



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

June 22, 2023

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

RE: License #: AH820409556  
Investigation #: 2023A1019045  
The Westland House

Dear Mr. Schott:

Attached is the Special Investigation Report for the above referenced facility; disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 284-9730.

Sincerely,

A handwritten signature in blue ink, appearing to read "Elizabeth Gregory-Weil".

Elizabeth Gregory-Weil, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(810) 347-5503

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH820409556
<b>Investigation #:</b>	2023A1019045
<b>Complaint Receipt Date:</b>	05/22/2023
<b>Investigation Initiation Date:</b>	05/23/2023
<b>Report Due Date:</b>	07/21/2023
<b>Licensee Name:</b>	WestlandOPS, LLC
<b>Licensee Address:</b>	600 Stonehenge Pkwy, 2 <sup>nd</sup> Floor Dublin, OH 43017
<b>Licensee Telephone #:</b>	(614) 420-2763
<b>Administrator:</b>	Wanda Kreklau
<b>Authorized Representative:</b>	Christopher Schott
<b>Name of Facility:</b>	The Westland House
<b>Facility Address:</b>	36000 Campus Drive Westland, MI 48185
<b>Facility Telephone #:</b>	(734) 326-6537
<b>Original Issuance Date:</b>	02/25/2022
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/11/2022
<b>Expiration Date:</b>	08/10/2023
<b>Capacity:</b>	102
<b>Program Type:</b>	AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident D is receiving inappropriate treatment by facility staff.	No
Additional Findings	Yes

## III. METHODOLOGY

05/22/2023	Special Investigation Intake 2023A1019045
05/23/2023	Special Investigation Initiated - Face to Face Onsite inspection completed
05/23/2023	Inspection Completed On-site
05/24/2023	APS Referral
05/24/2023	Inspection Completed-BCAL Sub. Compliance

### **ALLEGATION:**

Resident D is receiving inappropriate treatment by facility staff.

### **INVESTIGATION:**

On 5/22/23, the department received a complaint that read that staff are treating Resident D inappropriately. The complaint did not include examples of what the inappropriate treatment was, and no additional detail was provided. Due to the anonymous nature of the complaint, I was unable to obtain more detail.

On 5/23/23, I conducted an onsite inspection. Administrator Wanda Kreklau was onsite, however unavailable for an interview; I interviewed Employee 1 in her place. Employee 1 reported that Resident D is a new move in as of March 2023 and was unaware of any concerns associated with this resident. Employee 1 stated that Resident D is independent with all activities of daily living and that staff only provide medication assistance and housekeeping services to Resident D. Employee 1 stated that Resident D is independent with mobility, does not use any assistive devices and added that Resident D can freely leave the facility without supervision and that he does so frequently.

While onsite, I obtained Resident D’s service plan which confirmed Employee 1’s statements about his level of care. The service plan indicated that staff assist him with medications and housekeeping; all other care and tasks are done independently by the resident (mobility, transferring, dressing, bathing, grooming, toileting, feeding and laundry).

On 5/23/23, I interviewed Resident D at the facility. Resident D denied any issues with staff and stated that he has had a very positive experience living at the facility. Resident D stated that all of his needs are met, staff frequently check in on him and stated that the food at the facility is good. Resident D had no complaints about the facility and stated “It has been wonderful here. It is really nice what they do for all of the people here.”

<b>APPLICABLE RULE</b>	
<b>MCL 333.20201</b>	<b>Policy describing rights and responsibilities of patients or residents;</b>
	<b>(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.</b>
<b>For Reference MCL333.20201</b>	<b>(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.</b>

<b>ANALYSIS:</b>	Review of service plan documentation combined with Resident D's interview, there is insufficient evidence to substantiate the allegation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

In follow up correspondence with Ms. Kreklau, she reported that Employee 1 misspoke about Resident D's medication administration status and provided a copy of the incorrect service plan. Ms. Kreklau clarified that Resident D self-administers his medication and provided an updated service plan dated 4/1/23 that identified this change.

Ms. Kreklau stated that the facility has protocol in place that staff are to follow before allowing a resident to administer his/her own medications. Per the facility's "self administered medication" policy, the following must be done:

- *Resident must complete and pass the assessment for Self Administration of Medications*
- *Must have a signed letter from primary physician stating resident can self administrate [sic] all medications*

Per Ms. Kreklau, the facility did not require the resident to complete the assessment before permitting him to administer his own medications and the facility does not have a letter from the physician deeming him appropriate to complete this task. Ms. Kreklau also stated that the facility obtained permission from Resident D's guardian to allow him to administer his own medications, however, was unable to provide any evidence of such.

<b>APPLICABLE RULE</b>	
<b>R 325.1921</b>	<b>Governing bodies, administrators, and supervisors.</b>
	<b>(1) The owner, operator, and governing body of a home shall do all of the following:</b>
	<b>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</b>

<b>ANALYSIS:</b>	Facility staff did not follow their policy for medication administration and allowed Resident D to be responsible for his medications without him passing their assessment or obtaining a written letter from his physician granting permission.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

I recommend issuance of a Corrective Notice Order.



06/21/2023

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Elizabeth Gregory-Weil  
Licensing Staff

Date

Approved By:



06/21/2023

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

Date