GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 30, 2023

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

RE: License #: AH820409556
Investigation #: 2023A1027083
The Westland House

Dear Licensee:

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,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2023A1027083
Complaint Receipt Date:	07/25/2023
Investigation Initiation Date:	07/26/2023
Report Due Date:	09/24/2023
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 lacked care consistent with his service plan.	Yes
The facility was short staffed.	No
Additional Findings	Yes

III. METHODOLOGY

07/25/2023	Special Investigation Intake 2023A1027083
07/26/2023	Special Investigation Initiated - Letter Email sent to Wanda Kreklau and Chris Schott requesting documentation pertaining to Resident A
07/26/2023	Contact - Document Received Email received from Wanda Kreklau with requested documentation
08/25/2023	Inspection Completed On-site
08/25/2023	Inspection Completed-BCAL Sub. Compliance
08/31/2023	Exit Conference Conducted with Christopher Schott by email

ALLEGATION:

Resident A lacked care consistent with his service plan.

INVESTIGATION:

On 7/25/2023, the Department received allegations from Adult Protective Services (APS) which read Resident A had two strokes one month ago which caused him to have mobility problems. The allegations read Resident A's daughter was his durable power of attorney. The complaint read Resident A required staff assistance with activities of daily. The allegations read facility staff believe Resident A requires skilled nursing care due to his needs. The allegations read staff believed Resident A was falling on purpose and do not say hello to him. The allegations read Resident A had not been out of bed for three days because staff were not assisting him. The

allegations read Resident A calls his daughter when he needs something. The APS report read that the allegations were not opened for investigation.

On 7/26/2023, additional allegations were received through the online complaint system which read consistent with the allegations received from APS. The complaint read Resident A was not turned/rotated to prevent bed sores. The complaint read on 7/20/23 and 7/22/23 emergency medical services (EMS) were called to assist Resident A because he had fallen out of bed due to staff not being able to respond promptly. The complaint read Resident A had experienced delays in his meals and assistance with transfers.

On 8/25/2023, I conducted an on-site inspection at the facility. I interviewed administrator Wanda Kreklau who stated Resident A had multiple sclerosis (MS) and utilized a motorized wheelchair. Ms. Kreklau stated staff would ride in the elevator throughout the day with Resident A to ensure he was safe entering and exiting. Ms. Kreklau stated Resident A utilized his cell phone to call the front desk to request assistance instead of the pull cord to summon for staff. Ms. Kreklau stated Resident A would get upset with staff if they were unable to respond to his call in a timely manner. Ms. Kreklau stated there was receptionist on duty seven days a week form 9:00 AM to 10:00 PM which was split between two staff. Ms. Kreklau stated the call light monitor was located at the receptionist desk. Ms. Kreklau stated the receptionist staff utilized a walkie talkie to inform staff of resident's call lights so they could respond. Ms. Kreklau stated staff were required to check the call light monitor minimally once an hour throughout the night and anytime receptionist was not present at the front desk. Ms. Kreklau stated if the telephone rang at the front desk and it was not answered and the voicemail picked up, then whether a voicemail message was left or not; she received an email informing her of the time and date of the missed call. Ms. Kreklau stated she had observed in her emails when Resident A had called the front desk then followed up with staff on duty.

While on-site, I interviewed Resident A who stated, "most of the time it's pretty good." Resident A stated his pull cord did not work. Resident A stated he had a wound on buttock area in which the Veterans Affairs (VA) provided a nurse for weekly visits. Resident A stated staff "cleaned" him up twice daily. Resident A stated staff were supposed to check on him every two hours, but they didn't. Resident A stated he got up every morning for breakfast; however, sometimes staff did not get him up for breakfast so he would need to call to have his meal delivered. Resident A stated he had left sided weakness in which he had minimal use of his left arm and leg. Resident A stated he was in his bed currently due to the power outage.

While on-site, I observed Resident A's pull cord next his bed was too short for him to reach. I observed the pull cord in the bathroom was longer and appeared to have an extension on it. I observed Resident A's cell phone was located on his bedside table next to him. At the time of inspection, there was a power outage in which the generator was running all emergency outlets and main lighted areas; however, the call lights were not working so staff were conducted frequent rounds on all residents.

While on-site, I interviewed Employee #1 who stated if it was too early in the morning, Resident A preferred to get out of bed and into his wheelchair after breakfast. Employee #1 stated Resident A was in his wheelchair during lunch and dinner. Employee #1 stated every morning she conducted rounds on all residents assigned to her, then let the kitchen staff know who would need a meal tray delivered. Employee #1 stated the meal trays were delivered to the resident's apartments at the same time the meals were served in the dining room. Employee #1 stated Resident A automatically received a meal tray for breakfast. Employee #1 stated sometimes Resident A would call too early for the tray in which case it would be delivered as soon as the meal was served.

While on-site, I interviewed Employee #2 whose statements were consistent with previous staff interviews. Employee #2 stated Resident A utilized the bathroom pull cord appropriately. Employee #2 stated there was an extension on the pull cord next to his bed, but someone must have removed it. Employee #2 stated Resident A utilized a seatbelt in his wheelchair as well as a cushion between his legs. Employee #2 stated she observed resident's meal trays were delivered at meals times around 7:00 to 8:00 AM for breakfast and 11:30 AM to 1:00 PM for lunch.

While on-site, I interviewed Employee #3 whose statements were consistent with previous staff interviews. Employee #3 stated Resident A required two-person assistance to transfer to his wheelchair.

I reviewed Resident A's face sheet which read his daughter was his authorized representative.

I reviewed Resident A's service plan which read he admitted on 4/14/2023 and was reviewed on 8/1/2023. The plan read Resident A required one person assistance and was fully dependent for personal hygiene in which he received showers on Tuesdays and Fridays. The plan read Resident A had left sided weakness. The plan read for staff to try to place things in Resident A's hand so he could do some self-care. The plan read Resident A was fully incontinent and required complete assistance from staff. The plan read Resident A was fully dependent, and one person assist for dressing and transfers. The plan read Resident A could self-propel with a wheelchair and one person assistance. The plan read Resident A was a fall risk, to be sure his seatbelt is on and to put things within reach when possible. The plan read Resident A had a history of an ulcer on his buttocks in which was currently healed, and the VA nurse was using a preventative dressing to keep skin intact. The plan read Resident A was fully alert and orientated. The plan read to place items near Resident A to avoid having him reach. The plan read Resident A had behavioral concerns in which he may yell at staff and knock things over if upset. The plan read to approach him calmly and allow him to express frustration in which it did not happen often. The plan read Resident A was on a regular diet and had an allergy to cheese, as well as the medication Amlodipine. The plan read Resident A had a VA nurse who visited weekly for a wound.

I reviewed Resident A's "*Assessment Resident Form*" which read consistent with his service plan.

I reviewed Resident A's incident reports.

> Incident report dated 4/29/2023 read in part Resident A was on the floor by his chair. The report read in part the measures to prevent reoccurrence was to implement a foot pedal buddy to prevent him from sliding out of the wheelchair and should be checked every shift to ensure his seatbelt was in place.
>
> Incident report dated 6/5/2023 read in part staff observed Resident A on the floor on his right side. The report read in part the nurse completed an assessment. The report read in part under measures to prevent reoccurrence to tilt back the wheelchair to prevent Resident A from sliding out if it and that his seatbelt must be checked every shift.
>
> Incident report dated 7/19/2023 read in part Resident A tried to reach from his phone and fell off the bed. The report read under corrective measures to prevent reoccurrence that staff educated Resident A to summon for assistance by pulling the call cord and staff will ensure all items are on his bed side table within reach.

I reviewed Resident A's care coordinator notes.

> Note dated 5/2/2023 and written by Employee #4 read consistent with the incident report dated 4/29/2023. The note read in part Resident A stated he fell leaning too far forward to reaching for his cell phone.
>
> Note dated 6/5/2023 and written by Employee #4 read consistent with the incident report dated 6/5/2023. The note read Resident A stated he hit his head and had a small laceration on assessment in which Employee #4 monitored him every 15 minutes for a change in condition.
>
> Note dated 7/20/2023 and written by Employee #4 read consistent with the incident report dated 7/19/2023. The note read Resident A called EMS to pull him up in bed because no staff responded when he called the front desk. The note read Employee #4 was informed there were not staff at the front desk and staff came to check the call lights frequently, as well as the residents. The note read Resident A stated he liked to get up at 8:00 AM and sometimes he did not want to get up because it took staff too long to put him back to bed. The note read staff would be educated on Resident A's care.
>
> Note dated 7/23/2023 read in part Resident A declined to get out of bed at 8:00 AM and Employee # 1 cleaned and dressed him for the day. The note read at 1:30 PM on 7/23/2023, Resident A called the front desk and asked to get out of bed and Employee #1 stated she needed to complete her medication pass, as well as check and changes, then she could assist him. The note read the

afternoon shift arrived and assisted Employee #1 with Resident A's care in which he then declined to get out of bed and was on his phone. The note read Resident A knocked items of his bedside table. The note read Resident A called 911 and police to assist him off the floor; however, when they arrived, he was in bed on his phone. The note read Employee #1 called Resident A's daughter who stated she would speak with him about his behaviors.

I reviewed Resident A's Behavior Management Plan dated 7/14/2023 which read in part Resident A swore at a staff member due to the staff member asking him several questions about traveling up and down the elevator since staff were unable to transfer with him several times. The plan read when Resident A does not get his way, he yells and knocks things over.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1901	**Definitions. Rule 1. As used in these rules:**
	(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.

ANALYSIS:	Staff attestations and review of Resident A's records revealed he was dependent for staff assistance with his activities of daily living and had a history falls. Staff attestations revealed Resident A was required two-person assistance for care; however, his service plan read one person assistance. There was insufficient evidence to substantiate Resident A was left in his bed for days or that staff did not respond when summoned. Observations revealed Resident A's pull cord next to the bed was too short for it to be utilized and to summon for staff assistance, as well as it could not be determined if he required one- or two-person assistance, thus the facility lacked ensuring protection was provided.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Please reference Corrective Notice Order dated 6/22/2023]**

ALLEGATION:

The facility was short staffed.

INVESTIGATION:

On 7/26/2023, additional allegations were received through the online complaint system which read Resident A experienced delays in meals and assistance for transfers due to short staffing.

On 8/25/2023, I conducted an on-site inspection at the facility. I interviewed administrator Wanda Kreklau who stated staff worked three shifts: 6:00 AM to 2:30 PM, 2:00 PM to 10:30 PM and 10:00 PM to 6:30 AM. Ms. Kreklau stated there were usually six resident care staff on duty for both the morning and afternoon shifts, and three staff on duty at night. Ms. Kreklau stated staff on midnights were assigned to first, third and fifth floors. Ms. Kreklau stated the facility utilized a staffing agency called Kare agency when staff called off duty.

While on-site, I interviewed Employee #3 who stated there were approximately three residents who required two-person assistance and two resident who were bed-bound.

While on-site, I observed six resident care staff on duty. I observed approximately 20 residents who appeared clean and well groomed.

I reviewed the resident roster which read there were 82 residents.

I reviewed the July and August 2023 staffing schedules which read consistent with statements from Ms. Kreklau.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Staff attestations and review of facility documentation revealed there was sufficient staff on duty to meet the needs of the residents consistent with their service plans. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's face sheet revealed it was left blank in the following areas: move in date, civil status, and physician's address.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(3) The resident record shall include at least all of the following: **(a) Identifying information, including name, marital status, date of birth, and gender.** **(b) Name, address, and telephone number of next of kin or authorized representative, if any.** **(c) Name, address, and telephone number of person or agency responsible for the resident's maintenance and care in the home.** **(d) Date of admission.** **(e) Date of discharge, reason for discharge, and place to which resident was discharged, if known.** **(f) Health information, as required by MCL 333.20175(1), and other health information needed to meet the resident's service plan.**

	(g) Name, address, and telephone number of resident's licensed health care professional. **(h) The resident's service plan.**
ANALYSIS:	Resident A's face sheet record was incomplete thus a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/30/2023

Jessica Rogers — Date
Licensing Staff

Approved By:

08/31/2023

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