GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 17, 2024

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

RE: License #: AL820073559
Investigation #: 2024A0101034
Crystal Creek Assisted Living I

Dear Ms. 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,

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 #:	2024A0101034
Complaint Receipt Date:	07/23/2024
Investigation Initiation Date:	07/23/2024
Report Due Date:	09/21/2024
Licensee Name:	Crystal Creek Assisted Living Inc
Licensee Address:	8121 N. Lilley Canton, MI 48187
Licensee Telephone #:	(734) 927-7025
Administrator:	Michelle Cloyd
Licensee Designee:	Michelle Cloyd
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:	04/03/2024
Expiration Date:	04/02/2026
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was found in the woods behind the facility tipped over in her wheelchair.	Yes
Additional finding(s).	Yes

III. METHODOLOGY

07/23/2024	Special Investigation Intake 2024A0101034
07/23/2024	Special Investigation Initiated -Telephone Licensee Designee, Michelle Cloyd
07/25/2024	Contact - Telephone call received Ms. Cloyd
07/25/2024	Contact - Telephone call made Resident A's caseworker, Margo Cooper, The Information Center
07/30/2024	Contact – Document received Incident report Resident A's assessment plan
07/31/2024	Adult Protective Services referral made
08/08/2024	Inspection Completed-BCAL Sub. Compliance Interviews Resident A Ms. Cloyd
08/27/2024	Contact – Document received Assessment plans on all the residents
08/28/2024	Contact – Document sent Canton Police Department Records Request A letter requesting the police report.
08/28/2024	Contact – Telephone call made Med Tech Tamari Ford

08/28/2024	Contact – Telephone call made Direct care staff (DCS) Taylor Bradley
08/30/2024	Contact – Telephone call made DCS Justice Sanders
09/10/2024	Contact – Document received Police report
09/10/2024	Contact – Telephone call made Ms. Cloyd
09/17/2024	Contact - Telephone call made Resident A's Power of Attorney James Bacheller
09/26/2024	Contact – Document received Ms. Sanders
09/27/2024	Inspection completed onsite. Interviewed Ms. Cloyd and DCS Yolanda Williams.
10/09/2024	Exit Conference with Ms. Cloyd

ALLEGATION: Resident A was found in the woods behind the facility tipped over in her wheelchair.

INVESTIGATION: Crystal Creek Assisted Living I is a large group home on a campus with three other large group homes. Each of these facilities have a licensed capacity is 20. Crystal Creek I consists of eighteen resident bedrooms and the common area. The common area is at the front of the facility and consists of the dining room, living room and activity room. There are no walls separating the common area. The kitchen is off the common area and is shared with Crystal Creek II. There is a door in both buildings leading to the kitchen. The kitchen has a door to the outside.

On 07/23/2024, I contacted the Licensee Designee, Michelle Cloyd regarding the allegation. Ms. Cloyd stated that she was unaware that an incident of that nature occurred at Crystal Creek Assisted Living Inc. On 07/25/2024, I received a telephone call from Ms. Cloyd. Ms. Cloyd stated when she arrived to work on 07/24/2024, she noticed that an incident report had been placed under her office door. Ms. Cloyd stated on 07/06/2024, there were three staff on duty Direct Care Staff (DCS) Taylor Bradley, DCS Justice Sanders and the Med Tech, Tamari Ford. Ms. Cloyd stated it was Ms. Sanders' first day of work and she spent it shadowing Ms. Bradley. Furthermore, at the time of the incident Ms. Ford was not in Crystal Creek I. The

Med Tech is responsible for administering medication in the four licensed facilities located on the corporation's campus. According to Ms. Cloyd, Resident A was left in the common area of the facility unattended. Resident A entered the kitchen and left the building through the kitchen door leading to the outside. Ms. Cloyd stated the door alarm to the kitchen door is only audible in Crystal Creek II and during this incident Crystal Creek II was not occupied. Therefore, no one heard the alarm when it went off.

On 08/08/2024, I interviewed Ms. Cloyd and Resident A. Ms. Cloyd reiterated the information she stated in our phone conversation on 07/23/2024. On 07/25/2024, Ms. Cloyd sent me a copy of Resident A's assessment plan. According to Resident A's assessment plan she has dementia. On 08/08/2024, I attempted to interview Resident A. Resident A could not provide any information relevant to this investigation.

On 08/28/2024, I received a copy of the police report from the Canton Police Department. According to the police report a portion of the third shift was dispatched to the facility at 10:16 p.m. for a missing person. The police report documented, "Employees informed that Resident A had been missing since 6:30 pm. Employees had advised she uses a wheelchair and that she often sneaks out toward a vacant building employee also advised of trails in the forest west of Crystal Creek. Officers discovered [Resident A] lying on the ground in the forest." After the Canton Fire Department Emergency Medical Technician completed a triage assessment, Resident A's power of attorney declined sending her to the hospital.

On 08/28/2024, I spoke with the Med Tech Tamari Ford. Ms. Ford stated on 07/06/2024, at approximately 7:30 p.m. she administered Resident A's medication at the dining room table. Ms. Ford stated she was not in Building I when Resident A went missing. She was in another building passing medications. Ms. Ford stated at approximately 9:00 p.m. she received a telephone call from Ms. Bradley. Ms. Bradley informed Ms. Ford that she could not find Resident A.

I spoke with DCS Taylor Bradley on 08/28/2024. Ms. Bradley stated on 07/06/2024, she arrived to work at 6:30 p.m. and could not locate Resident A. Ms. Bradley would not or could not provide any other information. When I proceeded to ask Ms. Bradley detailed questions she responded, "I don't remember." On 09/10/2024, I spoke with Ms. Cloyd. Ms. Cloyd stated the day after I spoke with Ms. Taylor she quit.

On 08/28/2024, I attempted to call DCS Justice Sanders at the phone number she provided to her employer. The telephone number on file with her employer is currently a non-working number. On 09/10/2024, I spoke with Ms. Cloyd. Ms. Cloyd stated Ms. Sander also quit at the commencement of my investigation.

On 09/10/2024, I spoke with Ms. Cloyd. Ms. Cloyd stated Resident A does not have a history of sneaking out of the facility.

On 09/17/2024, I spoke with Resident A's power of attorney. Resident A's power of attorney stated when his mother eloped, he was notified at approximately 11:45 p.m. and he declined sending her to the hospital. He also stated that he was not aware that Resident A had any other elopements. Resident A's power of attorney stated he is satisfied with his mother's placement.

On 09/27/2024, I interviewed DCS Yolanda Williams. Ms. Williams stated that on 07/06/2024, Resident A went through the kitchen and entered Building II. Resident A was able to open the front door in Building II. Even though the alarm did go off in Building II you cannot hear it in Building I. Ms. Williams stated Resident A was familiar with gaining access to Building II via the kitchen because she would enter Building II that way before the fire.

On 09/27/2024, I conducted on onsite inspection. Ms. Cloyd clarified that Resident A did not exit via the kitchen door. Ms. Cloyd stated Resident A entered Building II through the kitchen and went out of Building II front door.

On 10/09/2024, I conducted an exit conference with Ms. Cloyd. Ms. Cloyd agrees with my findings.

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:	The licensee did not attend to Resident A's personal needs including, protection and safety at all times. On 07/06/2024, Resident A eloped from Crystal Creek in her wheelchair. The Canton Police found her in the forest behind the facility lying on the ground.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/08/2024, I reviewed the resident register and the staff schedule. The capacity in Building I is 17. According to the resident's assessment plans, two residents are diagnosed with dementia and two residents are labeled as confused. Two residents require a two-person lift and seven residents are in wheelchairs. Residents in wheelchairs require assistance from one staff when

transferring. According to the staff schedule two DCS are scheduled to work a 12-hour shift. Also scheduled during the 12-hour shift is a med tech. The med tech floats between the four licensed facilities on this campus. However, the med tech is responsible for administering the medications in all four facilities which would prevent her from leaving if an emergency should arise. Therefore, whenever the two people on shift are assisting in a two-person lift, there is no one else available to meet the needs of the other residents. Furthermore, according to Ms. Cloyd and Ms. Ford it was Ms. Sanders first day of work and she was shadowing Ms. Bradley. On 09/26/2024, Ms. Cloyd forwarded me a copy of Ms. Sanders' training. On 07/06/2024, Ms. Sanders was also assigned the task of completing the Toolbox Training, an approved self-study training tool. On 09/27/2024, I reviewed Ms. Sanders employee record. Ms. Sanders was not fully trained. She did not have cardiopulmonary resuscitation and first aid training. Therefore Ms. Sander should not have been included the ratio of DCS to residents because she did not meet the qualifications of DCS.

On 10/09/2024, I conducted an exit conference with Ms. Cloyd. Ms. Cloyd agrees with my findings.

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:	Having two DCS on duty is not adequate to meet the needs of the population and the number of residents this home serves. On 08/08/2024, 17 residents were residing in the home. According to the residents' assessment plans two residents are diagnosed with dementia and two residents are labeled as confused. Two of the residents require a two-person lift and seven residents are in wheelchairs. Residents in wheelchairs require one person assistance with transferring. Whenever the two DCS on shift are assisting in a two person lift there is no one else available to meet the needs of the other residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(3) Any individual, including a volunteer, shall not be considered in determining the ratio of direct care staff to residents unless the individual meets the qualifications of a direct care staff member.
ANALYSIS:	July 6, 2024, was Ms. Sanders first day of work. On that date Ms. Sanders' assigned tasks consisted of completing the Toolbox Training and shadowing trained staff. Furthermore, on 07/06/2024, Ms. Sanders was not fully trained. She did not have cardiopulmonary resuscitation and first aid training. Therefore Ms. Sander should not have been included in the ratio of DCS to residents because she did not meet the qualifications of DCS.
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
Licensing Consultant

10/15/2024
Date

Approved By:

10/17/2024

Ardra Hunter
Area Manager

Date