GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2023

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

RE: License #: AH820409556
Investigation #: 2023A1019014

Dear Mr. 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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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. 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,

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

License #:	AH820409556
Investigation #:	2023A1019014
Complaint Receipt Date:	01/18/2023
Investigation Initiation Date:	01/19/2023
Report Due Date:	03/17/2023
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 is being improperly discharged.	No
Additional Findings	Yes

III. METHODOLOGY

01/18/2023	Special Investigation Intake 2023A1019014
01/19/2023	Special Investigation Initiated - Letter Emailed administrator for additional information.
01/24/2023	APS Referral Notified APS of the allegations via email referral template.
01/24/2023	Inspection Completed On-site
01/24/2023	Inspection Completed BCAL Sub. Compliance
01/26/2023	Contact- telephone call made Called administrator to conduct interview, left message with staff who reported she was in a meeting.
01/27/2023	Contact- telephone call received Phone interview conducted with administrator.

ALLEGATION:

Resident A is being improperly discharged.

INVESTIGATION:

On 1/18/23, the department received a complaint that Resident A is being evicted from the facility. The complaint read that he/she does not feel that the resident can be evicted based on the reasons listed in the notification provided to the resident and reports that Resident A's rent is paid.

On 1/24/23, I conducted an onsite inspection. Administrator Wanda Kreklau was not present, so Employee 1 was interviewed in her absence. Employee 1 reported that

Resident A was given a discharge notice on 1/18/23 due to his illicit drug use. Employee 1 stated that Resident A was supposed to receive substance abuse treatment, but he has never followed through. Employee 1 stated that this has been an ongoing issue with and most recently Resident A suffered an overdose on 1/9/23 after being found slumped over and unresponsive on the toilet in his apartment. Employee 1 stated that prior to his overdose, she and Ms. Kreklau found a suspicious powdery substance in Resident A's apartment. Employee 1 stated that police were contacted. Employee 1 stated that the police came out to the facility and confiscated the substance but confirmed that it was an illegal drug. Employee 1 stated that it was believed to be heroin.

On 1/27/223, I conducted a phone interview with Ms. Kreklau. Ms. Kreklau stated that there have been ongoing behavioral issues with Resident A pertaining to his substance abuse. Ms. Kreklau stated that Resident A was offered drug treatment and declined. Ms. Kreklau confirmed Employee 1's attestation that the police were called after drugs were found in Resident A's apartment. Ms. Kreklau stated that the police stated the substance was either heroin or methamphetamine. Ms. Kreklau also reported that Resident A was found unresponsive and needed to be revived by EMS on 1/9/23. Ms. Kreklau stated that the drug Narcan, which is used to reverse the effects of opioids had to be used twice on Resident A. Ms. Kreklau stated that following that incident she spoke with Resident A, his sister who is his authorized representative and The Information Center (supports coordinator through the Medicaid waiver program) and discussed that he was going to be given a discharge notice. Ms. Kreklau stated that they are working collaboratively to find placement for Resident A although he does not want to move out.

Resident A's discharge letter was reviewed, and it contained all of the information that home for the aged administrative rules require.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(a) The reasons for discharge.** **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**

ANALYSIS:	Resident A's discharge notice was in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/9/23, staff found Resident A on unconscious on the toilet. Emergency medical services were called, and Resident A needed to be revived by administering Narcan to him. Ms. Kreklau stated that it was confirmed Resident A had overdosed. Resident A was sent to the hospital following this incident however the facility did not submit an incident report for the event.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.** **(2) The original incident/accident report shall be maintained in the home for not less than 2 years.** **(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.**

ANALYSIS:	The facility failed to submit an incident report to the department for Resident A's 1/9/23 medical emergency.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [for reference, see special investigation report (SIR) 2023A0784014 and 2022A1027058]**

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

01/27/2023

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

02/02/2023

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