GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2024

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

RE: License #: AH820409556
Investigation #: 2024A1035049
The Westland House

Dear Christopher Schott:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2024A1035049
Complaint Receipt Date:	06/10/2024
Investigation Initiation Date:	06/11/2024
Report Due Date:	08/10/2024
Licensee Name:	WestlandOPS, LLC
Licensee Address:	2nd Floor 600 Stonehenge Pkwy Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Administrator:	Christopher Schott
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:	08/11/2023
Expiration Date:	08/10/2024
Capacity:	102
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was abused by a staff member.	No
Additional Findings	No

III. METHODOLOGY

06/10/2024	Special Investigation Intake 2024A1035049
06/11/2024	Special Investigation Initiated - Letter
07/10/2024	Contact - Face to Face
08/05/2024	Inspection Completed BCAL Full Compliance
08/05/2024	Exit Conference Conducted by email with the authorized representative.

ALLEGATION:

Resident A was abused by a staff member

INVESTIGATION:

On June 10, 2024, the Department received a complaint forwarded from Adult Protective Services (APS) which read “Resident A suffered a fall and closed displaced fracture of left ring finger. On 06/08 around 1am, Resident A was transported to Trinity Health Livonia via ambulance. Resident A had a large bruise on her right temple. Resident A’s left ring finger was dislocated. Resident A initially did not remember what happened. Resident A thought she may have fallen and hit her head. Later on, during the morning, Resident A recalled that she was pushed by a staff member into a chair and that's how she was hurt. Resident A believes that she got the broken finger and bruise due to an aggressive aid in the facility. Resident A did not disclose the aid's name that was at the facility. Resident A feels safe at the home to return.” APS did not open an investigation pertaining to the allegations.

On June 14, 2024, the department received an additional complaint forwarded from APS initiated by law enforcement which read: Resident A has difficulty walking and uses a walker to ambulate. She receives assistance with ambulating, using the restroom, and maintaining her living space. Staff Person (SP)3 is a caregiver at Westland House. On 6/7/2024, Resident A was trying to call for help for 45 minutes to

use the bathroom. Resident A soiled herself while waiting. SP3 came into the room to help and walked Resident A to the restroom. SP3 did not help Resident A with changing her clothes and Resident A changed her own clothes. SP3 did not take off Resident A's soiled brief and put a new brief on over top of the soiled one. SP3 wheeled Resident A back to the recliner and asked her to stand. Resident A asked for help with standing up, and SP3 told her "no you can do it". SP3 grabbed Resident A's left hand and slammed her into the recliner. Resident A also fell on the night after this incident, and she went to St Mary's Hospital. Resident A was found to have a broken left finger, bruise on right side of her face from the incident or the fall. SP3 was hired temporarily through Care.com and is no longer employed at Westland House.

On July 10, 2024, an onsite investigation was conducted. While onsite I interviewed Christopher "Chris" Schott AR/ Admin who states investigation was conducted by the Director of Nursing who no longer is employed with the company. Chris was able to provide facility investigation, progress notes, and education provided to staff. Chris reports SP3 was contracted through an agency, the incident was reported to the police, and her employer.

On July 10, 2024, I interviewed Resident A who stated this was an isolated event, the home itself is not the problem SP3 is the problem. Resident A does not recall falling and states she requested to be placed in her wheelchair and escorted to the main door for EMS to pick her up. Resident A statement of events related to the care provided by SP3 coincides with statements above and incident report. Resident A reports she plans on returning to the facility post hospital stay.

On July 10, 2024, I interviewed SP1 who states Resident A was observed laying on her right side next to her bed. SP1 states Resident A stated she did not fall, restated SP3 was rough with her and was nervous about going to the hospital. SP1 states a male agency staff member assisted getting Resident A up.

On July 10, 2024, I interviewed SP2 who states he wasn't there for the incident, he responded to assist SP1. SP2 states lates time he rounded prior to the incident, Resident A was in her recliner and declined going to bed. SP2 states Resident A was observed on floor and he assisted SP1 with placing her in the chair. At this time "Resident A didn't not want to go to the hospital."

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(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:	Through record review and interview, Resident A is Alert & Orientated x 4 able to make needs known, requires one person assist with transfers, and uses a walker. Resident A states she plans on returning to the facility. Resident A recalled SP3 mistreating her but does not recall falling. SP1 and SP2 followed facility policy when Resident A was observed on floor with "bruised left finger and large knot on head." Range of Motion was preformed and documented prior to positioning Resident A in chair, vital signs taken, physician, responsible party, and Director of Nursing Notified. Resident A was sent to the hospital for further evaluation. Resident A and SP1 notified Clinical Care Coordinator of incident related to SP3 being rough, not handling Resident A with care, and lacking professionalism, with Director of Nursing, at the time, initiated an internal investigation notifying local law enforcement and agency in which SP3 worked. Facility following incident and accident policy and procedure and ensured that SP3 would no longer work at the facility. Therefore, this allegation has not been substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

8/1/2024

Jennifer Heim — Date
Licensing Staff

Approved By:

08/05/2024

Andrea L. Moore, Manager — Date

Long-Term-Care State Licensing Section