GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 15, 2024

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

RE: License #: AH820409556
Investigation #: 2024A1035065
The Westland House

Dear Christopher 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 responsible party 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) 284-9730.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2024A1035065
Complaint Receipt Date:	07/24/2024
Investigation Initiation Date:	07/24/2024
Report Due Date:	09/23/2024
Licensee Name:	WestlandOPS, LLC
Licensee Address:	2nd Floor 600 Stonehenge Pkwy Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Administrator:	Christopher Schott
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:	08/11/2023
Expiration Date:	08/10/2024
Capacity:	102
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Med Techs are pre-popping medication and not administering medications as ordered.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

07/24/2024	Special Investigation Intake 2024A1035065
07/24/2024	Special Investigation Initiated - Letter
08/12/2024	Contact - Face to Face

ALLEGATION:

Med Techs are pre-popping medication and not administering medications as ordered.

INVESTIGATION:

On July 24, 2024, the department received a complaint through the online complaint system stating medication technician staff members are pre-popping medication without labeling medication cup putting residents at risk for receiving the wrong medication and staff members are not administering medications as ordered.

On August 12, 2024, an onsite investigation was conducted. While onsite I interviewed Eric Simcox Regional Operations, Sarah Reynolds Regional Operations, Kathy McMonagle Regional Nurse, and Nikki Long Director of Nursing who state they are new to the facility and will assist in gathering requested data.

While onsite I interviewed Staff Person (SP)1 who states she has been with the facility approximately one month. The facility recently had a medication administration class which covered med pass, medication rights, and not pre-popping medications. SP1

reports never pre-popping medication nor seeing medications pre-popped. SP1 able to articulate proper medication administration.

While onsite I interviewed SP2 who states medication should not be pre-popped and should be given at time of medications being removed from blister pack. While auditing SP2 medication cart on the second floor a medication cup was noted with pre-popped medication without labeling. SP2 states she was unaware of the medications being pre-popped and placed in drawer. Pre-popped medication discarded at this time. Several loose medications noted in top drawer.

While onsite I interviewed Nikki Long Director of Nursing who states she started approximately one month ago. Nikki states she has been auditing resident charts, medication carts along with providing education to staff members to improve quality of service being provided.

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. **(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.** **(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:** **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given. (vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	It was noted through direct observation one med cup filled with pre-popped medications in the top drawer of med cart on second floor. SP2 states she's not sure how pre-popped and non-labeled medication got in the cart "it must have been there from a previous shift." Medication administration records reviewed on four residents; medications noted to be administered as ordered. Based on direct observation one pre-popped and non-labeled medication cup noted in second floor medication cart this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/13/2024

Jennifer Heim — Date
Licensing Staff

Approved By:

08/14/2024

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