GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 3, 2022

Christopher Schott
The Westland House
36000 Campus Drive
Westland, MI 48185

RE: License #: AH820409556
Investigation #: 2023A1027014
The Westland House

Dear Mr. Schott:

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 authorized representative 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 (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2023A1027014
Complaint Receipt Date:	11/07/2022
Investigation Initiation Date:	11/09/2022
Report Due Date:	1/07/2023
Licensee Name:	WestlandOPS, LLC
Licensee Address:	2nd Floor 600 Stonehenge Pkwy Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Administrator:	Wanda Kreklau
Authorized Representative:	Christopher Schott
Name of Facility:	The Westland House
Facility Address:	36000 Campus Drive Westland, MI 48185
Facility Telephone #:	(734) 326-6537
Original Issuance Date:	02/25/2022
License Status:	REGULAR
Effective Date:	08/11/2022
Expiration Date:	08/10/2023
Capacity:	102
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was aggressively approached by a staff member.	No
Staff did not respond to Resident A's call light.	No
Additional Findings	Yes

III. METHODOLOGY

11/07/2022	Special Investigation Intake 2023A1027014
11/09/2022	Special Investigation Initiated - Letter APS referral sent by email
11/09/2022	APS Referral Completed by email
11/17/2022	Inspection Completed On-site
11/22/2022	Contact - Document Received Email received with letter from APS notifying the Department the referral was not opened for investigation
12/05/2022	Inspection Completed – BCAL Sub. Compliance
12/19/2022	Exit Conference Conducted with authorized representative Christopher Schott by telephone

ALLEGATION:

Resident A was aggressively approached by a staff member.

INVESTIGATION:

On 11/7/2022, the department received a complaint through the online complaint system which read on 10/23/2022, a staff member took Resident A's breakfast tray then aggressively approached her.

On 11/7/2022, I forwarded the allegations to Adult Protective Services (APS) which was not opened for investigation.

On 11/17/2022, I conducted an on-site inspection at the facility. I interviewed administrator Wanda Kreklau who stated Resident A usually slept through breakfast in which she would eat both her breakfast and lunch meals together. Ms. Kreklau stated Employee #1 threw Resident A's breakfast tray away mistakenly.

While on-site, I interviewed Resident A who stated around lunch time she questioned a staff member on where her breakfast tray went in which the staff member "charged" her. Resident A stated the staff member did not touch her. Resident A stated she did not know the staff member's name. I observed a hand-written note on the outside of Resident A's apartment door which read "*Please knock before entering I may be sleeping. If so please leave food on table. Thank u*."

While on-site, I reviewed Employee #1's file and training records which read she was hired on 7/27/2022 and started on 8/17/2022. Employee #1's Michigan Workforce Background Check dated 8/11/2022 read she was eligible for employment. Employee #1's training records dated 8/16/2022 read she received training on the following but was not limited to resident rights and responsibilities, the facility's program statement, reporting requirements and documentation, resident care supervisor duties, and the facility's associate manual.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	Resident A's attestations revealed an unknown staff member took her breakfast tray and aggressively approached her. The specific staff member was unknown, thus there was insufficient evidence to substantiate this allegation. Review of the facility's orientation training records revealed staff were trained on resident rights and responsibilities upon hire.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not respond to Resident A's call light.

INVESTIGATION:

On 11/7/2022, the department received a complaint through the online complaint system which read Resident A waited hours to receive assistance from staff.

On 11/17/2022, I conducted an on-site inspection at the facility. I interviewed Ms. Kreklau who stated staff responded to call lights promptly however there could be delays if staff were providing resident care. Ms. Kreklau stated the call light response system communicated with each staff member's walkie talkie and at the computer located at the front desk. Ms. Kreklau stated staff must enter each resident's room to turn the call light off and they could not be turned off at the computer located at the front desk. Ms. Kreklau stated if a call light was not turned off, then it rang to the front desk telephone. Ms. Kreklau stated if someone did not answer the front desk phone, then the call went to a voicemail system in which went directly to her email. Ms. Kreklau stated the facility call light system did not maintain a record of the calls. Additionally, Ms. Kreklau stated each call light had a blinking green light in which staff would press the call button as a "check-in" for each resident. Ms. Kreklau stated the blinking green light was not indicative that the call light was pushed by the resident.

While on-site, I interviewed Employee #2 whose statements were consistent with Ms. Kreklau. Employee #2 stated staff responded to call lights in the order in which they were turned on.

While on-site, I interviewed Resident A who stated it took staff "hours" to respond to her call light on numerous occasions. I observed Resident A's call light which was blinking green.

While on-site, I interviewed Resident B who stated staff responded to her call light and care was "good."

While on-site, I interviewed Resident C who stated staff responded to her call light.

I reviewed Resident A's service plan which read she self-administered her medications, dressed herself, and required checks from staff every shift.

I reviewed the facility's staff training which read in part that every resident was to be checked on.

Review of the facility's file revealed five incident reports dated from 10/21/2022 through 11/30/2022, in which two reported residents had falls in their apartments and three residents had falls in the common areas of the facility.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Resident A's attestations were consistent with the complaint. Staff attestations revealed staff responded to call lights in which a system was in place in the event staff were unable to respond in sufficient time. Review of incident reports revealed although residents had falls, there was insufficient evidence to support it was in relation to lack of response to resident's call lights.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/17/2022, Ms. Kreklau stated Resident A was respite resident through a contract with Senior Alliance. Resident A's face sheet read she moved into the facility on 10/14/2022 and was 54 years old.

APPLICABLE RULE	
MCL 333.21311	**minimum age for admission; waiver of age limitation.**
	(3) Except as otherwise provided in this subsection, a home for the aged shall not admit an individual under 55 years of age. Upon the request of a home for the aged and subject

	to subsection (4), the director shall waive the age limitation imposed by this subsection if the individual, the individual's guardian or other legal representative, if appointed, and the owner, operator, and governing body of the home for the aged, upon consultation with the individual's physician, agree on each of the following: **(a) The home for the aged is capable of meeting all of the individual's medical, social, and other needs as determined in the individual's plan of service.** **(b) The individual will be compatible with the other residents of that home for the aged.** **(c) The placement in that home for the aged is in the best interests of the individual.**
ANALYSIS:	Review of Resident A's face sheet revealed she was 54 years old in which the facility lacked documentation of an age waiver limitation request from the Department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/05/2022

Jessica Rogers Date
Licensing Staff

Approved By:

12/19/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section