GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 1, 2024

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

RE: License #: AL820294548
Investigation #: 2024A0121041
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 #:	2024A0121041
Complaint Receipt Date:	07/23/2024
Investigation Initiation Date:	07/24/2024
Report Due Date:	09/21/2024
Licensee Name:	Crystal Creek Assisted Living Inc
Licensee Address:	8121 N. Lilley Canton, MI 48187
Licensee Telephone #:	(734) 453-3203
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 7/11/24, staff failed to take Resident A's blood pressure as required before each medication pass.	No
Staff left Resident A's medication in her room without seeing the resident take them.	Yes

III. METHODOLOGY

07/23/2024	Special Investigation Intake 2024A0121041
07/24/2024	Special Investigation Initiated - Letter Email to licensee designee, Michelle Cloyd; notified Mrs. Cloyd of the new allegations.
07/26/2024	Contact - Document Sent Email to Mrs. Cloyd requesting Resident A's medication records.
07/30/2024	Contact - Document Received Received Resident A's medical records requested (Medication Administration Records and Physician orders)
08/02/2024	Contact - Telephone call made Left message for Mrs. Cloyd
08/05/2024	Contact - Telephone call received Text from Mrs. Cloyd to confirm receipt of voice message. Licensee indicated she will call back after 2:00 p.m. today.
08/06/2024	Contact - Telephone call made Follow up call to Mrs. Cloyd since she didn't call yesterday as planned. No answer, to I left a message.
08/09/2024	Contact - Telephone call received Phone interview with Mrs. Cloyd.
08/23/2024	Contact - Telephone call made Left message for Karen Roberson with The Information Center
08/27/2024	Contact - Telephone call made

	Left message for Ms. Roberson.
08/28/2024	Inspection Completed On-site (unannounced) Interviewed Mrs. Cloyd, Resident B and C.
09/03/2024	Contact – Telephone call made Relative B
09/04/2024	Contact - Telephone call made Phone interview with Ms. Roberson.
09/17/2024	Contact - Telephone call made Phone interview with Relative A.
09/19/2024	Contact - Telephone call made Direct Care Staff (DCS) Latoria Culver
09/23/2024	Contact - Telephone call made Phone interview with Resident A.
09/23/2024	Contact - Telephone call made Phone interview with Resident B.
09/23/2024	Exit Conference Mrs. Cloyd
09/25/2024	Contact – Telephone call made Follow up with Mrs. Cloyd; left a message since there was no answer.

ALLEGATION: On 7/11/24, staff failed to take Resident A's blood pressure as required before each medication pass.

INVESTIGATION: I initiated the complaint with an email to licensee designee, Michelle Cloyd. Upon request, Mrs. Cloyd sent copies of Resident A's July 2024 Medication Administration Records (MAR) and vitals. Resident A is prescribed Midodrine Tab 2.5MG with label instructions to "take 1 tablet by mouth twice daily *Hold for systolic blood pressure greater than 140, diastolic blood pressure is greater than 90". Therefore, Resident A is required to have her blood pressure taken twice daily before administering each dose of Midodrine which is used to increase her blood pressure. I reviewed Resident A's MAR. I determined Resident A's midodrine was signed out on 7/11/24 at 9:00AM by DCS Myesha Hines; it was signed out again the same day at 9:00PM by DCS Latoria Culver. I also reviewed Resident A's vital records. On 7/11/24 at 9:00AM, Resident A's blood pressure is recorded as

136/84 and at 9:00PM it's recorded as 120/80. Based on these readings, Resident A was directed to take both doses of midodrine on 7/11/24 since her blood pressure was within the normal range on this day.

On 9/23/24, I completed an exit conference with Mrs. Cloyd. Resident A moved out of the facility on 8/9/24; it was a voluntary discharge per Mrs. Cloyd. Mrs. Cloyd maintains that all residents, including Resident A receive their medications as prescribed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	DCS Myesha Hines and Latoria Culver administered Resident A's midodrine medication as prescribed on 7/11/24 based on the daily MAR.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff left Resident A's medication in her room without seeing the resident take them.

INVESTIGATION: On 9/17/24, I interviewed Relative A who emphasized Resident A must have her blood pressure taken before staff administer the midodrine tablet because it can have severe consequences causing stroke if the medication isn't regulated properly. According to Relative A, Resident A keeps a log of her blood pressure readings every time they're taken. In addition, Relative A and Resident A have a daily routine that affords Relative A the opportunity to monitor Resident A's medication from a distance. Resident A counts the number of pills given and reports that number to Relative to ensure everything is accurate. Relative A reported that she was on the phone with Resident A on 7/11/24, when Ms. Culver brought her evening medication to the bedroom. Relative A explained Resident A was given 4 pills like normal which included the midodrine tablet. However, Relative A reported Ms. Culver left the room before Resident A consumed the tablets.

On 9/19/24, I interviewed DCS Latoria Culver. Ms. Culver confirmed Resident A and Relative A usually talk on the phone when it is time for medication to be administered. In fact, Ms. Culver reported Relative A calls like "clockwork" when it's time to administer resident medication. I asked Ms. Culver if she stands there to watch Resident A consume all tablets and she responded, "I give them privacy … that's their routine …" Ms. Culver also stated she doesn't have to stand there and

“micro-manage” Resident A taking medication because she can “trust her” to take her medicine, unlike some of the lower-functioning residents.

On 9/23/24, I interviewed Resident A by phone. Resident A reported sometimes staff would not watch her take the medicine, “but most times they would.” Resident A could not recall the name(s) of staff that did not supervise her taking medication.

Relative B was interviewed by phone on 9/3/24. Relative B reported staff do not always supervise the taking of resident medication. Relative B reported there are major staffing issues at the facility which negatively impacts resident care. Relative B expressed concern that residents are not properly cared for at the facility with special emphasis on the lack of supervision.

On 9/23/24, I completed an exit conference with Mrs. Cloyd. I called Mrs. Cloyd back on 9/25/24, and since there was no answer, I left a message with the updated findings and recommendation concerning resident medication.

APPLICABLE RULE	
R 400.15312	**(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.**
ANALYSIS:	Relative A-B and Resident A all reported direct care staff do not always supervise the taking of resident medication. Instead, staff will place resident medication in a dispenser cup and deliver it to their respective bedrooms without staying until all medication is consumed. Ms. Culver is a trained Med Tech who reported she doesn’t always “stand over” certain residents as they take prescribed medication, if she deems them responsible.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/25/24

Kara Robinson — Date
Licensing Consultant

Approved By:

10/01/2024

Ardra Hunter — Date
Area Manager