

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA ACTING DIRECTOR

September 8, 2023

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

> RE: License #: AH820409556 Investigation #: 2023A0585069

> > The Westland House

Dear Christopher Schott

While violations have been identified in the report, a written corrective action plan is not being requested as the violations identified are covered by the scope and actions required in the Correction Notice Order dated June 22, 2023.

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 877-458-2757

Sincerely,

Brender Howard, Licensing Staff

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Bureau of Community and Health Systems

611 W. Ottawa Street

P.O. Box 30664

Lansing, MI 48909

(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2023A0585069
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Complaint Receipt Date:	06/13/2023
Investigation Initiation Data:	06/14/2023
Investigation Initiation Date:	00/14/2023
Report Due Date:	08/13/2023
Licensee Name:	Westland OPS, LLC
Licensee Address:	2nd Floor
	600 Stonehenge Pkwy
	Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Licensee Telephone #.	(014) 420-2700
Administrator:	Wanda Kreklau
A 11 : 15	
Authorized Representative:	Christopher Schott
Name of Facility:	The Westland House
Facility Address:	36000 Campus Drive
	Westland, MI 48185
Facility Telephone #:	(734) 326-6537
	20/05/2000
Original Issuance Date:	02/25/2022
License Status:	REGULAR
Effective Date:	08/11/2022
Expiration Date:	08/10/2023
Expiration batol	00,10,2020
Capacity:	102
Due sugare True co	ACED
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A could not be found in the facility for an unknown length of time.	Yes
Additional Findings	No

III. METHODOLOGY

06/13/2023	Special Investigation Intake 2023A0585069
06/14/2023	Special Investigation Initiated - Letter Emailed referral to Adult Protective Services (APS).
07/07/2023	Inspection Completed On-site Completed with observation, interview and record review.
07/12/2023	Contact Document Sent Requested additional documents from administrator Wanda Kreklau.
07/12/2023	Contact Document Received. Requested documents received.
07/12/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A could not be found in the facility for an unknown length of time.

INVESTIGATION:

On 6/13/2023, the department received the allegations via the BCHS Online Complaint website. The complaint alleged that they received a call on 2/1/2023 at 10:30 a.m. that Resident A was missing, and they couldn't find her. The complaint alleged that at 1:00 p.m. she got another call from the staff telling her that they had found Resident A. It was alleged that Resident A was found at the bottom of the stairwell on the first floor.

On 6/14/2023, I made a referral to Adult Protective Services (APS).

On 7/7/2023, an onsite was completed at the facility. I interviewed administrator Wanda Kreklau at the facility. Ms. Kreklau stated that staff went to get Resident A after breakfast, and she was not in her room. She stated that staff started searching for Resident A and they couldn't find her at first. Ms. Kreklau stated that she found

her sitting on the first-floor steps. She stated that Resident's room is on the fourth floor, and she was able to go down the stairwell. She stated that Resident A was monitored every two hours. She stated that the alarm was working but she doesn't know how Resident A got down the stairwell.

On 7/28/2023, I interviewed Relative A1 by telephone. Relative A1 stated that when they found Resident A at the bottom of the stairs on the first floor, she stated that Resident A was sent to the hospital and was diagnosed with hypothermia. She stated that although Resident A did not go outside in the freezing temperature, her body temperature was down.

Service plan for Resident A read, "check on every hour."

APPLICABLE RULE		
R 325.1931	Employees; general provisions.	
	(2) A home shall treat a resident with dignity and his or personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.	

R 325.1901	Definitions.
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
	(f) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A was noted to be missing around 10:30 a.m. from her apartment of the fourth floor. Resident A was found around 1:00 p.m. sitting on the steps of the stairwell on the first floor of the facility. The service plan noted that Resident A is to be checked on every hour. She was able to go down the stairwell without any staff knowing her whereabouts for at least two and a half hours before the facility initiated searching for Resident A. Therefore, the facility did not comply with this rule.
CONCLUSION:	REPEAT VIOLATION ESTABLISHED [Please reference Corrective Notice Order dated 6/22/2023, R 325.1931(2)]

IV. RECOMMENDATION

I recommend continued monitoring through the Corrective Notice Order dated 6/22/2023.

Grender d. Howard 08	9/08/2023
Brender Howard Licensing Staff	Date
Approved By:	
mohed maore	9/08/2023
Andrea L. Moore, Manager Long-Term-Care State Licensing Section	Date