GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 24, 2023

Rhandi Smith
Crystal Creek Assisted Lvng Inc
8121 N. Lilley
Canton, MI 48187

RE: License #: AL820264717
Investigation #: 2023A0901033
Crystal Creek Assisted Living 2

Dear Rhandi Smith:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820264717
Investigation #:	2023A0901033
Complaint Receipt Date:	06/28/2023
Investigation Initiation Date:	06/28/2023
Report Due Date:	08/27/2023
Licensee Name:	Crystal Creek Assisted Lvng Inc
Licensee Address:	8121 N. Lilley Canton, MI 48187
Licensee Telephone #:	(121) 977-1540
Administrator:	Rhandi Smith
Licensee Designee:	Rhandi Smith
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:	03/28/2023
Expiration Date:	03/27/2025
Capacity:	20

Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was able to elope out of a window due to the facility being short of staff at the time.	Yes

III. METHODOLOGY

06/28/2023	Special Investigation Intake 2023A0901033
06/28/2023	Special Investigation Initiated - Telephone Complainant
07/03/2023	Inspection Completed On-site Staff, Shardanay McWright
07/03/2023	Contact - Telephone call made Licensee Designee, Rhandi Smith
07/07/2023	Contact - Document Received
07/14/2023	APS Referral
07/19/2023	Contact - Telephone call made Staff, Tamari Ford
07/19/2023	Contact - Telephone call made Staff, Latoria Culver
08/04/2023	Exit Conference Licensee Designee, Rhandi Smith
08/04/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was able to elope out of a window due to the facility being short of staff at the time.

INVESTIGATION:

On 06/28/2023, I made a telephone call to the complainant. The complainant indicated that on 06/22/2023 Resident A eloped out of a window but was quickly recovered by the police and returned. The complainant was concerned that the incident happened due to being short staffed. It was explained that incident happened between 7:00 p.m. – 8:00 p.m. and there was a total of 17 residents at the time. Chenae Henry was working alone at the time and there was a floating medication technician, Tamari Ford. Tamari was responsible for administering medication in the above facility (building 2) as well as the adjourning building (building 1). The two buildings are connected by the kitchen. At the time of the elopement, Tamari was in building 1.

On 07/03/2023, I conducted an onsite inspection at the above facility during the early afternoon hours. I observed staff, Shardanay Wright, administering medication. Shardanay indicated that there were currently 17 residents in the facility. Shardanay was the medication technician on duty for the 2 adjourning buildings. The caregiver on duty at the time for the above facility was Ja'nae Parnell, who was busy assisting a resident in her room. When asked if there was any other staff currently working in the building that assist with caregiving, Shardanay indicated no just housekeeping.

On 07/03/2023, I made a telephone call to the licensee designee, Rhandi Smith. Rhandi explained that the incident happened on their midnight shift, which is 6:30 pm - 6:30 am. Rhandi stated that at the time of the incident, there was 17 residents, 1 floating medication technician, and 2 care givers on duty. When asked if they were all in building 2, Rhandi explained that there were 3 people campus wide but that the buildings are connected by the kitchen. There was a caregiver in building 1 and building 2, and the medication technician works between the two buildings.

On 07/07/2023, I received a copy of the incident report and staffing schedule from Rhandi. Based on the incident report, the elopement happened on 06/22/2023 at 7:30 pm. The incident report and staffing schedule listed 3 people working, Chenae Henry, Tamari Ford, and Latoria Culver. It was only one schedule that combined scheduling for the 2 buildings as if it was one.

On 07/19/2023, I made a telephone call to Tamari, who stated there were 3 staff on duty total amongst the 2 buildings. Tamari was the medication technician and was responsible for administering medications in both buildings. During the time of the incident, Tamari was in building 1 Chenae was the only staff in building 2.

On 07/19/2023, I made a telephone call to Latoria. Latoria was working in building 1 at the time of the incident and indicated that there were 2 staff on duty for each building. When asked who was on duty, Latoria stated Tamari worked with her in building 1 and assisted Chenae in building 2.

On 08/04/2023, I conducted an exit conference with Rhandi. I explained that although the midnight shift is 6:30 p.m. – 6:30 a.m., it consists of wake hours. The incident happened at 7:30 p.m. and based on licensing rules, there should have been at least 2 staff on duty. Rhandi insisted that this has always been the staffing schedule and that there were 2 staff on duty. I explained that a floating medication technician cannot be in both buildings at that same time and therefore, cannot be counted as staff in both buildings. I also explained that although the buildings are connected, they are licensed separately and should be treated as such.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the

	responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Based on the information obtained during this investigation, the allegations are confirmed. On 06/22/2023, there was insufficient staff on duty during wake hours. It was confirmed that there were 17 residents and only one staff in the building. The other staff, Tamari Ford, was the floating medication technician, and was in the other adjourning building working at the time. Therefore, during the time of the incident the staffing ratio was 1:17. **{REPEAT VIOLATION SIR #2021A0778032}**
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the license remains unchanged.

_________________________________ 08/17/2023
Regina Buchanan Date
Licensing Consultant

Approved By:

_________________________________ 08/24/2023
Ardra Hunter Date
Area Manager