GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 7, 2023

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

RE: License #: AH820409556
Investigation #: 2023A1027078
The Westland House

Dear Christopher Schott:

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) 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 #:	2023A1027078
Complaint Receipt Date:	06/29/2023
Investigation Initiation Date:	06/30/2023
Report Due Date:	08/29/2023
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 protection.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

06/29/2023	Special Investigation Intake 2023A1027078
06/30/2023	Special Investigation Initiated - Telephone Telephone call conducted with complainant
06/30/2023	Contact - Telephone call made Telephone call conducted with hospice nurse
07/05/2023	Contact - Document Sent Email sent to Wanda Kreklau and Chris Schott to request documentation pertaining to Resident A
07/06/2023	Contact - Document Received Email received from Wanda Kreklau with requested documentation
07/07/2023	Inspection Completed-BCAL Sub. Compliance
08/21/2023	Exit Conference Conducted by telephone with authorized representative Christopher Schott

ALLEGATION:

Resident A lacked protection.

INVESTIGATION:

On 6/29/2023, the Department received a complaint through the online complaint system which read Resident A passed away while receiving hospice services on 5/18/2023. The complaint read staff did not respond to Resident A's call light. The complaint read staff had the sound on the call light system turned down. The complaint read staff called the ambulance twice for Resident A.

On 6/30/2023, I conducted a telephone interview with the complainant who stated Resident A required staff assistance with his activities of daily living; however, sometimes he would not accept help from staff. The complainant stated Resident A would call her during the night because he required staff's help. The complainant stated while visiting Resident A, she summoned staff for assistance, waited approximately one hour, then went to the front desk to ask for staff's help. The complainant stated the front desk staff member informed her that someone had turned the sound down on the call light system. The complainant stated she spoke with the administrator Wanda Kreklau regarding her concerns. The complainant stated Resident A had more than one fall at the facility and was sent to the hospital. The complainant stated Resident A had signed onto hospice services after returning to the facility from the hospital but could not recall the exact date. Additionally, the complainant stated a staff member had called the ambulance due to a fall after Resident A signed onto hospice services in which staff should have contacted his hospice agency first. The complainant stated she owed money for Resident A's ambulance rides to the hospital.

On 6/30/2023, I conducted a telephone call with a Heart to Heart hospice nurse who stated although she was not Resident A's assigned nurse, she had stayed at bedside with him for approximately eight hours one night. The hospice nurse stated she summoned staff for assistance with changing, cleaning, and repositioning Resident A. The hospice nurse stated second shift staff who cared for Resident A were "*really good*." The hospice nurse stated she summoned for third shift staff and waited approximately 20 minutes; however twice that shift, she had to leave Resident A's room to locate a staff member to assist her with his care.

On 7/5/2023, a telephone call conducted with administrator Wanda Kreklau who stated the facility call system did not maintain records, thus call light response time logs were not retrievable.

I reviewed Resident A's face sheet which read in part he moved into the facility on 4/5/2023 and Relative A1 was his authorized representative.

I reviewed Resident A's service plan dated 4/5/2023 which read in part Resident A's physician was the facility's visiting physician. The plan read in part Resident A transferred himself from chair/bed and required no assistance, as well as was independent with dressing. The plan read in part Resident A required stand by assist with toileting and needed assistance transferring to the toilet as well as help with personal hygiene care afterwards. The plan read in part Resident A required physical assistance from staff with showering and that he was unable to shower

himself. The plan read in part Resident A required one hour checks due to just moving into the facility. The plan read in part Resident A was prescribed a mechanical soft diet with nectar thick liquids and required reminders to come to meals. The plan read in part Resident A was able to get to the dining room on his own and was forgetful as to the times meals were served. The plan read in part Resident A was not confused and was orientated to person, place, and time. The plan read in part Resident A was combative. The plan read in part Resident A require staff to assist with pushing his wheelchair to activities.

I reviewed Resident A's incident reports.

Report dated 4/13/2023 read in part Resident A fell out of bed trying to go to the bathroom because his bed shifted. The report read he called Relative A1 who called the front desk to notify them Resident A needed assistance. The report read staff assisted Resident A off the floor in which he stated he hit his head but had no pain other than his back which was chronic. The report read corrective measures were to lower the bed to the floor and conduct frequent checks. An attachment to the report read Employee #1 monitored Resident A's mentation, pain, vital signs and conducted a skin assessment on 4/13/2023, 4/14/2023, and 4/15/2023. The attachment read Resident A was "*A&O x 2-3*."

Report dated 4/26/2023 read in part Resident A's family left his apartment to provide him privacy to use the restroom and he fell on the floor. The report read in part a skin tear was observed on top of his scalp with bruising. The report read in part staff reminded Resident A to summon for staff assistance and to wear shoes or non-skid socks. The report read in part emergency medical services (EMS) was contacted and Resident A was transferred to the hospital.

Report dated 5/5/2023 read in part Resident A was very confused, fatigued with change in condition in which EMS was contacted and he was transferred to the hospital.

Report dated 5/16/2023 read in part Resident A was found on the floor by his bed in which staff contacted EMS and Relative A1, and he transferred to the hospital. The report read in part the corrective measures were to ensure the bed height was at the appropriate level and that his call pendant was with reach.

I reviewed Resident A's care coordination notes which read consistent with the incident reports.

Note dated 4/26/2023 and written by Employee #1 read in part Resident A returned from the hospital in which a scan was completed showing no injury.

Note dated 5/5/2023 and written by Employee #1 read in part Resident A was more confused than usual and "*dozing off mid conversation*." The report read in part EMS was contacted and he transferred to the hospital.

Note dated 5/8/2023 and written by Employee #1 read in part Resident A returned from the hospital on 5/8/2023. The note read in part Resident A had declined in his alert status and was now "*A&O 1-2*." The note read in part Resident A signed onto Heart to Heart Hospice services and adjustments were made to his medications.

Note dated 5/16/2023 and written by Employee #1 read in part Resident A fell on midnight shift around 3:00 AM in which he was observed on the floor by staff. The note read in part Resident A was sent to the hospital and his family was notified by staff. The note read in part Resident A returned from the hospital around 9:50 AM and was active for hospice, in which Heart to Heart was notified and the hospice nurse arrived on-site.

Note dated 5/17/2023 and written by Employee #1 read in part Resident A expired on 5/17/2023 with hospice services and family at bedside.

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.
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.
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Review of Resident A's service plan revealed he was alert and orientated to person, place and time which initially read consistent with his care coordination notes. Review of Resident A's care coordination notes revealed his mental status declined around 5/8/2023. Review of Resident A's incident reports revealed he was at risk for falls. Although it could not be determined if Resident A used his call pendent appropriately or not to summon for staff assistance, per his service plan, staff were to conduct hourly checks. Additionally, review of Resident A's medical records revealed the service plan lacked communication regarding his hospice services, as well as his risk for falls. Furthermore, the plan read Resident A was independent for transferring from his chair/bed, however review of incident reports revealed he was at risk for falls and required reminding to utilize his call pendant. In addition, complainant and hospice nurse interviews revealed staff did not always respond to Resident A's call pendent in a timely manner. Based on this information, this allegation was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Please reference Corrective Notice Order dated 6/22/2023, R 325.1931(2)]**

IV. RECOMMENDATION

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

07/07/2023

Jessica Rogers — Date
Licensing Staff

Approved By:

08/21/2023

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