GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 30, 2023

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

RE: License #: AH820409556
Investigation #: 2023A1027079
The Westland House

Dear Licensee:

While violations have been identified in the report, a written corrective action plan is not being requested as the violations identified are covered by the scope and actions required in the Correction Notice Order dated June 22, 2023.

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, 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
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2023A1027079
Complaint Receipt Date:	06/30/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	08/30/2023
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 lacked care.	No
Resident A's medications were not administered as prescribed.	Yes
Additional Findings	No

III. METHODOLOGY

06/30/2023	Special Investigation Intake 2023A1027079
07/03/2023	Special Investigation Initiated - Letter Referral emailed to APS
07/03/2023	APS Referral Conducted by email
07/18/2023	Contact - Telephone call received Telephone interview conducted with APS worker
08/11/2023	Contact - Document Sent Email sent requesting documentation pertaining to Resident A
08/11/2023	Contact - Document Received Email received with requested documentation
08/18/2023	Contact - Telephone call made Telephone call conducted to two different offices at Beacon Hospice in which there was no answer.
08/21/2023	Contact - Document Sent Email sent to Wanda Kreklau and Chris Schott to request additional documentation
08/23/2023	Contact - Document Received Email received from Wanda Kreklau with requested documentation.
08/25/2023	Inspection Completed On-site
08/25/2023	Inspection Completed-BCAL Sub. Compliance

08/31/2023	Exit Conference Conducted with Christopher Schott by email

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 7/3/2023, the Department received a complaint through the online complaint system which read Resident A lacked care. The complaint read Resident A and her apartment were “filthy.” The complaint read Resident A had several falls in front staff and was sent to the hospital. The complaint read Resident A had multiple problems in which were not communicated.

On 8/18/2023, I attempted to contact Beacon Hospice Services by telephone at two separate offices in which the phone rang but was not answered nor went to voicemail.

On 8/23/2023, per email correspondence with Wanda Kreklau, Resident A’s showers were provided by Beacon Hospice, once she signed onto services.

On 8/25/2023, I conducted an on-site inspection at the facility. I interviewed administrator Wanda Kreklau who stated Resident A ambulated by wheelchair and had a history of falling out it trying to reach for things. Ms. Kreklau stated Resident A’s daughter provided her cigarettes in which staff would accompany her outside to smoke intermittently throughout the day. Ms. Kreklau stated Resident A’s apartment had some of her belongings in it in which her family was planning to pick them up soon.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Kreklau. Employee #1 stated Resident A required one person assistance for all activities of daily living. Employee #1 stated Resident A’s briefs were changed consistently and her showers were provided as scheduled. Employee #1 stated Resident A’s apartment appeared clean; however, she enjoyed snacking so often food was observed on the floor which staff picked up and threw away. Employee #1 also stated Resident A enjoyed eating her snacks in bed.

While on-site, I interviewed Employees #2 and #3 whose statements were consistent with previous staff interviews.

While on-site, I observed Resident A’s apartment in which the carpet appeared discolored around where her bed was located, along with a few food crumbs on the floor, otherwise it appeared unsoiled. I observed various snacks on the counter. While on-site, I observed four other apartments on the same floor as Resident A’s apartment in which the carpeting appeared clean.

I reviewed Resident A's admission contract dated 11/3/2022 which read in part:

"Facility will provide a daily check on the status of the Resident."

"The facility will make personal assistance and care services available to the Resident, according to his or her needs, as determined by the resident's service plan, and utilizing its routine levels of staffing and equipment."

"The unit will be provided with housekeeping services as directed in the levels of care."

I reviewed Resident A's face sheet which read in part she moved into the facility on 11/4/2022. The face sheet read in part Resident A's authorized representative and responsible person for her bills was Relative A1. The face sheet read in part Resident A passed away on 8/2/2023.

I reviewed Resident A's service plan updated and reviewed with Relative A1 on 7/9/2023. The plan read in part Beacon Hospice services was initiated on 6/28/2023. The plan read in part Resident A required one person assistance for showering. The plan read in part her shower/bath days were Wednesdays and Saturdays. The plan read in part Resident A was a fall risk. The plan read in part Resident A required one person assistance for dressing, transfers, and mobility. The plan read in part Resident A required supervision while smoking because she would drop things while outside and would fall while picking them up. The plan read in part Resident A required reminding and cueing.

I reviewed Resident A's incident reports. Incident report dated 6/7/2023 read in part Resident A was observed on the floor during rounds. The report read she was trying to get out bed, tripped and fell. The report read Resident A expressed that her hip hurt. The report read staff contacted Resident A's daughter, the Director of Nursing, and emergency medical services. The report read the measures to prevent occurring events was to conduct more frequent checks and to ensure her room was free from clutter. The report read Resident A was sent to the hospital.

I reviewed Resident A's care coordinator notes which read consistent with her service plan regarding her hospice services.

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:	Staff attestations and review of Resident A's medical records revealed she required one person assistance with her activities of daily living, needed reminding, and had a history of falls. Observations revealed although her apartment carpeting was discolored in some areas, there was lack of evidence it was not cleaned. Additionally, there was insufficient evidence to support Resident A lacked care consistent with her service plan, thus this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medications were not administered as prescribed.

INVESTIGATION:

On 7/3/2023, the Department received a complaint through the online complaint system which read Resident A's medications were not administered at the appropriate time.

I reviewed Resident A's service plan which read in part staff administered her medications.

I reviewed Resident A's June, July and August 2023 medication administration records (MARs).

The June 2023 MAR read in part staff documented Resident A was out of the facility as the reason why medications Famotidine and Acetaminophen were not administered on the following dates 6/7/2023 through 6/22/2023, except on 6/11/2023 in which it was documented her morning medications were administered. The MAR read in part Resident A was out of the facility from 6/22/2023 to 6/29/2023. The MAR read in part it was left blank for one or medications on the following dates 6/9/2023, 6/11/2023, and 6/30/2023.

The July 2023 MAR read in part Resident A was prescribed Quetiapine Fumarate 25 mg tablet, take ½ tablet by mouth every other day. The MAR read in part staff administered Quetiapine Fumarate on consecutive days such as 7/8/2023 and 7/9/2023, 7/15/2023 and 7/16/2023, and 7/22/2023 and 7/23/2023, and 7/29/2023 and 7/30/2023. The MAR read in part Resident A was prescribed Famotidine 20 mg tablet, take one tablet by mouth every day in which there were two orders. The MAR read in part Famotidine was ordered 1/7/2023 and stopped on 7/6/2023 at 12:00 PM, the other order read Famotidine was ordered 7/5/2023 and stopped on 8/2/2023 at 12:00AM. The MAR read in part staff documented two doses of Famotidine administered on 7/6/2023.

The August 2023 MAR read in part the following medications were duplicated Docusate Sodium, Famotidine, Ferrous Sulfate, Quetiapine Fumarate, Senna, Vitamin D3, Oxycodone; however, staff documented and initialed one prescription as administered.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's medical records revealed the facility was responsible for her medication administration. Review of Resident A's medication administration records revealed they were not always administered as prescribed by her licensed health care professional; thus, this allegation was substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Please reference Corrective Notice Order dated 6/22/2023]**

IV. RECOMMENDATION

I recommend continued monitoring through the Corrective Notice Order dated 6/22/2023.

08/30/2023

Jessica Rogers Date
Licensing Staff

Approved By:

08/31/2023

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