GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 29, 2023

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

RE: License #: AH820409556
Investigation #: 2023A0784094
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 responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2023A0784094
Complaint Receipt Date:	09/19/2023
Investigation Initiation Date:	09/19/2023
Report Due Date:	11/18/2023
Licensee Name:	Westland OPS, LLC
Licensee Address:	600 Stonehenge Pkwy 2nd Floor Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Administrator/Authorized Representative:	Christopher Schott, Authorized Repr.
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 is not assisted with medication administration	No
Facility will not bring Resident A food	No
Staff did not clean Resident A's room	Yes
Additional Findings	Yes

III. METHODOLOGY

09/19/2023	Special Investigation Intake 2023A0784094
09/19/2023	Special Investigation Initiated - Telephone Contact attempted with Complainant. Message left requesting a return call
09/21/2023	Inspection Completed On-site
09/21/2023	Contact - Telephone call made Attempted with complainant.
09/22/2023	Contact - Document Received Email received from administrator/AR Christopher Schott with an attached written statement from a staff.
TBA	Exit Conference

ALLEGATION:

Resident A is not assisted with medication administration

INVESTIGATION:

On 9/19/2023, the department received this online complaint.

According to the complaint, the facility will not assist Resident A with her prescriptions.

On 9/21/2023, I interviewed Resident A at the facility. Resident A stated she was recently in the hospital and returned to the facility a couple days ago. Resident A stated that prior to going to the hospital, she had been administering her own medications, however she is unable to do so anymore, and staff assist her with this. Resident A stated staff have been assisting her since she returned to the facility.

On 9/21/2023, I interviewed director of nursing Jeanae Tripp at the facility. Administrator/authorized representative Christopher Schott was present during the interview. Ms. Tripp confirmed statements provided by Resident A regarding her medication administration. Ms. Tripp stated Resident A was recently at a rehab facility and returned on 9/19/2023. Ms. Tripp stated she is not aware of any issues with Resident A getting her medications administered by staff.

I reviewed Resident A's medication administration record (MAR) for September 2023 which read consistently with Ms. Tripp's statements indicating Resident A had been administered medications since 9/19/2023.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	The complaint alleged the facility would not assist Resident A with medication administration. Interviews with Resident A and the director of nursing as well as review of Resident A's MAR do not support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility will not bring Resident A food

INVESTIGATION:

According to the complaint, staff will not bring Resident A food.

When interviewed, Resident A stated staff do not bring food to her room. Resident A stated staff do assist her down to the dining area at meals times. Resident A stated she was told that if she wanted to have food delivered to her room, she would have to pay an additional fee for this service.

When interviewed, Ms. Tripp confirmed Resident A's statements regarding food delivery. Ms. Tripp stated that if it was necessary to deliver food to Resident A, the facility would do so as needed, however she stated Resident A does not currently have a need, medical or otherwise, for this service.

I reviewed Resident A's resident contract or *Resident Care Agreement*, provided by Ms. Tripp. Under a section titled Tray Service, the agreement read "Facility will provide tray service to a Resident's room at the discretion of the staff due to illness/injury. In the event Resident requests meal trays on a daily basis, points will be added to Resident's assessment and may raise monthly rate".

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents. **(3) A home shall assure that the temporary needs for meals delivered to a resident's room are met.**
ANALYSIS:	The complaint alleged the facility will not bring meals to Resident A's room. Interviews with Resident A and Ms. Tripp confirmed Resident A does not have meals delivered to her room, however the investigation revealed Resident A does not have a medical need for such service and that the facilities actions are consistent with the contract agreed upon by Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not clean Resident A's room

INVESTIGATION:

According to the complaint, staff are refusing to clean Resident A's room.

During the onsite, I observed Resident A sitting in a recliner chair in her room a few feet directly in front of a tv which was sitting on a desk. Upon entering Resident A's room, in the pathway to Resident A, directly to her left side, there was a chair, with a wheelchair to the left of that chair, blocking the space between Resident A and the short hallway out of her room. On the floor directly in front of Resident A, between

her and the tv, there was what appeared to be a crumbled-up sheet, several small, empty, potato chip bags, an adult brief, several random items, such as a box of Kleenex and a power strip with multiple cords plugged into it which were all crowding the floor space in front of Resident A.

When interviewed Resident A stated staff have periodically cleaned her room, but that they do not seem to do so very often. Resident A stated she does not see very well. Resident A stated she could tell that the floor around her was messy, however she could not see well enough to know what was there.

When interviewed, Ms. Tripp stated housekeeping staff conduct “deep cleaning” for each room at least once a week and more as needed. Ms. Tripp stated housekeeping cleans the first-floor rooms, where Resident A’s room is, on Fridays for the normally scheduled cleaning. Ms. Tripp stated housekeeping has a document which staff note the date they cleaned a room and the room number with the initials of the staff who cleaned the room. Ms. Tripp stated care staff also help to clean throughout the day. Ms. Tripp stated the current condition of Resident A’s room was not consistent with expectations and was not normal. During the interview, I walked with Ms. Tripp to Resident A’s room so she could observe the condition of the room. Upon observing Resident A’s room, Ms. Tripp reiterated that the current condition of Resident A’s room was not normal. Ms. Tripp stated she had observed Resident A’s room since her return on 9/19/2023 and that the room had been clean prior to this day.

I reviewed the *Housekeeping/Laundry Schedule*, provided by Ms. Tripp, which read consistently with her statements.

I reviewed the housekeeping tracking document described by Ms. Tripp, and provided by Ms. Tripp, which read consistently with her statements indicating Resident A’s room was last cleaned on 9/15/2023.

On 9/22/2023, I received an email from Mr. Schott with an attached written statement from Associate 1. In the letter, Associate 1 attested that she had provided care to Resident a on the morning of 9/21/2023 and that she did not observe any trash on the floor. Additionally, Associate 1’s letter alleges Resident A purposely “cut up her briefs and put the trash on the floor” and that, after I left the facility, Resident A reported to Associate 1 “That’s what Chris (Mr. Schott) get and I know that Chris got chewed out + [and] I hope he lose his job”.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

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.**
ANALYSIS:	The complaint alleged staff do not clean Resident A's room. Upon inspection Resident A's room during the onsite on 9/21/2023, Resident A's room was observed to be unclean and arranged in a way which it would be reasonable to concluded would not be conducive to allowing staff to assist Resident A out of her room in an emergency situation for her safety. While evidence does not suggest staff never to clean Resident A's room, the poor condition of Resident A's room at the time of the onsite was undeniable. Additionally, While Associate 1 insinuated that Resident A purposely made a mess in her own room, presumably to get Mr. Schott in some kind of trouble, the department, as mandated, conducted an unannounced visit so there is no way Resident A could have known a department representative would have come to the facility at that particular date and time in order to plan such a situation. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the inspection of Resident A's room, I observed the top drawer of the desk that Resident A's TV was sitting on, directly in front of her, to be open with two medication bubble packs inside. Both bubble packs contained Levothyroxine (Thyroid medication), one with a dispensed date of 6/16/2023, with two pills left in the pack, and one with a dispensed date of 7/28/2023, with 12 pills left in the pack.

When interviewed, Resident A stated she was not aware that the medications were in the drawer. Resident A stated the medications were probably still there from when she had previously administered her own medications.

When interviewed, Ms. Tripp stated she was not aware Resident A had any medications in her room. Ms. Tripp stated the facilities policy is to have all resident

medications secured. Ms. Tripp stated that since the medications in Resident A's drawer were not in use anymore, they should have been disposed of. Ms. Tripp stated the facilities medication policy also addresses proper medication disposal.

I reviewed the facilities *Medication Storage* policy, provided by Ms. Tripp. The beginning statement of this policy read, "Medication's will be stored in a manner that ensures maintenance of both the integrity of the medication and the safety of all residents residing in the community". Under a section titled Guidelines, the policy read, in part, "All medications, including over-the-counter, are kept in locked storage at all times" and "If resident is allowed to keep his/her own medications, the Executive Director/designee ensures: a. Locked storage is maintained in the resident's room to prevent access by other residents". Under a section titled Expired Medications, the policy read, in part, "Medications expired are brought to the Westland Police Department monthly for destruction within their policy guidelines".

Associate 1, within the written statement provided, indicated she did not see any medications in Resident A's room while providing care on the morning of 9/21/2023.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) Prescribed medication that is no longer required by a resident must be properly disposed of consistent with the policy established by the home and manufacturer guidelines.
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	During the onsite, medications were observed to be unsecured in a desk drawer of Resident A's room. Not only were these meds not stored properly to ensure the integrity of the medication or the safety of residents who could possibly have had access to them as reasonably expected, and directed within the facilities medication policies, but the medications were not disposed of properly, as directed within the facilities medication policies. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable correction action plan, it is recommended that the status of the license remain unchanged.

10/25/2023

Aaron Clum — Date
Licensing Staff

Approved By:

11/29/2023

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