GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 03, 2025

Marcia Curtiss
Crystal Creek Assisted Living Inc
8121 N. Lilley
Canton, MI 48187

RE: License #: AL820294548
Investigation #: 2025A0992005
Crystal Creek Assisted Living 3

Dear Mrs. Curtiss:

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 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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820294548
Investigation #:	2025A0992005
Complaint Receipt Date:	11/08/2024
Investigation Initiation Date:	11/12/2024
Report Due Date:	01/07/2025
Licensee Name:	Crystal Creek Assisted Living Inc
Licensee Address:	8121 N. Lilley Canton, MI 48187
Licensee Telephone #:	(734) 453-3203
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
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?
● Resident medications were observed unattended on top of the medication cart to be administered to each resident. The resident medications were in small cups with their room number on it. There are concerns regarding the lack of supervision and the possibility of a resident getting the wrong medication. ● The night shift medication techs are not consistently administering scheduled medications to Resident B. The staff is signing the medication log as if the medications were given.	No Yes
On 11/10/24, Resident C was sleeping all day and had not eaten. She was hungry and thirsty. The staff were unable to supply a snack for Resident C. Resident C did not have access to water. The staff directed Resident C's visitor to go to the kitchen to get water. There are concerns Resident C may be sleeping through her meals and is not being fed properly.	No
Note: There were allegations surrounding staffing that were reported and were not addressed in this investigation. The allegations surrounding staffing were previously investigated in SIR #2024A0121039.	

III. METHODOLOGY

11/08/2024	Special Investigation Intake 2025A0992005
11/11/2024	APS Referral #203253, denied.
11/12/2024	Special Investigation Initiated - On Site Vice President of Operations, Marcia Curtiss; Regional Director of Operations, Kelly Mcann; Medication Tech 2.
11/12/2024	Contact - Telephone call made Complainant
11/14/2024	Contact - Telephone call made Resident B's power of attorney, Relative B1.
11/15/2024	Inspection Completed On-site

	Ms. Curtiss; Operations manager, Sarah Reynolds; and Ms. Mcann.
11/18/2024	Contact - Document Received Resident B's medication administration record (MAR) for six months.
12/04/2024	Inspection Completed On-site Ms. Reynolds.
12/04/2024	Contact - Telephone call made Ms. Curtiss was unavailable. Message left.
12/12/2024	Contact - Telephone call made Ms. Curtiss
12/20/2024	Exit Conference Ms. Curtiss
12/30/2024	Contact - Telephone call made Medication Tech 3
1/02/2025	Contact - Telephone call made Resident C's power of attorney, Relative C1.
1/02/2025	Inspection Completed On-site Residents B and C.

ALLEGATION:

● Resident medications were observed unattended on top of the medication cart to be administered to each resident. The resident medications were in small cups with their room number on it. There are concerns regarding the lack of supervision and the possibility of a resident getting the wrong medication.

● The night shift medication techs are not consistently administering scheduled medications to Resident B. The staff are signing the medication log as if the medications were given.

INVESTIGATION: On 11/12/2024, I completed an unannounced onsite inspection and interviewed Vice President of Operations, Marcia Curtiss; Regional Director of Operations, Kelly McCann; and Medication Tech 2 regarding the allegation. Prior to addressing the allegation, Ms. Curtiss made me aware that Parallel Management has entered into a purchase agreement with the current owner of the facility and there has been a change in leadership, and some were terminated. She stated as a

result of these changes, a lot of complaints have been filed against the facility, as a method of retaliation. Ms. Curtiss denied having any knowledge of the allegation. However, Ms. McCann stated she was previously made aware of the allegation and conducted an internal investigation. She stated she interviewed Medication Techs 1 and 2; and had them walk through the process as they prepare to administer and pass medications. Ms. McCann stated Medication Techs 1 and 2 did not prep the medications or put the residents' medication in small cups with their room number on it. She stated all "rights of medication" were followed.

I interviewed Medication Tech 2. She denied the allegation. She stated medications are given at the time they are prescribed. She denied having any knowledge of the medications being prepped and dispensed into cups or left unattended. She stated only the medication techs administer medications and there is one medication tech per shift. She stated they use an electronic MAR, which is username and password protected. She stated medications are time specific and administered one resident at a time. I requested her to demonstrate a medication pass, which she agreed. She escorted me to the medication cart, which was locked in the office, and residents do not have access to the office. I did not observe any medications prepped in cups or left unattended. Medication Tech 2 stated the medication cart is mobile and there are times when she will take the cart to the resident's room, if they are unable to make it to the cart or having a bad day. She stated while in the resident's bedroom, the cart is locked, and she only accesses that specific resident's medications. She stated that medications are not left unsupervised. As she demonstrated each step, she made me aware that the MAR separates the residents by picture and name for accuracy. She stated you must scan the medication and once the medication is given the medication technician clicks the day and time, and her initials automatically populate. I observed all "rights of medication" were followed and no discrepancies noted.

On 11/14/2024, I contacted Resident B's power of attorney, Relative B1 regarding the allegation. Relative B1 was reluctant to address the allegation. Relative B1 stated that Resident B is doing well and there are no concerns at this time. Relative B1 stated there is "no need to rock the boat." Relative B1 stated Resident B is very happy with the living arrangements and all is well. Relative B1 stated whatever occurred in the past has been addressed and there are no issues at this time. Relative B1 stated there has been some restructuring and staffing changes and expressed satisfaction with the quality-of-care Resident B is receiving.

On 11/15/2024, I completed a follow-up inspection and made face-to-face contact with Ms. Curtiss; Operations manager, Sarah Reynolds; and Ms. Mcann. I requested six months of MAR records for Resident B, which Ms. Curtiss agreed to provide.

On 11/18/2024, I received Resident B's medication administration record (MAR) for six months. Based on the documentation reviewed, the following medications were not initialed:

June 2024
6/28/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
6/30/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
6/28/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
6/30/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
6/28/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.
6/30/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.

July 2024
07/06/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
07/07/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
07/10/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
07/21/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
7/06/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
7/07/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
7/10/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
7/21/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
7/06/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.
7/07/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.
7/10/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.
7/21/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.

August 2024
08/04/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
08/10/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
8/04/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
8/10/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
8/04/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.
8/10/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.

September 2024
09/18/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
9/18/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
9/18/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.

October 2024
10/02/2024 - busPIRone HCL 10MG TAB, take 2 tablets (20MG) by mouth three times daily for behavioral disorder was not initialed at 9:00 p.m., no explanation provided.
10/02/2024 - Divalproex TAB 500MG DR, take 1 tablet by mouth every 12 hours was not initialed at 9:00 p.m., no explanation provided.
10/02/2024 - Trazadone TAB 50MG, take ½ tablet (25MG) by mouth twice daily for anxiety was not initialed at 9:00 p.m., no explanation provided.

November 2004
No discrepancies noted.

It should be noted that there seems to be a pattern June through October when the medications were not administered and/or initialed at 9:00 p.m., with no explanation provided.

On 12/04/2024, I completed an unannounced onsite inspection and made face-to-face contact with Ms. Reynolds. I explained to Ms. Reynolds that after reviewing the MARs there were several areas of concern and asked if she could provide clarity regarding the electronic MAR. I reviewed Resident B's MARs with her. Ms. Reynolds was not sure why the medication techs initials were not entered, and no explanation

was provided. Ms. Reynolds took notes and agreed to make Ms. Curtiss aware. I observed the medication cabinet stationed in the office. No medication or cups were observed on the cart or left unattended.

On 12/12/2024, I contacted Ms. Curtiss and explained that after reviewing Resident B's past MARs there are several areas of concern. Ms. Curtiss acknowledged that there were some issues at the facility, hence the reason the facility is under new management. She stated she had assumed the responsibility a month ago and is diligently working to bring the facility into compliance.

On 12/20/2024, I conducted and exit conference with Ms. Curtiss and made her aware of my findings. I explained that although the allegation expressed concern regarding staffing, this issue was previously investigated in SIR #2024A0121039 and will not be addressed in this investigation. As far as the medications there were several areas that did not contain initials. I acknowledged that Ms. Curtiss recently assumed responsibility of the facility but stated that MARs need to be reviewed, and the medication techs made aware and in-serviced. Ms. Curtiss assured me that she will address the issues and handle it accordingly. She stated she is working around the clock to bring that facility into compliance.

On 12/30/2024, I contacted Medication Tech 3 and interviewed her regarding the allegations, which she denied. Medication Tech 3 denied that she has ever witnessed the medications being prepped and dispensed into cups or left unattended. She stated when she is on shift, she administers medications timely and is aware of the rights of medication. She further stated there are times when she must administer medications in both facilities due to staff calling off, and she still manages to administer all the resident's medications timely. Medication Tech 3 denied having any knowledge of Resident B not receiving his medications as prescribed. She said there has been a lot of changes in the company as far as hiring new staff and firing staff, but positive changes are forthcoming.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Based on my investigation, there is no evidence to support the allegation that the medication is left unattended and not in a locked cabinet. I completed multiple unannounced onsite inspections. Neither time did I observe medications left unattended or accessible to the residents. In fact, while onsite I observed the medication cart locked and in the office, which is not accessible to the residents. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on my interviews with management, facility staff members, Resident B's power of attorney and reviewing Resident B's MARs from June 2024 through November 2024, there were multiple medications that were not documented as administered. The allegation is therefore substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 11/10/24, Resident C was sleeping all day and had not eaten, she was hungry and thirsty. The staff were unable to supply a snack for Resident C. Resident C did not have access to water. The staff directed Resident C's visitor to go to the kitchen to get water. There are concerns Resident C may be sleeping through her meals and is not being fed properly.

INVESTIGATION: On 11/12/2024, I contacted the complainant regarding the allegation. The complainant stated when she arrived to visit with Resident C, Resident C was asleep. The complainant stated she spoke with the staff and staff stated Resident C had been up all night and sleeps all day. The complainant stated she observed Resident C sleeping when she entered her bedroom, but she woke up soon thereafter. The complainant stated Resident C stated it was approximately 2:30 and she had not eaten breakfast and was hungry. The complainant stated she went to alert the staff, but the staff was assisting another resident. The complainant stated she went to the kitchen to find a snack for Resident C but was unable to do so. The complainant stated the staff assisted with getting Resident C some water but was unable to provide her with a snack. The complainant was unable to recall the staff's name but stated the staff said Resident C will eat at 5:00 p.m. when dinner is served. The complainant stated the staff was very pleasant, but she is concerned Resident C is not being properly fed.

On 11/14/2024, I contacted Resident B's power of attorney, Relative B1 and inquired about the meals. Relative B1 denied having any concerns and stated the meals are "great". She stated the chef "really knows how to cook" and Resident B always finishes his food. She stated Resident B did not finish all his food when he lived at home, but the chef makes "amazing" food.

On 11/15/2024, I completed an unannounced onsite inspection. I made Ms. Curtiss; Operations manager, Sarah Reynolds; and Ms. Mcann aware of the allegation. Ms. Curtiss stated all food is prepared in building 1 and carted to building 3. However, she stated each building is stocked with snacks for the residents. She stated if a resident is sleeping at the time a meal is served, the staff will try and wake the resident and if unsuccessful, the meal is stored for them. Ms. Curtiss stated breakfast is served at 8:00 a.m.; lunch at 12:00 p.m.; and dinner at 5:00 p.m. She stated snacks are offered between meals and the staff goes around the building with the cart of snacks. Ms. Curtiss explained that although each bedroom is not equipped with a telephone, each resident has a pull cord in their bedroom if they need something such as a snack or staff assistance.

Ms. McCann provided me with a tour of the kitchen to observe the food supply. I observed the cook preparing a meal. The building is equipped with an industrial refrigerator and freezer, both of which were stocked with food items for breakfast, lunch and dinner. I also observed snack items such as peanut butter, bread, crackers, deli meat, fruit, cereal, granola bars and milk. I observed the menu which contained a minimum of 3 regular, nutritious meals daily.

On 12/20/2024, I contacted Ms. Curtiss and made her aware of my findings as it pertains to Resident C., I explained that I am unable to determine that Resident C was not provided with a minimum of 3 regular, nutritious meals daily. I further stated that I was able to observe the cook preparing food, there was adequate and nutritious food onsite. I further stated the allegation is unsubstantiated.

On 1/02/2025, I contacted Resident C's power of attorney, Relative C1 and interviewed him regarding the allegation. Relative C1 stated that unfortunately due to the demands of his employer he has not been able to visit with Resident C as frequent as he would like. He stated Resident C is 90 years old and has a very poor quality of life. He stated she sleeps 20 out of 24 hours a day. He stated he is not aware of any complaints regarding Resident C receiving food, but stated he would assess the situation. Relative C1 denied having any concerns at this time.

On 1/02/2025, I completed an unannounced onsite inspection and observed Residents B and C. I observed Resident B resting in his bedroom. Resident C was sitting in the common area. I interviewed her regarding the allegation. Resident C could not recall the reported incident. She stated the food is fine. She was unable to recall what she had to eat today. When asked about the quality of care, Resident C stated it is fine. She stated the food is fine and she is fine. Resident C denied having any concerns. Based on Resident C’s flat affect, I am not certain Resident C is competent to be interviewed.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my interviews with management, facility staff members, Resident B and C’s power of attorney and observing the food supply, there is no evidence to support the allegation that Resident C is not provided a minimum of 3 regular, nutritious meals daily. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

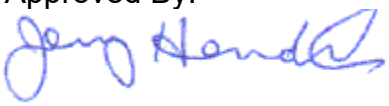
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same

01/03/2025

Denasha Walker Date
Licensing Consultant

Approved By:



01/03/2025

Jerry Hendrick Date
Area Manager