GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2022

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

RE: License #: AH820409556
Investigation #: 2022A1027058
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

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.

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 #:	2022A1027058
Complaint Receipt Date:	05/13/2022
Investigation Initiation Date:	05/13/2022
Report Due Date:	07/12/2022
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:	TEMPORARY
Effective Date:	02/11/2022
Expiration Date:	08/10/2022
Capacity:	102
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his prescribed medications.	No
Additional Findings	Yes

III. METHODOLOGY

05/13/2022	Special Investigation Intake 2022A1027058
05/13/2022	Special Investigation Initiated - Letter Email sent to Adult Protective Services (APS) worker to inform her of licensing staff assigned to investigation
05/17/2022	Inspection Completed On-site
06/06/2022	Contact - Telephone call made Telephone call conducted with administrator Ms. Kreklau to request additional documentation
06/07/2022	Contact - Document Received Email received from Ms. Kreklau with requested documentation
06/09/2022	Inspection Completed-BCAL Sub. Compliance
06/28/2022	Exit Conference Conducted with authorized representative Christopher Schott by telephone

ALLEGATION:

Resident A did not receive his prescribed medications.

INVESTIGATION:

On 5/13/2022, the department received allegations forwarded by Adult Protective Services (APS) which read Resident A did not receive his insulin on weekends. The complaint read Resident A was ordered to have his blood sugar checked and receive medication three times per day. The complaint read Resident A was taken to Garden City Hospital on 2/11/2022 due to decreased mental status and his blood sugar was 47.

On 5/17/2022, I conducted on-site inspection at the facility. I interviewed administrator Wanda Kreklau who stated Resident A resided at the facility for a long time and had history of diabetes as well kidney failure. Ms. Kreklau stated Resident A would intermittently refuse services including his medications, blood sugar checks, housekeeping, and personal care. Ms. Kreklau stated Resident A had an episode in which he became non-responsive in February 2022, so the ambulance was called to take him to the hospital. Ms. Kreklau stated Resident A received dialysis weekly on Tuesday, Thursday, and Saturday, so he was not in the facility at the time of inspection.

While on-site, I interviewed medication technician supervisor Employee #1 who stated she had sent Resident A to the hospital on 2/11/2022 because he was not responding, had shallow breaths and he "seemed out of it." Employee #1 stated Resident A had refused medications at times and sometimes would not allow staff in his room. Employee #1 stated when Resident A would refuse medications or services, staff would ask him a second time, then a third time later in the shift.

I reviewed Resident A's face sheet which read he admitted to the facility on 10/31/2017 and was responsible for himself.

I reviewed Resident A's service plan which read in part "*resident refuses medications he feels aren't life sustaining."*

I reviewed Resident A's February, March, and April 2022 medication administration records (MARs) which read consistent with staff interviews and his service plan. The MARs read Resident A refused his medication intermittently each month. The February MAR read on 2/11/2022 Resident A received his insulin at 8:00 AM, 12:00 PM and 4:00 PM but refused his remaining 8:00 AM medications.

I reviewed Resident A's February, March and April 2022 diabetic blood sugar check logs which read his blood sugar was checked four times daily at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. The logs also read Resident A had refused blood sugar checks intermittently or was on a leave of absence when the check occurred. The February log read Resident A's blood sugars on 2/11/2022 were 147 at 8:00 AM, 162 at 12:00 PM, 216 at 4:00 PM and 235 at 8:00 PM.

I reviewed Resident A's February and March 2022 chart notes which read consistent with staff interviews. The notes read Resident A had refused medications on 2/4/2022, 2/18/2022, 2/28/2022, 3/17/2022, and 3/31/2022.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Review of facility documentation revealed Resident A had refused medications intermittently, however when amendable, staff had administered his insulin as well as his other medications as prescribed by the licensed health care professional. Additionally, Resident A's blood sugar check logs read staff conducted checks four times daily unless Resident A had refused. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/13/2022, the department received allegations forwarded by APS which read Resident A was taken to Garden City Hospital on 2/11/2022 for decreased mental status.

On 5/17/2022, at the on-site inspection, Ms. Kreklau stated the wellness director was to ensure incident reports were sent to the department.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**

ANALYSIS:	Review of the facility's file revealed there was not an incident report submitted to the department for Resident A's hospitalization, thus the facility was not incompliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/28/2022, I shared the finding of this report with authorized representative Christopher Schott by telephone. Mr. Schott verbalized understanding of the findings.

IV. RECOMMENDATION

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

6/9/2022

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Jessica Rogers Date
Licensing Staff

Approved By:

06/28/2022

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