



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 27, 2025

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

RE: License #: AL820073559
Investigation #: 2025A0101033
Crystal Creek Assisted Living I

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 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) 456-0439.

Sincerely,

A handwritten signature in blue ink, appearing to read "Edith Richardson".

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 #:	2025A0101033
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/10/2025
Report Due Date:	09/05/2025
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 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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The licensee did not report that direct care staff Dominique Lynn slapped Resident A and that she stole some narcotics from the medication cart.	No
Additional Findings	Yes

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0101033
07/10/2025	Special Investigation Initiated - On Site Licensing consultant LaKeitha Stevens
07/13/2025	Contact - Telephone call made
07/31/2025	Contact - Telephone call made complainant
08/28/2025	Inspection Completed On-site Interviewed Designated person, Zachary Fisher and Jeannine Hayes RN Regional Director of Clinical Services Obtained incident report Reviewed direct care staff Dominique Lynn employee record
10/15/2025	APS Referral
10/15/2025	Inspection Completed On-site interviewed licensee designee Marcia Curtiss and Ms. Hayes Obtained letter sent to the Canton police department regarding the residents' medications.
10/16/2025	Contact – Document received Resident A's assessment plan.
10/21/2025	Contact- Telephone call made Relative A1

10/21/2025	Contact- Telephone call made Direct care staff Dominique Lynn No answer, left message
10/23/ 2025	Exit conference Ms. Curtiss

ALLEGATION: The licensee did not report that direct care staff Dominique Lynn slapped Resident A and that she stole some narcotics from the medication cart.

INVESTIGATION: On 07/31/2025, I spoke with the complainant. The complainant stated that he and ten other people observed a confrontation between direct care staff Dominique Lynn and Resident A. The complainant stated Ms. Lynn was arguing with Resident A and then she slapped her. The complainant stated it was reported to management and they did nothing about it.

On 08/28/2025, I received a copy of the written incident report documenting the verbal and physical altercation Ms. Lynn had with Resident A. According to the incident report Relative A1 was notified of this incident on the same date it occurred, 06/10/2025.

On 08/28/2025, I reviewed Dominique Lynn employee record. Ms. Lynn employee record was in compliance with licensing rules and Public Act 218.

On 10/15/2025, I interviewed the licensee designee Marcia Curtiss and the clinical nurse Ms. Hayes. They denied the allegation that Ms. Lynn stole narcotics from the medication cart. They stated that medications are counted at the end of each shift and all narcotic medications have been accounted for.

On 10/16/2025, I reviewed Resident A's assessment plan. I did not interview Resident A. According to Resident A's assessment plan Resident A is not competent due to cognitive decline.

On 10/21/2025, I spoke with Dominique Lynn. Ms. Lynn denied the allegations.

On 10/21/2025, I spoke with Relative A1. Relative A1 stated that she was notified regarding staff arguing with and slapping her mother.

APPLICABLE RULE	
R 400.15311	Incident notification, incident record.
	<p>(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following:</p> <p>(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.</p>
ANALYSIS:	<p>Based upon the preponderance of evidence the licensee reported to Resident A's representative that direct care staff Dominique Lynn was observed arguing with Resident A and then she slapped her.</p> <p>According to the incident report Resident A's representative was notified about this incident on 06/10/2025.</p> <p>Resident A's representative stated that she was notified about this incident.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION: On 07/31/2025, I spoke with the complainant. The complainant stated he observed direct care staff Dominique Lynn arguing with Resident A and then Ms. Lynn slapped her.

On 08/28/2025, I interviewed the designated person Zachary Fisher and the clinical nurse Jeannine Hayes. They stated that on 06/10/2025, direct care staff Dominique Lynn was observed arguing with Resident A and then she slapped her. They stated Ms. Lynn was taken off the scheduled pending an investigation. According to Mr. Fisher and Ms. Hayes, Ms. Lynn was terminated on 06/18/2025, for arguing with and slapping Resident A.

APPLICABLE RULE	
R 400.15308	Incident notification, incident record.
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the

	<p>licensee, employees, or any person who lives in the home shall not do any of the following:</p> <p>(b) Use any form of physical force other than physical restraint as defined in these rules.</p> <p>(f) Subject a resident to any of the following:</p> <p>(i) Mental or emotional cruelty.</p> <p>(ii) Verbal abuse.</p>
ANALYSIS:	<p>Based upon the preponderance of evidence, direct care staff Dominique Lynn used physical force with Resident A and subjected her to emotional cruelty and verbal abuse.</p> <p>The complainant stated that he observed Dominique Lynn arguing with Resident A and then Ms. Lynn slapped her.</p> <p>Mr. Fisher and Ms. Hayes stated Ms. Lynn was observed arguing with Resident A and then she slapped her. They further stated this is the reason why Ms. Lynn was terminated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommend closure of this special investigation because Crystal Creek changed ownership.



Edith Richardson
Licensing Consultant

10/21/2025
Date

Approved By:



10/27/2025

Ardra Hunter
Area Manager

Date