GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 2, 2022

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

RE: License #: AH820409556
Investigation #: 2023A1027007
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.
- 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 (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 #:	2023A1027007
Complaint Receipt Date:	10/18/2022
Investigation Initiation Date:	10/19/2022
Report Due Date:	12/17/2022
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:	REGULAR
Effective Date:	08/11/2022
Expiration Date:	08/10/2023
Capacity:	102
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medications as prescribed.	Yes
Resident A lacked catheter care and showers.	Yes
Additional Findings	No

III. METHODOLOGY

10/18/2022	Special Investigation Intake 2023A1027007
10/19/2022	Special Investigation Initiated - Letter Email sent to administrator Ms. Kreklau requesting Resident A's face sheet, service plan and October medication administration records
10/20/2022	Contact - Document Received Email received from Ms. Kreklau with requested documentation
10/21/2022	Contact - Telephone call made Telephone interview conducted with Employee #1
11/17/2022	Inspection Completed On-site
11/17/2022	Inspection Completed-BCAL Sub. Compliance
11/29/2022	Contact - Document Sent Email sent to Ms. Kreklau requesting additional documentation
11/30/2022	Contact - Document Received Requested documentation received from Ms. Kreklau
12/19/2022	Exit Conference Conducted with authorized representative Christopher Schott by telephone

ALLEGATION:

Resident A did not receive her medications as prescribed.

INVESTIGATION:

On 10/18/2022, the department received a complaint through the online complaint system which read Resident A was prescribed an antibiotic for a urinary tract infection (UTI) on 10/14/2022. The complaint read staff initialed the antibiotic as given but it was not in the facility. The complaint read Resident A was prescribed as needed cough medicine which was also not given.

On 10/18/2022, additional information was received through the online complaint system which read the complainant confirmed with a pharmacist that Resident A's antibiotic was ordered on 10/14/2022 and delivered the same day. The additional information read Resident A had not received the antibiotics and they were found unopened at the front desk on 10/17/2022.

On 10/20/2022, I received an email from administrator Wanda Kreklau with Resident A's medication administration records (MARs) dated October 1, 2022, through October 20, 2022. The MAR read Resident A was prescribed Nitrofurantoin capsules 100 mg, take one capsule by mouth twice daily for 5 days written on 10/14/2022, started on 10/15/2022 and stopped on 10/20/2022. The MAR read Resident A missed one or more doses of Nitrofurantoin on the following days 10/17/2022, 10/18/2022, and 10/20/2022. Additionally, the MAR read Resident A missed one or more doses of other medications prescribed on 10/7/2022, 10/8/2022, 10/9/2022, 10/13/2022, 10/17/2022, 10/20/2022. The MAR read the following as needed medications were prescribed for Resident A: Extra Strength Tylenol, Miralax, and Pepcid (discontinued on 10/13/2022).

On 10/21/2022, I conducted a telephone interview with Employee #1 who stated there were no pills left of the antibiotic Nitrofurantoin.

On 11/17/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A was hospitalized then returned with a prescription for an antibiotic. Employee #1 stated the facility had changed pharmacies.

While on-site, I interviewed Resident A who stated she received her medications.

I reviewed Resident A's service plan dated 7/14/2022 which read staff were to administer her medications which were delivered through the house pharmacy.

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 Resident A's service plan revealed facility staff were to administer and manage her medications. Review of Resident A's MARs revealed there were dates left blank in which it could not be determined if Resident A received her antibiotic or other medications as prescribed. Based on this information, this allegation was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For reference, see licensing study report (LSR) dated 8/31/2022, CAP dated 9/23/2022]**

ALLEGATION:

Resident A lacked catheter care and showers.

INVESTIGATION:

On 10/18/2022, the department received a complaint through the online complaint system which read Resident A had not received showers twice weekly and had poor hygiene. The complaint read Resident A possibly developed a urinary tract infection (UTI) due to poor hygiene and staff placing her foley bag upside down causing it to back flow into her bladder.

On 11/17/2022, I conducted an on-site inspection at the facility. I interviewed administrator Wanda Kreklau who stated Resident A had been hospitalized for an extended period and returned to the facility in beginning of September 2022 with a foley catheter. Ms. Kreklau stated approximately one month after Resident A returned to the facility with the catheter, Employee #2 had placed the foley catheter bag upside down mistakenly. Ms. Kreklau stated Employee #2 was trained in orientation on how to empty and change the foley catheter bag. Ms. Kreklau stated Employee #2 was re-trained on catheter care after the isolated incident along with other staff.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Kreklau.

While on-site, I interviewed Resident A who stated the foley bag leaked once. Resident A stated the care was "pretty good" in which she received showers, however not always on the scheduled day.

While on-site, I observed Resident A who appeared dressed in clean clothing and groomed. I observed her foley catheter bag was not leaking.

I reviewed Resident A's face sheet which read Relative A1 was her authorized representative and she had moved into the facility on 7/26/2022.

I reviewed Resident A's service plan dated 7/14/2022 which read Resident A required physical assistance with dressing, grooming and showers. The plan read Resident A needed a standby assistance for transfers, as well as assistance to/from meals and activities. The plan read Resident A's shower days were Tuesdays and Fridays. The plan read Resident A had a urinary catheter in which the drainage bag was to be emptied at the end of each shift.

I reviewed Resident A's resident care coordinator notes which read Resident A was sent to the hospital on 7/28/2022 and returned from the hospital on 9/1/2022. The notes read on 9/30/2022, her catheter was placed incorrectly in which staff were in-serviced.

I reviewed Resident A's shower sheets for October 2022 which read she received showers on 10/4/2022, 10/7/2022, 10/11/2022, 10/14/2022, 10/20/2022, 10/25/2022, and 10/31/2022.

I reviewed Employee #2's file and training records which read she was hired on 7/11/2022 and received training on 7/19/2022 for medication administration in which included catheter care.

I reviewed the medication administration training packet which read steps for catheter care including but not limited to how to change the leg drainage bag, how to change the overnight bag, removal, and cleaning of the overnight bag, as well as information on catheter valves.

I reviewed the facility's in-service dated 10/3/2022 which was titled *Catheter Care Video* and signed by Employee #2 and other staff.

APPLICABLE RULE	
R 325.1931	**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:	Review of Resident A's service plan revealed staff were to empty the catheter drainage bag at the end of each shift, as well as assist with showers every Tuesday and Friday. Review of Employee #2's training records revealed she was trained on catheter care and corrective measures were implemented after incorrect placement of the bag. However, review of Resident A's October 2022 shower sheets revealed Resident A lacked documentation of showers twice weekly from 10/15/2022 through 10/29/2022 as per her service plan, thus this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/02/2022

_____

Jessica Rogers Date
Licensing Staff

Approved By:

12/19/2022

_____

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