GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 7, 2023

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

RE: License #: AH820409556
Investigation #: 2023A1035008
The Westland House

Dear Mr. Schott:

While violations have been identified in the report, a written corrective action plan is not required for violations established related to R 325.1931 (2) as the violations identified are covered by the scope and action required in the Correction Notice Order dated June 22, 2023.

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report related to 333.20201 (2) (d), 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. 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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH820409556 |
| | |
| **Investigation #:** | 2023A1035008 |
| | |
| **Complaint Receipt Date:** | 07/17/2023 |
| | |
| **Investigation Initiation Date:** | 07/17/2023 |
| | |
| **Report Due Date:** | 09/16/2023 |
| | |
| **Licensee Name:** | Westland OPS, LLC |
| | |
| **Licensee Address:** | 2nd Floor<br>600 Stonehenge Pkwy<br>Dublin, OH 43017 |
| | |
| **Licensee Telephone #:** | (614) 420-2763 |
| | |
| **Administrator:** | Christopher Schott |
| | |
| **Authorized Representative/** | Christopher Schott |
| | |
| **Name of Facility:** | The Westland House |
| | |
| **Facility Address:** | 36000 Campus Drive<br>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 service plan not followed. | Yes |
| Resident A fell. | No |
| Resident A right to privacy. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 07/17/2023 | Special Investigation Intake<br>2023A1035008 |
| 07/20/2023 | Special Investigation Initiated - On Site |
| 07/21/2023 | Contact – Document Received<br>Email received from administrator with additional information that was requested onsite. |
| 7/24/2023 | Contact – Document Received<br>Emailed received from administrator with additional information. |
| 7/28/2023 | Additional Complaint received through BCAL Online Complaints Department. |
| 7/31/2023 | Contact – Documents Requested<br>Policy related to recording devices requested. |
| 7/31/2023 | Contact – Document Received. |
| 8/23/2023 | Contact – Document Requested<br>Face sheet, POA paperwork, Admission contract requested. |
| 9/13/2023 | Contact – Document Requested |
| 9/13/2023 | Contact – Document Received |
| 1/17/2024 | Inspection Completed – BCAL Sub. Compliance. |
| 1/17/2024 | Contact – Document Received<br>Email received with requested documentation. |
| 1/17/2024 | Exit Conference<br>Conducted via phone and email with authorized representative. |

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**ALLEGATION:**

Resident A service plan not followed.

**INVESTIGATION:**

On 7/17/2023 the department received a referral from APS, in which their department did not open an investigation. The complaint stated “On 07/14/2023 Resident A was observed in her bed in a saturated brief. Her breakfast was observed sitting on a hamper next to her. However, she was unable to access it on her own so there was no way for her to eat it. Resident A has wounds on her buttocks that are not being cared for. The staff members are supposed to assist with wound care once a week and provide Resident A with a bed bath twice a week. Resident A was recently observed in briefs that were soiled with diarrhea. Her clothing has been observed saturated in urine and thrown in her closet instead of washed. Unable to access call light.

7/20/2023 onsite survey conducted. I attempted to interview facility Administrator Wanda Kreklau. However, Wanda was unable to answer questions at the time related to a scheduled meeting.

7/20/2023 Interviewed Resident A. Resident A was lying in bed eating lunch. Lunch tray observed on lap of resident with beverages on hamper at bedside. Resident A states she prefers to eat in bed. Items on lunch tray are appropriately opened and set up.

While onsite Resident A states there are long call light wait times, but “my needs are met when they finally come”. It was noted though direct observation, call light is at the foot of bed and difficult for resident to reach. Call light was applied by writer while interviewing Resident A, no staff members attended to light within the approximately thirty-five-minute interview.

Post interview writer walked around unit looking for staff assistance. Staff observed at the end of hall and stated they were not alerted to call-light and stated many call lights are “broken”. Staff person (SP) SP1 & SP2 accompanied writer back to Resident A room where call light remained on. SP1 shut call light off and contacted front desk inquiring if it was working. Per SP1 the call light is working, and the front desk had not notified staff member. SP1 & SP2 state when a member applies the call light the front desk is notified then the attendant at the front desk notifies the care staff. SP1 & SP2 report delays in call light response time related to not being notified of the light being on.

Facility was unable to provide call light response times related to the call light system not having advanced capabilities.

While onsite I review Resident A shower sheets located in the “shower book.” Shower sheets for the months of June and July were requested for review. Facility administrator provided six shower sheets for the month of July; no other shower sheets provided.

On 9/8/2023 additional information received from Christopher Schott Executive Vice President stating Resident A receives all wound care services through Elara Caring agency.

Elara Caring offered to teach facility staff on wound care treatment, facility informed Elara Caring Agency wound care services exceeds the abilities of facility staff.

Review of Elara Caring documentation and electronic medical record EMR indicate medications and wound care orders are being followed as ordered.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931 (2)** | **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.** |
| **ANALYSIS:** | It was noted through record review of Resident A shower sheets; resident is offered two showers a week as indicated in service plan. Six shower sheets for the month of July provided by the facility. Resident A declined four days of offered showers and accepted two bed baths for the month of July. Three of the shower sheets indicated shower/ bed bath had been offered three times each day in which Resident A declined. Resident A states she does not like nor require weekly showers and the “girls” take care of me when needed.<br><br>The facility was unable to provide shower sheets for the month of June. There were multiple missing shower sheets for the month of July. Resident A service plan states showers days are Monday and Thursday. Based on this information, this allegation was substantiated.<br><br>It was noted through direct observation, resident call light is located at the foot of bed and difficult to reach. Writer applied call light with no response from staff during the duration of interview time with Resident A. Through interview with SP1 & SP2 it was reported many call lights are broken and we are not alerted of activated call lights timely. Based on this information, this allegation was substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

Resident A fell.

**INVESTIGATION:**

On 7/18/2023, the department received a referral from APS, in which their department did not open an investigation. The complaint stated In June 2023, Resident A fell and was left on the floor for 2.5 hours before an aid came in to check on her. Resident A has a nurse alert on her bed but was unable to access it.”

On 7/20/2023, Resident A states “I don’t recall falling.”

On 9/8/2023, Facility provided a statement that Resident A had not had a fall or noted incidents in the month of June 2023.

| APPLICABLE RULE | |
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| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| | **(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:** | Resident A denies having a fall in the month of June where she remained on the floor. Facility was unable to locate documentation related to a fall or incident in the month of June. Therefore, this allegation was not substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

Resident A right to privacy.

**INVESTIGATION:**

On 7/28/2023 additional concerns received through online complaint department stating. "Resident A has a Ring camera in her home in order for her daughter, to monitor her care. Management has informed residents daughter she can no longer have a Ring camera in Resident A apartment. Daughter is also no longer allowed to remain in the room while staff are caring for her mother."

On 8/23/2023, Facility administrator provided a copy of the resident Care Agreement which indicates on page 2 bullet 5 "No cameras, or video equipment are to be placed in Residents' room" which was signed and agreed upon by Resident A and Resident A's daughter. However, I was informed during my onsite visit on 07/20/2023 that Resident A had a Ring camera active in her room. The presence of the Ring camera during the interview was against the facility policy.

During onsite interview on 07/20/2023, Resident A states she would prefer privacy when being changed and sometimes "my daughter is a little overbearing."

| APPLICABLE RULE | |
|---|---|
| **333.20201 (2) (d)** | **Right to privacy.** |
| | (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:<br>(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality. |

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| **ANALYSIS:** | A Ring camera was installed in Resident A's room, which was against facility policy and this policy was acknowledged by Resident A through the admission contract. During initial interview on 07/20/2023, Resident A states she prefers privacy when incontinent care is being rendered. With the information collected and reviewed allegation is substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan for violation MCL 333.20201 (2) (d), I recommend no licensure change.

9/14/2023

Jennifer Heim — Date
Licensing Staff

Approved By:

01/16/2024

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