GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 5, 2023

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

RE: License #: AH820409556
Investigation #: 2023A1027055
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 #:	2023A1027055
Complaint Receipt Date:	03/26/2023
Investigation Initiation Date:	03/27/2023
Report Due Date:	05/25/2023
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 prescribed medications.	Yes
Relative A2 was not permitted to visit Resident A.	No
Resident A was missing personal property. The facility did not provide Resident A's medical records to emergency medical services.	No
Additional Findings	No

III. METHODOLOGY

03/26/2023	Special Investigation Intake 2023A1027055
03/27/2023	Special Investigation Initiated - Telephone Telephone interview conducted with administrator Ms. Kreklau and authorized representative Mr. Schott
03/29/2023	Contact - Document Received Email received from Ms. Kreklau with requested documentation
03/29/2023	Contact - Document Received Additional allegations received through email from the online complaint system
04/03/2023	Contact - Document Received Additional allegations received through email from the online complaint system
04/12/2023	Contact - Document Received Additional allegations received through email from the online complaint system
04/13/2023	Contact - Document Received Additional allegations received through email from the online complaint system
05/02/2023	Inspection Completed On-site
05/05/2023	Inspection Completed-BCAL Sub. Compliance

05/26/2023	Exit Conference Conducted by email with authorized representative Christopher Schott

ALLEGATION:

Resident A did not receive her prescribed medications.

INVESTIGATION:

On 3/27/2023, the Department received a complaint through the online complaint system which read Resident A had not received her Insulin from 3/22/2023 to 3/24/2023. The complaint read on 3/26/2023 at 7:45 PM, a medication technician took Resident A's blood sugar which was 111 and attempted to give her 27 units of Insulin. The complaint read the complainant, the medication technician and shift supervisor on duty confirmed Resident A was supposed to receive 12 units of Insulin. The complaint read the previous order of 27 units was not discontinued.

On 3/27/2023, I conducted a telephone interview with authorized representative Christopher Schott and administrator Wanda Kreklau. Ms. Kreklau stated the medication technician was training with another staff member in which the Insulin dose was confirmed prior to administration. Ms. Kreklau stated Relative A2 was looking at another resident's insulin dose.

On 4/3/2023, the Department received additional allegations through the online complaint system which read Relative A2 reviewed Resident A's medication administration records with the medication technician on duty to confirm the dose of Insulin.

On 4/12/2023, the Department received additional allegations through the online complaint system which read Resident A's Insulin medication was never documented as given from 3/1/2023 to 3/12/2023. The complaint read Macrobid was ordered on 3/9/2023 and as of 3/12/2023, was not documented as given. The complaint read Resident A had several antibiotics ordered in the past in which were listed on the MAR and should have been discontinued, as well as were given beyond the time frame ordered. The complaint read Resident A's medications were not documented as administered the morning of 3/10/2023. The complaint read on 3/11/2023, Resident A's medications were not documented as administered. The complaint read on 3/12/2023, Resident A went to the hospital at 6:30 pm and her medications were not documented as administered.

On 5/3/2023, I conducted an on-site inspection at the facility. I reviewed the March 2023 MARs with Employee #3 who stated the pharmacy had not removed the

antibiotic medications from Resident A's administration record. Employee #3 and I reviewed the April 2023 MARs in which the antibiotics were discontinued.

I reviewed Resident A's service plan updated on 3/22/2023 which read staff administered her medications and she utilized the house pharmacy.

I reviewed Resident A's March 2023 medication administration records (MARs). The MARs read Resident A was prescribed Humalog 100 Unit/ml inject three times daily at 8:00 AM, 4:00 PM and 8:00 PM with food, 0-150= zero units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, over 400 contact the physician. The MARs read Humalog doses at 4:00 PM and 8:00 PM were left blank from dates 3/1/2023 to 3/8/2023. The MARs read the Humalog orders were updated and read to administer three times daily at 8:00 AM, 12:00 PM and 4:00 PM. The MARs read staff documented Humalog doses were held per physician orders on 3/22/2023 for the 8:00 AM, 12:00 PM, 4:00 PM doses, and on 3/23/2023 for the 4:00 PM dose. The MARs read there were one or more doses of medications left blank on 3/10/2023. The MARs read on 3/26/2023 at 8:00 PM staff initialed Lantus Solostar, inject 27 units at bedtime as administered. The MARs read Nitrofurantoin [Macrobid] take one capsule by mouth every twelve hours for seven days was ordered on 3/9/2023 and not administered as prescribed. The MARs read antibiotic medications were prescribed for a specific period without start or end dates for the following Amoxicillin Clavulanate take one tablet by mouth every 12 hours for ten days, Cefuroxime Axetil take one tablet by mouth twice daily for five days, Cephalexin take one capsule by mouth four times daily for seven days, and Metronidazole take one tablet by mouth every eight hours for seven days.

I reviewed Resident A's March 2023 physician orders which read consistent with the MARs.

I reviewed a written statement from Employee #1 and dated 3/30/2023 which read Employee #1 was training Employee #2 and they were administering insulin together. The statement read Employee #2 took Resident A's blood glucose reading as directed and Relative A2 asked how many units of Insulin she received. The statement read Employee #2 was instructed only to take her blood glucose reading at that time and report back. The statement read Employee #2 walked out of Resident A's apartment and Relative A2 followed her out the door then viewed the medication log. The statement read Relative A2 viewed the wrong medication log. The statement read Relative A2 asked Employee #1 about the insulin dosage in which it was confirmed Resident A was to receive 12 units of Insulin.

APPLICABLE RULE	
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.

ANALYSIS:	Review of Resident A's medication administration records revealed Resident A did not receive her medications as prescribed. Based on this information, this allegation was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [for reference, see Special Investigation Reports (SIRs) 2022A1027092, 2023A1027007, 2023A1019013, and 2023A0784014]**

ALLEGATION:

Relative A2 was not permitted to visit Resident A.

INVESTIGATION:

On 3/29/2023, the Department received allegations through online complaint system which read the facility had "banned" Relative A2 and her spouse from visiting the facility.

On 3/31/2023, the Department received email correspondence from authorized representative Christopher Schott with a letter addressed to Relative A2. The letter read in part Relative A2 was permitted to visit Resident A within the confines outlined by the facility's legal counsel.

I reviewed Resident A's admission contract dated 7/29/2022 and signed by Relative A1 which read in part

> *"Resident accepts full responsibility for any injury or damage caused to others, or suffered by the Resident, as a result of the Resident's own acts or omissions, and those of the Resident's guests or invitees, and Resident indemnifies and holds harmless the facility and its owners/directors, agents and employees from any and all liability for such injury or damage, including attorney's fees."*
> *"Resident hereby acknowledges receipt of a copy of the Resident Rights and Responsibilities – see Attachment D."*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(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: **(k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.**
ANALYSIS:	Review of the facility's letter addressed to Relative A2 revealed she was permitted to visit Resident A; thus, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was missing personal property. The facility did not provide Resident A's medical records to emergency medical services.

INVESTIGATION:

On 4/13/2023, the Department received additional allegations through the online complaint system which read Resident A's medical devices and her microwave were missing from her apartment. The complaint read the missing items were reported to the facility's management. Additionally, the complaint read Relative A2 visited Resident A on 3/12/2023 in which she woke up confused, however became more orientated but was not her normal self when Relative A2 left. The complaint read Relative A2 received a call from the staff two hours later to inform her that Resident A "was not right." The complaint read facility staff called emergency medical services (EMS), who after speaking with Relative A2, agreed that Resident A should be taken to the hospital. The complaint read the EMS drivers spoke with Relative A2 at the hospital in which they stated the facility staff had not provided them Resident A's medical information. The complaint read facility staff could not provide Resident A's last name and did not provide her history or medication records. The complaint read facility staff stated to EMS that Resident A's leg hurt, that her speech was always slurred, and she was always confused. The complaint read the facility staff did not provide EMS Resident A's medical information so they could complete their job.

On 5/2/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Kreklau who stated all Resident A's missing personal property was replaced. Ms. Kreklau stated the facility provided microwaves in each apartment. Ms. Kreklau stated a microwave was found in the 2nd floor lobby in which after investigation, it belonged to Resident A, and was replaced with a new microwave because the previous one was broken. Ms. Kreklau stated Resident A's blood pressure cuff and pulse oximetry were replaced, as well as her blow dryer. Ms. Kreklau stated the staff member working the day Resident A went to the hospital had a heavy accent so possibly EMS staff did not understand her, but she knew Resident A's name, in which she would have needed to know to call her family, as well as her history.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Kreklau. Employee #1 stated she has assisted and observed staff provide paperwork to EMS including a face sheet and medication list. Employee #1 stated the face sheets were maintained in a binder at the front desk to be copied and then the medications administration records were printed for EMS.

While on-site, I interviewed Resident A who appeared well groomed and dressed in clean clothing. Resident A stated she was doing well and was looking forward to her family coming to visit her. I observed a microwave and blow dryer in Resident A's apartment.

While on-site, I reviewed the facility's resident register which was maintained at the facility's front desk and read consistent with statements from Employee #1.

I reviewed Resident A's admission contract dated 7/29/2022 and signed by Relative A1. The contract read in part:

"The facility shall not be responsible for the loss of any personal property belonging to Resident due to theft, fire, or any other cause, unless loss or damage was caused by the negligence of the facility or its employees. In the event of such loss refer to personal property/content loss policy. The facility strongly recommends that Resident obtains, at Resident's own expense, insurance for the replacement valve of Resident's personal property, at adequate coverage and liability limits. It is not recommended that Resident keep cash nor valuables in Unit. As noted above, Facility is not responsible for cash nor valuables kept in Resident's room."

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Review of Resident A's contract revealed the facility was not responsible for loss of personal property; however, observations, along with staff attestations, revealed her personal belongings were replaced. There was lack of substantial evidence to support staff did not provide Resident A's medical information or records to EMS.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

05/05/2023

Jessica Rogers Date
Licensing Staff

Approved By:

05/26/2023

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