STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

August 26, 2024

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

RE: License #: AH820409556
Investigation #: 2024A1022060
The Westland House

Dear Christopher. 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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2024A1022060
Complaint Receipt Date:	06/28/2024
Investigation Initiation Date:	07/01/2024
Report Due Date:	08/28/2024
Licensee Name:	WestlandOPS, LLC
Licensee Address:	2nd Floor 600 Stonehenge Pkwy Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Administrator/Authorized Rep	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?
The Resident of Concern (ROC) has bruising and skin tears of unknown origin.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/28/2024	Special Investigation Intake 2024A1022060
07/01/2024	Special Investigation Initiated - Letter Request sent to APS worker for additional information.
07/10/2024	Contact - Telephone call made Investigation conducted remotely via videoconference.
08/26/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) has bruising and skin tears of unknown origin.

INVESTIGATION:

On 06/28/2024, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that read, “There was a routine visit (by the APS worker) with [name of the Resident of Concern/ROC] on May 13th and May 16th. [Name of the ROC] has bruises all over her legs and arms. There is a skin tear on one of her legs. There were new bruises on [name of the ROC] from one day to the next. When the facility was asked about it, they are not sure how it happened and did not have any incident reports or other documentation. [Name of the ROC] has been observed with new bruises over the last week. She is combative at times, but it is unknown if the bruises are from that or something else. [Name of the ROC]'s short-term memory is very bad, and she is unable to provide any explanation for the bruises.”

The APS worker did not provide any additional information.

On 07/01/2024, additional information was supplied by APS, regarding the ROC. According to this second referral, “On Friday, June 28, 2024, [name of the ROC] was observed with marks on her left cheek… The scabs look as if something happened to her face and/or her face was injured and there are now scabs on her face. The origin of these marks is unknown, and [name of the ROC] does not know what caused them either…” The referral source for his additional information was the hospice social worker.

On 07/10/2024, I interviewed the authorized representative (AR), the resident care coordinator and the business office manager remotely, in a videoconference. According to the AR, the previous administrator who was a licensed nurse, had been terminated for cause and the facility’s only other licensed nurse, the director of nursing (DON) had quit without prior notice on 07/08/2024. When I asked them about the ROC and the events described in the two complaints, none of the facility managers were able to explain as there had been no charting done in the ROC’s health record since the beginning of June 2024.

The ROC was described as requiring total care from caregivers and was on hospice care due to dementia. She was unable to reliably answer questions, required the assistance of 2 caregivers to complete her activities of daily living, had a diagnosis of atrial fibrillation and was on a blood thinner. According to her service plan, the ROC was combative and resistive to care.

The facility provided multiple Residential Communication Forms, written by hospice staff that included documentation dated 06/26/2024, written by hospice employee #1 that documented, “scratch with scab on left cheek…”

The facility provided two incident reports (IR), the first one dated 05/03/2024, when hospice nurse #2 made a visit to the ROC and subsequently reported that the ROC had skin tears of both hands, as well as an old bruise. The IR indicated that the hospice nurse would provide protective sleeves as well as a protective skin treatment for the ROC. The second IR, dated 05/14/2024, documented that the caregiver observed that the ROC’s right hand was bruised and swollen. This IR further noted that the ROC had “thin, frail skin” and should have her right hand elevated when swelling was observed. Neither of the IRs noted the cause of the tears or the bruising. The AR acknowledged that there had been no follow-up to investigate the origins of the bruising or the scabs. The AR went on to say that those investigations were the responsibility of the former administrator and the former DON, but neither of them were present to answer for their lack of follow-up.

Review of the facility’s policy, Accident/Incident Documentation and Reporting revealed that the policy expected the report to include “The corrective measures taken to prevent future incident/accidents from occurring.”

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(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: **(e) A patient or resident is entitled to receive adequate and appropriate care** **(l) A patient or resident is entitled to be free from mental and physical abuse**
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.**
For Reference: R325.1901	**Definitions.**
	(16) "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:	It was not possible for the facility to determine what measures should be instituted to prevent recurrence because they had not determined what caused the injuries in the first place.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the investigation, neither the AR, the resident care coordinator, nor the business office manager were able to say why the facility's documentation did not match up with the reports provided by the APS worker or hospice nurse #1. When asked which employees were expected to document in the resident health record, the AR stated that at the present, it was only the licensed staff, which would have been either the former DON or former administrator. The AR went on to say that the facility was in the middle of transitioning from a paper record to an electronic one, and once that transition had been made, all of the caregivers and medication technicians would be able to enter notes into the record. However, for the time being, caregivers and med techs made entries into a communications log. This log would be reviewed by either of the two licensed staff members before the pertinent information was transferred into the health record. However, the AR acknowledged that this system had not functioned as intended for the ROC. According to the business office manager, the last charting entry for the ROC was made at the beginning of June 2024.

The facility provided a series of Communication Log entries, used by the caregivers to communicate to the managers observations they made of residents. Review of these log entries revealed the following information.

> On 05/14/2024, caregiver #2 documented "(resident) has right had swelling."
>
> On 05/16/2024, caregiver #2 documented that "hospice (nurse) wrapped right arm and said the swelling was fluid retained in arms/hands. Resident (the ROC) has swelling on right (illegible). Redness and warm to the touch. Hospice is aware. Please keep an eye out (illegible) if it worsens call hospice…"
>
> On 06/07/2024, caregiver #1 documented "As I (caregiver #1) was changing [name of the ROC] I observed a skin tear on her lower back right side. [Hospice name] was also contacted."

On 06/25/2024, caregiver #3 documented "went into room to complete check and change and (observed) skin tear on cheek, chin and arm. Ointment applied."

On 06/29/2024, caregiver #1 documented, "I (caregiver #1) walked in (resident) scratched her face. Blood was dripping from the scratch. There wasn't a nurse here (at the facility)."

As the AR had explained, none of the caregiver observations had been recorded in the ROC's heath record, because only the licensed staff were able to do that.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility did not document important observations made by personnel other than their licensed nurses.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 08/26/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

08/26/2024

Barbara Zabitz — Date
Licensing Staff

Approved By:

08/20/2024

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