GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2025

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

RE: License #: AH820409556
Investigation #: 2025A1027026
The Westland House

Dear Licensee:

Attached is the Special Investigation Report for the above-mentioned 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 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 #:	2025A1027026
Complaint Receipt Date:	01/15/2025
Investigation Initiation Date:	01/17/2025
Report Due Date:	03/14/2025
Licensee Name:	WestlandOPS, LLC
Licensee Address:	2nd Floor 600 Stonehenge Pkwy Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Authorized Representative/ Administrator:	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:	08/11/2024
Expiration Date:	07/31/2025
Capacity:	102
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
There were expired narcotics in the cupboards and refrigerator.	Yes
Residents were not receiving showers.	Yes
A resident had an open sore to the bone. Residents passed away. Some residents do not have heat.	Yes No No
An employee was stuck in the elevator.	No
The owner resides on the 5th floor.	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

01/15/2025	Special Investigation Intake 2025A1027026
01/17/2025	Special Investigation Initiated - On Site
01/17/2025	Inspection Completed-BCAL Sub. Compliance
0/29/2025	Exit Conference Conducted by email with Christopher Schott

ALLEGATION:

There were expired narcotics in the cupboards and refrigerator.

INVESTIGATION:

On 1/15/2025, the Department received an anonymous complaint through the online system, which read that expired narcotics were found in the cupboards and refrigerator. Due to the anonymous nature of the complaint, further information could not be obtained.

On 1/17/2025, I conducted an on-site inspection and interviewed staff members.

Interviews with the authorized representative and administrator, Chris Schott, as well as Employee #1, confirmed that a nurse was assigned to oversee medication management within the facility.

Employee #2 explained that expired or unused narcotics were properly disposed of by two staff members, typically a nurse and one additional staff member, using the drug buster system. Employee #2 also clarified that there were no narcotics in the refrigerator, which only contained insulin and other general medications, nor the cupboards.

During the site visit, I observed narcotic medications stored in medication carts on floors one through four. I noted that one narcotic medication was past its disposal date of 12/4/2024, and in another medication cart, two other medications were expired as of 11/2/2024 and 1/8/2025.

I reviewed the facility's medication disposal policy, which outlines procedures for the disposal of controlled substances. The policy read that controlled substances should not be returned to the pharmacy and should instead be removed from their original containers, mixed with cat litter or used coffee grounds, placed in an empty container such as a milk gallon, and disposed of in the trash. Additionally, the policy required two staff signatures for the disposal of controlled substances and specified that the drug buster system deactivates and contains the active ingredients of non-hazardous medications.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	While the facility generally followed its policy for the disposal of controlled substances, the presence of expired narcotics in the medication carts confirmed the substantiation of the complaint and the potential for residents to be administered expired narcotics.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents were not receiving showers.

INVESTIGATION:

On 1/15/2025, the Department received an anonymous complaint through the online system, alleging that residents were not receiving showers. Due to the anonymous nature of the complaint, no further information was available.

On 1/17/2025, I conducted an on-site inspection and interviewed staff members.

Interviews with the authorized representative and administrator, Chris Schott, as well as Employee #1, revealed that showers were scheduled to be provided twice weekly, but were individualized according to each resident's service plan. Employee #1 also stated that showers should be documented in both the shower logs and the Point Click Care (PCC) system. The current resident census was reported as 51.

During the site visit, I reviewed the shower log books for floors one and two and found that not all residents had shower records documented in accordance with the facility's policy.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Due to the incomplete shower logs, it could not be confirmed whether residents consistently received their showers. As a result, the allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

A resident had an open sore to the bone. Residents passed away. Some residents do not have heat.

INVESTIGATION:

On 1/15/2025, the Department received an anonymous complaint through the online system, which alleged that an unknown resident had an open sore to the bone, eight residents had passed away in the past 30 days, and that some residents did not

have heat. Due to the anonymous nature of the complaint, further information could not be obtained.

On 1/17/2025, I conducted an on-site inspection and interviewed staff members

Interviews with the authorized representative and administrator, Chris Schott, as well as Employee #1, revealed that Resident A had an open wound to the bone, and her wound care was being managed by her hospice team. Employee #1 confirmed that, in the past 30 days, residents had passed away while receiving hospice services; however, one resident had been hospitalized for a bowel obstruction, had multiple admissions and discharges, and ultimately passed away in the hospital.

The authorized representative and administrator stated that each resident room had an individual heating system, and the heat was generally working appropriately. They also confirmed that there had been occasional heating issues, which were promptly addressed. Employee #1 stated that the heater in room 519 had broken, and the resident was moved to another room temporarily until the heater was repaired. Employee #1 added that the facility contracted with Preferred Heating, a company that responded quickly and provided 24-hour emergency service. Additionally, the maintenance staff member was also HVAC certified.

During the site visit, I observed that Preferred Heating was on-site that day, repairing a heater in a resident's room prior to a new move-in. I also observed approximately 20 residents who appeared comfortable, and the facility’s temperature seemed appropriate throughout.

I reviewed Resident A’s face sheet and service plan. The face sheet indicated she moved into the home on 9/30/2021, with Relative A1 listed as her responsible party. The most recent service plan dated 10/14/2024, noted that hospice monitored her skin condition on shower days. The plan read Resident A scratched at her skin (buttock area) and staff were to apply ointment with each brief changes, and to notify Director of Nursing (DON) or Resident Care Coordinator (RCC) if breakdown continues. Additionally, the plan read that staff were to turn Resident A every two hours to prevent skin breakdown. She was receiving St. Croix hospice services, with a hospice aide visiting twice weekly and a registered nurse visiting weekly.

I also reviewed the facility’s move-out report for the past 30 days, which confirmed that five residents had passed away.

I reviewed the home’s disaster plan, particularly the loss of heat policy, which was consistent with staff interviews.

APPLICABLE RULE	
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.**
For Reference: **R 325.1901**	**Definitions.** **Rule 1. As used in these rules:**
	(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:	Staff attestations, along with documentation and observations, indicated that the allegations regarding resident deaths and heating issues could not be substantiated. However, it was noted that the facility lacked an organizational plan to update Resident A's service plan with her open wound to the bone, the involvement of her hospice team in managing her wound needs, as well as instructions for staff to report signs and symptoms of a wound infection.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

An employee was stuck in the elevator.

INVESTIGATION:

On 1/15/2025, the Department received an anonymous complaint through the online system, which read that an employee had been stuck in an elevator for two hours, the fire department responded, and the owner refused to fix the elevator. The complaint also mentioned an issue with the fire alarm system.

On 1/17/2025, I conducted an on-site inspection and interviewed staff.

Interviews with the authorized representative and administrator, Chris Schott, as well as Employee #1, revealed that there were no issues with the fire alarm system. The authorized representative and administrator confirmed that an employee had been stuck in the elevator for approximately 20 minutes, and that they had maintained contact with the employee during the entire incident. The fire department responded and was able to bypass a loose sensor. The authorized representative and administrator also stated that the elevator had been shut down overnight, and Lardner Elevator Company serviced the elevator the following day. Meanwhile, the other elevator was functioning properly. The authorized representative and administrator further noted that Lardner Elevator Company provided regular maintenance services for the elevators, both on a routine schedule and as needed.

I reviewed the Lardner Elevator invoices, which showed that on 12/20/2024, a belt was replaced due to a malfunction with the first-floor door, and on 12/28/2024, the doors on the 5th floor were adjusted to open properly. Additional invoices from 11/1/2024, 12/1/2024, and 1/1/2025, indicated monthly maintenance service for the elevators.

I reviewed the facility's report from Fire Systems of Michigan, dated 10/22/2024, which documented the inspection and testing of the fire alarms. The test results indicated that all alarms passed. On 1/24/2025, email correspondence with Employee #1 read the fire alarms were inspected annually. Employee #1's correspondence read that there was issue with the fire alarms having a low battery; however, it was promptly fixed by Fire Systems of Michigan. Review of Fire Systems of Michigan work acknowledgment dated 12/23/2024 revealed it read consistent with staff statements and they were contacted, then on-site the same day to resolve the issue.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Based on staff interviews and documentation, these allegations could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The owner resides on the 5th floor.

INVESTIGATION:

On 1/15/2025, the Department received an anonymous complaint through the online system, which read that the owner lived on the 5th floor of the home. Due to the anonymous nature of the complaint, no additional information could be gathered.

On 1/17/2025, I conducted an on-site inspection at the facility and interviewed authorized representative and administrator, Chris Schott, who confirmed that he typically resided on the 5th floor from Monday through Thursday.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(b) That a home shall not accept an individual seeking admission unless the individual's needs can be adequately and appropriately met within the scope of the home's program statement.**
ANALYSIS:	An employee was discovered living in an unoccupied licensed resident room at the facility. Employees cannot be considered for admission to the home and are not considered as residents and therefore cannot reside in licensed resident rooms. Therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jessica Rogers 01/21/2025

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Jessica Rogers Date
Licensing Staff

Approved By:

01/28/2025

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