated Resident A told her she did not want to go to the hospital. Ms. Milligner stated she called Relative 1 and Relative1 stated at this point there was no reason to send Resident A to the hospital.

I spoke with Relative 1 on 11/17/2022. Relative 1 stated she went to visit Resident A after each fall and Resident A was not in pain. Relative 1 stated Resident A was at the end stage of life and sending her to the hospital would only cause more distress. Furthermore, the hospital personnel would not have treated her because she was dying. The hospice nurse was at the facility on 09/17/2022, and Resident A passed away the following day.

APPLICABLE RULE	
R 400.15310	**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:	Pursuant to licensing rule 400.14304 (1) (m) a resident has "The right to refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal." Even though Resident A fell twice there was no accident or sudden adverse change in Resident A's condition that required needed care immediately. Resident A was at the end stage of life, and she refused treatment. On 10/04/2022, I reviewed the incident report regarding Resident A's fall on 09/13/2022, and 09/14/2022. Both incident reports indicate a ROM assessment was completed after each fall. Furthermore on 11/17/2022, I spoke with the hospice nurse Rachael Milligner. Ms. Milligner stated It was never determined Resident A's hip was fractured because an x-ray was never performed. According to Relative 1, Ms. Carver and Ms. Milligner, Resident A was not in pain. Also, Resident A's treatment plan indicates staff are to administer morphine and Ativan every four hours.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 09/13/2022, Resident A fell on the floor in the facility and the fall was not reported.

INVESTIGATION: On 10/04/2022, Ms. Carver emailed me the incident report regarding Resident A's fall on 09/13/2022. The incident report indicates the hospice nurse was contacted.

On 11/17/2022, I spoke with Relative 1. Relative 1 stated Resident A had resided in this facility since 2016 and the quality of care was good. Relative 1 stated whenever Resident A fell, she received a telephone call from the facility staff.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved, and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**

ANALYSIS:	There is no evidence to determine that Resident A fell on 09/13/2022, and it was not reported. On 10/04/2022, Ms. Carver emailed me the incident report regarding Resident A's fall on 09/13/2022. The incident report indicates the hospice nurse was contacted. On 11/17/2022, I spoke with Relative 1. Relative 1 stated Resident A had resided in this facility since 2016 and the quality of care was good. Relative 1 stated whenever Resident A fell, she received a telephone call from the facility's staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: The licensee failed to submit a written report to the resident's designated representative, and the adult foster care licensing division within 48 hours of Resident A's death.

On 10/04/2022, I asked Ms. Carver for the incident report regarding Resident A's death. Ms. Carver stated she could not locate an incident report regarding Resident A's death in Resident A's resident record.

On 11/17/2022, I spoke with Relative 1. Relative 1 stated she did not receive a written report regarding Resident A's death.

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:	The licensee failed to submit a written report to the resident's designated representative, and the adult foster care licensing division within 48 hours of Resident A's death. On 10/04/2022, I asked Ms. Carver for the incident report regarding Resident A's death. Ms. Carver stated she could not locate an incident report regarding Resident A's death in Resident A's resident record. On 11/17/2022, I spoke with Relative 1. Relative 1 stated she did not receive a written report regarding Resident A's death.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan I recommend the status of the license remains unchanged.

Edith Richardson — 11/18/2022 Date

Licensing Consultant

Approved By:

11/21/2022

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Ardra Hunter Date
Area Manager