GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2024

Michelle Cloyd
Crystal Creek Assisted Living Inc
8121 N. Lilley
Canton, MI 48187

RE: License #: AL820294548
Investigation #: 2024A0121039
Crystal Creek Assisted Living 3

Dear Mrs. Cloyd:

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,

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820294548
Investigation #:	2024A0121039
Complaint Receipt Date:	07/10/2024
Investigation Initiation Date:	07/15/2024
Report Due Date:	09/08/2024
Licensee Name:	Crystal Creek Assisted Living Inc
Licensee Address:	8121 N. Lilley Canton, MI 48187
Licensee Telephone #:	(734) 927-7025
Administrator:	Michelle Cloyd
Licensee Designee:	Michelle Cloyd
Name of Facility:	Crystal Creek Assisted Living 3
Facility Address:	8011 Lilley Canton, MI 48187
Facility Telephone #:	(734) 453-3203
Original Issuance Date:	03/16/2009
License **Status:**	REGULAR
Effective Date:	05/14/2024
Expiration Date:	05/13/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED; ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 7/6/24, there were no staff observed at the facility, only a housekeeper. The housekeeper stayed late because there was no other staff present. Staff are not present at least weekly, and this has been an ongoing issue at the facility. There have been times when staff left for the day, and no one showed up to cover the rest of the day or night shift.	Yes
Resident A is frequently left in soiled depends for an unknown amount of time. Resident A is supposed to be turned every 2 hours, but this isn't happening. As a result, the resident's bedsores are increasing in number and size.	No
Note: The allegation surrounding Nurse Supervisor, Yolanda Williams cursing at Resident B's family member will not be investigated as it is not rule related.	

III. METHODOLOGY

07/10/2024	Special Investigation Intake 2024A0121039
07/15/2024	Special Investigation Initiated - Telephone Call to Witness 1. Voicemail full, so I was unable to leave a message.
07/15/2024	Contact - Telephone call made Left message for Licensee designee, Michelle Cloyd
07/16/2024	Contact - Telephone call received Return call from Mrs. Cloyd
07/16/2024	Contact - Telephone call made Call to Witness 1. Voicemail is full again.
07/19/2024	Inspection Completed On-site Interviewed Activities Coordinator, Tori Williamson and Resident Care Coordinator, Yolanda Williams, Office Manager, Andrew Morris, and Resident B and C, and licensee designee, Michelle Cloyd.

08/05/2024	Contact - Telephone call made Follow up call to Mrs. Cloyd
08/08/2024	Contact - Telephone call made Direct Care Staff (DCS) Danielle Carter
08/08/2024	Contact - Telephone call made Call to Witness 1. Voicemail is full again.
08/09/2024	Contact - Telephone call made Follow up with Mrs. Cloyd
08/09/2024	Adult Protective Service (APS) Referral Janet Mills assigned.
08/16/2024	Contact - Telephone call received Janet Mills with APS
08/23/2024	Contact - Telephone call made Relative A
08/28/2024	Contact - Telephone call received Relative A
08/28/2024	Inspection Completed On-site Canton Police Department
08/28/2024	Inspection Completed-BCAL Sub. Compliance Interviewed Mrs. Cloyd, Ms. Williams, Resident D and E.
08/29/2024	Contact - Telephone call made Left message for Relative A
08/29/2024	Contact - Telephone call made Kenyatta Sabir with APS
09/03/2024	Contact - Telephone call made Relative A
09/04/2024	Contact - Telephone call made Karen Roberson with The Information Center
09/04/2024	Contact - Telephone call made Nurses Courtney Cope and Stepanie Huss with Angela Hospice
09/05/2024	Exit Conference

	Mrs. Cloyd

ALLEGATION: On 7/6/24, there were no staff observed at the facility, only a housekeeper. The housekeeper stayed late because there was no other staff present. Staff are not present at least weekly, and this has been an ongoing issue at the facility. There have been times when staff left for the day, and no one showed up to cover the rest of the day or night shift.

INVESTIGATION: On 7/15/24, I tried to initiate the complaint with a phone call to Witness 1, but I received the person's voicemail with an outgoing message that the mailbox is full and cannot receive messages at this time. I also conducted interviews with licensee designee, Michelle Cloyd, current and former direct care staff, and residents. I completed 2 unannounced on-site inspections, interviewed support staff from outside agencies, and family members. To date, I have not been able to make successful contact with Witness 1 after 2 more failed attempts to reach this witness by phone.

Mrs. Cloyd reported the facility maintains adequate staffing by scheduling one direct care staff (DCS) and one "Med Tech". According to Mrs. Cloyd, the Med Tech "floats" between building 3 and building 1. It should be noted that Crystal Creek has 4 licensed facilities side-by-side on the same campus. Staff are scheduled to work at each building as needed. Mrs. Cloyd reported there are currently 14 residents in care. Residents range in age between 50-100, and they have a variety of physical and mental issues, including, but not limited to, hypertension, incontinence, bed sores, dementia, and lack of mobility. Most residents also require assistance with their activities for daily living. Mrs. Cloyd indicated all staff are "cross-trained" to provide care no matter what job title they possess, including management positions.

On 7/19/24 and 8/28/24, I completed unannounced on-site inspections at the facility. Catrina Mitchell was the DCS on duty on 7/19/24 with Soluchukwu assigned as the Med Tech (floater). On 8/28/24, Erica Nathan was on duty and Yolanda Williams was the Med Tech (floater). However, when I arrived at the facility on 8/28/24, I only observed Ms. Nathan on the premises with Office Manager, Margo Ladd in her office. Ms. Ladd explained her role at the facility is Sales. When asked about staffing, Ms. Ladd told me there were 2 staff on duty, 1 DCS and 1 Med Tech. However, I only observed Ms. Nathan caring for residents. Ms. Ladd explained that the Med Tech was "in the back" probably caring for a resident in their bedroom. Once Mrs. Cloyd was notified of my arrival, she soon walked over. Ms. Williams walked over to building 3 with Mrs. Cloyd. They both reported that Ms. Williams is the assigned Med Tech on duty. Resident B-D reported that residents have been left unsupervised on multiple occasions. Each resident explained there have been times when they come out of their rooms to look for staff and no one is in sight. Resident B and D said they will even search the premises for staff assistance, and

no one was available in the common areas or the like. As a result, Resident B-D reported sometimes resident needs are left unmet due to staffing issues.

I interviewed former DCS Danielle Carter on 8/8/24. Ms. Carter confirmed residents are left unsupervised. Specifically, Ms. Carter reported that she observed former DCS Iyanna Smith leave the residents unsupervised for at least 2 hours in the evening on 4/6/24. Instead of providing care and supervision to residents at building 3, Ms. Carter reported Ms. Smith stayed over in building 1 chatting with another DCS on duty there. Ms. Carter expressed concern that Ms. Smith did not properly supervise the residents on 8/8/24.

On 9/3/24, I interviewed Relative A. Relative A reported staffing is a major problem at the facility. According to Relative A, visitors cannot leave the premises without sounding the door alarm unless staff enter a code to open the door. Relative A stated she's gone to the facility to visit Resident A, and there were at least 20 separate occasions that she had to wait an extended period for staff to let her in or out of the building. Relative A is adamant that staff are not always on the premises. Relative A explained that sometimes staff have come from other buildings to unlock the door. Per Relative A, she's had to wait up to 2 hours to get released from the building. Also, Relative A reported she's received phone calls from Resident A to report staff are not available to respond to the emergency call button placed in every resident bedroom. Relative A reported Resident A expressed fears about being left home alone at the facility.

On 9/5/24, I completed an exit conference with Mrs. Cloyd. I informed Mrs. Cloyd that the needs of the residents require at least 2 staff on duty at all times especially considering they have at least 4 residents who require the regular use of a wheelchair. Mrs. Cloyd concurred with the findings and recommendation of this investigation surrounding staffing and pledges to add additional staffing.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based upon my interviews with residents, family, and former staff, I determined Crystal Creek Assisted Living 3 has not maintained adequate staffing to care for the needs of the residents. Plus, on 8/28/24, I observed the facility was not adequately staffed as the second staff on duty (Ms. Williams) was not on the premises when I arrived at the facility. Because Mrs. Cloyd walked in with Ms. Wiliams on the day of inspection, it is apparent, Mrs. Cloyd had knowledge of the staffing shortage.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is frequently left in soiled depends for an unknown amount of time. Resident A is supposed to be turned every 2 hours, but this isn't happening. As a result, the resident's bedsores are increasing in number and size.

INVESTIGATION: I made 3 attempts to reach the complainant for additional information surrounding the allegation to no avail. Therefore, I relied heavily on witness statements from others, including Resident A's legal representative in the form of a healthcare power of attorney (POA). For reporting purposes, Resident A's POA will be referred to in this report as Relative A. I also interviewed Kenyatta Sabir with the APS "Strike Team" and 2 hospice nurses responsible for providing care to Resident A while she was placed at the facility. Per Mrs. Cloyd, Resident A was admitted to the facility in March, and she moved out on 7/26/24, so she was only in placement 4 months. Mrs. Cloyd indicated Resident A moved into the facility with a bedsore near her coccyx (A.K.A. "tailbone"). As the placement continued, Mrs. Cloyd acknowledged Resident A's wound worsened; however, Mrs. Cloyd stated Relative A contributed to the wound not healing properly. Mrs. Cloyd reported Relative A refused to follow physician orders regarding Resident A's wound care. Instead, Relative A would change Resident A's bandages more frequently than recommended. According to Mrs. Cloyd, the Medical Director at Angela's Hospice provided staff instructions to change Resident A's bandages every Monday, Wednesday, and Friday or more often if she soils with urine or feces. However, Mrs. Cloyd said Relative A would change the bandages daily, multiple times per day if desired. Mrs. Cloyd explained these frequent bandage changes likely interfered with the healing process because each time a bandage is removed, "skin cells are ripped away."

On 8/29/24, I interviewed Kenyatta Sabir with APS. Mr. Sabir reported Resident A's bedsore near her tailbone had worsened so bad, he called emergency services to have the resident transported to the hospital. According to Mr. Sabir, Resident A's bedsore had advanced to a Category 4 wound which caused "a big gapping hole

that turned black from rot." Additionally, Mr. Sabir reported Resident A required emergency surgery because "the black mass had to be cut out." Mr. Sabir also reported Mrs. Cloyd told him it wasn't the facility's responsibility to treat Resident A's wounds because the resident was on hospice.

On 9/4/24, I contacted the hospice nurses responsible for providing care to Resident A while at the facility. Nurse case manager, Courtney Cope with Angela Hospice cared for Resident A when she was first placed at the facility. Ms. Cope reported hospice went to the facility at least 1 time weekly to change Resident A's bandages. Ms. Cope indicated she is uncertain if the facility followed Resident A's care orders or not. However, Ms. Cope reported Resident A required a 2-person assist because the resident is obese, and bed bound. Ms. Cope stated, "We always had a hard time turning her … she was big and unable to move on her own." Ms. Cope determined Resident A required a higher acuity level of care than what the facility staff is equipped to provide based on a lack of staffing and experience. Nurse case manager, Stephanie Huss with Angela Hospice cared for Resident A two weeks prior to her discharge from the facility. Ms. Huss reported she went to the facility twice weekly to monitor and care for Resident A's wounds. Ms. Huss inherited Resident A's case from Ms. Cope, so she was not able to establish a baseline for the wound's progression. However, Ms. Cope acknowledged Resident A's wounds did worsen, so she added a debridement ointment to help preserve the remaining skin tissue. According to Ms. Huss, it is possible the ointment caused some moisture to the area. Overall, Ms. Huss stated she didn't notice any evidence to suggest the facility was not changing Resident A's bandages as directed.

On 9/5/24, I completed an exit conference with Mrs. Cloyd. Mrs. Cloyd remains adamant that the facility followed all physician orders in response to Resident A's wound care. Mrs. Cloyd denied having ever suggested the facility had been absolved of its responsibility to provide care to Resident A once hospice care was assigned. Mrs. Cloyd insisted Relative A contributed to Resident A's wound worsening. Mrs. Cloyd acknowledged she advised Mr. Sabir that Resident A would be terminated from hospice care if she goes to the hospital for emergency medical treatment.

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:	Based on my interviews with 2 nurse case managers responsible for providing wound care to Resident A while at the facility, I determined there is insufficient evidence to prove the facility was responsible for Resident A's wound worsening. Both nurses indicated there may have been other mitigating factors that contributed to Resident A's wound not healing properly.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

09/16/24

Kara Robinson Date
Licensing Consultant

Approved By:

9/16/24

Ardra Hunter Date
Area Manager