GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 31, 2022

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

RE: License #: AH820409556
The Westland House
36000 Campus Drive
Westland, MI 48185

Dear Mr. Schott:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 feel free to contact the local office at (517) 284-9730.

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) 241-1970

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820409556
Licensee Name:	WestlandOPS, LLC
Licensee Address:	2nd Floor 600 Stonehenge Pkwy Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Authorized Representative:	Christopher Schott
Administrator:	Wanda Kreklau
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
Capacity:	102
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 08/30/2022

Date of Bureau of Fire Services Inspection if applicable:8/22/2022

Inspection Type: ☐Interview and Observation ☒Worksheet ☐Combination

Date of Exit Conference: 8/31/2022

No. of staff interviewed and/or observed 14
No. of residents interviewed and/or observed 25
No. of others interviewed One Role a resident's family member

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds held.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Bureau of Fire Services reviews fire drills. Disaster plan reviewed and staff interviewed regarding disaster plan.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: SIR 2022A1027058 dated 6/9/2022 to CAP dated 7/6/2022: 1924(1)
- Number of excluded employees followed up? Two N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

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.**

(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and wellbeing 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.

At the time of inspection, two residents each had a bedside assist device on the right side of the bed. Observation of Resident D's hospital bed revealed a rail with eight slats attached to the frame of the bed. The slats were spaced in a manner in which Resident D's limb could become entangled. Observation of Resident E's bed revealed a curved u-shaped bar which was not directly affixed to the bedframe but instead was held in place by the weight of the occupant and mattress allowing for possible unrestricted movement away from the mattress possibly causing an area of entrapment.

Ms. Kreklau stated the facility prohibits use of bedside assist devices in which all residents received notification of when admitted to the facility.

The facility did not follow their policy regarding the use of bedside assist devices, thus given the observations listed above, the facility has not provided reasonable protective measures to ensure resident well-being and safety.

VIOLATION ESTABLISHED

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.

Review of Resident A's July 2022 medication administration records (MARs) revealed on the following dates one or more of the scheduled doses were missed: 7/2/2022, 7/3/2022, 7/6/2022, 7/7/2022, 7/8/2022, 7/9/2022, 7/10/2022, 7/11/2022, 7/12/2022, 7/14/2022, 7/15/2022, 7/16/2022, 7/19/2022, 7/20/2022, and 7/21/2022. Review of Resident B's July 2022 MARs revealed on the dates one or more of the scheduled doses were missed: 7/2/2022, 7/3/2022, 7/6/2022, 7/14/2022, 7/15/2022, 7/16/2022, 7/19/2022, 7/20/2022, 7/21/2022, and 7/30/2022. Review of Resident C's July 2022 MARs revealed on the following dates one or more of the scheduled doses were missed: 7/2/2022, 7/6/2022, 7/10/2022, 7/14/2022, 7/15/2022, 7/16/2022, 7/19/2022, 7/20/2022, 7/27/2022, and 7/30/2022. For all the dates, the MARs were blank for at least one medication/dose, and it could not be verified why the medications were not administered to the residents.

VIOLATION ESTABLISHED

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.

Review of Resident B's MARs revealed he received Hydrocodone/APAP as needed for pain. Review of Resident B's service plan revealed lack of instruction of identifying the source or type of pain, as well as if he could verbalize his pain and if not, what type of behaviors he would present for staff to provide intervention. Review of Resident C's MAR revealed he received Lorazepam as needed for anxiety. Review of Resident C's service plan revealed lack of instruction of identifying when the medication would be needed. For example, if a PRN medication were to be administered in response to "agitation" or "anxiety," the service plan would explain how the resident demonstrates that behavior.

VIOLATION ESTABLISHED

R 325.1932 Resident medications.

(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:

(c) Record the reason for each administration of medication that is prescribed on an as-needed basis.

Review of Resident B's July MARs revealed he was prescribed Hydrocodone/APAP tablets 7.5-325, take one tablet by mouth every 12 hours as needed for pain in which staff documented the reason as given as "relax." Review of Resident C's July MARs revealed she was prescribed Lorazepam 0.5 mg tablet, take one tablet by mouth every 12 hours as needed in which staff documented the reason as given as "relax." The reasons for the administration of Resident B and C's medications were not the reason they were prescribed as per their licensed healthcare professional.

VIOLATION ESTABLISHED

R 325.1953 Menus.

(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served.

Interview with Ms. Kreklau and observations of the menu posted revealed a weekly menu for regular diets. Review of facility records revealed some residents were prescribed therapeutic or special diets such as mechanical soft and pureed which were not posted for the current week.

VIOLATION ESTABLISHED

R 325.1964 Interiors.

(9) Ventilation shall be provided throughout the facility in the following manner:

(b) Bathing rooms, beauty shops, toilet rooms, soiled linen rooms, janitor closets, and trash holding rooms shall be provided with a minimum of 10 air changes per hour of continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.

Inspection of residents' bathing/toilet facilities located in rooms 102, 402, 304, 301, 209 and 202 lacked adequate and discernable air flow.

VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

8/31/2022

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Date

Licensing Consultant