GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 15, 2023

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

RE: License #: AH820409556
Investigation #: 2023A1027051
The Westland House

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. 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.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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) 241-1970.

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) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2023A1027051
Complaint Receipt Date:	03/08/2023
Investigation Initiation Date:	03/08/2023
Report Due Date:	05/07/2023
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 was neglected and lacked protection.	Yes
Additional Findings	No

III. METHODOLOGY

03/08/2023	Special Investigation Intake 2023A1027051
03/08/2023	Special Investigation Initiated - Letter Email sent to Mr. Schott and Ms. Kreklau requesting Resident A's medical records
03/08/2023	Contact - Document Received Email received from Ms. Kreklau with requested documentation
03/08/2023	Contact - Document Received Additional allegations received from complainant #2
04/14/2023	Inspection Completed-BCAL Sub. Compliance
04/27/2023	Exit Conference Conducted by voicemail with authorized representative Christopher Schott, then by email with Mr. Scott and Ms. Kreklau

ALLEGATION:

Resident A was neglected and lacked protection.

INVESTIGATION:

On 3/8/2023, the Department received a complaint through the online complaint system which read Resident A was neglected. The complaint read staff did not assist Resident A with dressing or toileting in which she had fallen three times in three days. The complaint read Resident A had fallen eight times since admission to the facility. The complaint read Resident A was left on the floor after her falls for hours. The complaint read the ambulance had been called twice to assist Resident A after her falls. The complaint read on 3/3/2023, Resident A fell and laid on the floor for hours in which she broke her femur bone. The complaint read Resident A was supposed to receive checks every two hours.

On 3/8/2023, the Department received additional allegations which read consistent with the previous allegations related to the fall 3/3/2023. The complaint read on 3/3/2023 Resident A pulled her emergency cord in the bathroom and staff did not respond. The complaint read Resident A called Complainant #2 to tell her she was on the floor and was in a lot of pain. The complaint read Complainant #2 called the facility's front desk and Employees #1 and #2 went to her room. The complaint read Complainant #2 arrived at the facility and called the ambulance from Resident A's lifeline button in which she was transported to the hospital. The complaint read Resident A required emergency surgery on 3/4/2023 for a broken femur bone. The complaint read Resident A had resided at the facility for six months.

I reviewed Resident A's face sheet which read she moved into the facility on 11/1/2022 and Relative A was her authorized representative.

I reviewed Resident A's service plan updated on 3/1/2023. The plan read Resident A's diagnoses were anemia, ASCVD [atherosclerotic cardiovascular disease], hypertension, COPD [chronic obstructive pulmonary disease], renal insufficiency, CKD 3A [chronic kidney disease, stage 3A], CVA [cerebrovascular accident], left sided weakness, diabetic neuropathy, hypothyroidism. The plan read Resident A administered her own medications. The plan read Resident A transferred herself from chair/bed and required no staff assistance. The plan read Resident A dressed herself and needed staff supervision to ensure proper clothing was put on according to climate and time of day. The plan read Resident A was independent with activities. The plan read Resident A received a diabetic diet and needed reminders to come to meals. The plan read Resident A was able to follow directions, oriented to her surroundings, recognized others, and was able to express her needs. The plan read Resident A was not confused and was not an elopement risk. The plan read Resident A toileted herself requiring no staff assistance and required a standby assistance from staff. The plan read Resident A required physical assistance for her showers on Mondays and Thursdays. The plan read Resident A self-propelled in her wheelchair. The plan read Resident A needed checks every hour for just moving into the facility.

I reviewed the resident care coordinator notes dated 10/27/2022 through 3/3/2023. Note dated 2/28/2023 read Resident A slipped out of bed at 4:35 AM and pressed her lifeline button in which emergency medical services (EMS) assisted her off the floor, then back to bed. Note dated 3/3/2023 read Resident A fell off the toilet and called Relative A. The note read Relative A called the administrator and refused to allow staff to call EMS until she arrived. The note read Relative A pressed Resident A's lifeline button and she was taken to the hospital.

I reviewed the facility's incident report for Resident A dated 3/3/2023 at 8:40 AM which read consistent with the resident care coordinator notes. The report read Employee #1 was the staff member on duty.

I reviewed the 3/3/2023 staff schedule which read Employee #1 was assigned to 2nd floor care.

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** **Rule 1.**	**Definitions.** **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.
	(t) "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:	Review of Resident A's records revealed although she could express her needs and administer her own medications, she required some staff assistance for her activities of daily. Although the facility does not maintain records for resident checks, review of Resident A's service plan read she was to receive one-hour checks. Additionally review of Resident A's service plan revealed she it was not updated to reflect that she was no longer a new resident, so it was unclear if she required one-hour checks and was inconsistent with her needs for toileting. For example, the plan read Resident A required no assistance and stand-by assistance for toileting. Furthermore, records revealed Resident A had a history of falls in which was not reflected in her plan. Resident A's plan lacked specific care and methods to instruct staff to meet her needs, thus the home was unable to take reasonable action to ensure the health, safety, and well-being of Resident A as indicated in the resident's service plan. Based on this information, the allegations were substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of acceptable corrective plan, I recommend the status of this license remain unchanged.

04/15/2023

Jessica Rogers Date
Licensing Staff

Approved By:

04/26/2023

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