GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 13, 2022

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

RE: License #: AH820409556
Investigation #: 2023A0784014
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 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L. Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2023A0784014
Complaint Receipt Date:	11/14/2022
Investigation Initiation Date:	11/15/2022
Report Due Date:	01/13/2022
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?
Residents did not receive medications for several days	Yes
Additional Findings	Yes

III. METHODOLOGY

11/14/2022	Special Investigation Intake 2023A0784014
11/15/2022	APS Referral
11/15/2022	Special Investigation Initiated - Letter APS Referral
11/15/2022	Contact - Telephone call made Attempted with complainant. Message left requesting a return call
11/15/2022	Contact - Telephone call made Interview with administrator Wanda Kreklau and wellness director Tianna Black via speaker phone
11/15/2022	Contact - Document Sent Email sent with request for investigative documentation/information
11/17/2022	Contact - Document Received Investigative documents/information received via email
11/30/2022	Contact - Telephone call made Interview with Ms. Kreklau
11/30/2022	Contact - Document Sent Additional request for documentation/information sent to Ms. Kreklau via email
12/01/2022	Contact - Document Received Documents received from Ms. Kreklau via email
12/13/2022	Exit Conference – Telephone Conducted with administrator Wanda Kreklau

ALLEGATION:

Residents did not receive medications for several days

INVESTIGATION:

On 11/14/2022, The department received this complaint.

According to the complaint, Resident A did not receive medications for several days after the facility changed the pharmacy they use, and the medications have not been delivered yet.

On 11/15/2022, I interviewed administrator Wanda Kreklau and wellness director Tianna Black by speaker phone. Ms. Kreklau stated that on approximately 11/11/2022, the facility changed to a new pharmacy for resident medications due to difficulties they were having with the old pharmacy related to communication and consistency. Ms. Black stated that after the change took place, a medication technician (med tech) reported that Resident A did not have all her medications from the new pharmacy. Ms. Black stated that, upon investigation, it was discovered that while the old pharmacy sent all recurring medication orders to the new pharmacy, they did not provide information to the new pharmacy for any medications that did not have auto-refill orders. Ms. Kreklau stated that, while the new pharmacy did fill all orders, and include them on the medication administration record (MAR) for any medications that had recurring refills, they were not aware of the non-recurring orders needing refills. Ms. Kreklau stated it was her expectation that the old pharmacy would send a list of all the medications each resident had been taking, and not just the orders for medications that had automatic refills. Ms. Black stated that once she was informed of the issue, she immediately started working with the new pharmacy to correct the issue. Ms. Kreklau and Ms. Black stated they did not, prior the changeover and discover of the missing medications, preemptively provide the new pharmacy with a list of all the medications each resident had been taking or ensure that the new pharmacy received new orders for any medications which did not automatically get refilled.

On 11/16/2022, I received an email from Ms. Black which read, in part, "The date the pharmacy officially switched over was Thursday November 10th at nighttime. We didn't start using the new meds until the 11th of November. When the pharmacy switch took place only thing we received for [Resident A] was her Gabapentin. So yes, she was without all of her meds from 11/11/22- 11/14/22. We became aware when the med tech was doing meds in the morning [of 11/11/22] and she called to inform me that Karen was out of pills. When I spoke with the new pharmacy, and they were able to send meds out. Some meds were not in the system because when the old pharmacy sent over the orders, they did not send anything that didn't have refills. So, I had to go through all the meds that were missing and tell the pharmacy everything that is missing, and we have to work with the doctors to get refills on everything missing".

I reviewed Resident A's November MAR, provided by Ms. Black, which read consistently with statements she provided regarding Resident A's missed medications from 11/11/22 to 11/14/22.

On 11/18/2022, the department received an additional complaint indicating Resident B did not receive her medications from 11/12/2022 until 11/18/2022.

On 11/22/2022, the department received an additional complaint indicating Resident C did not receive prescribed Eliquis, Vasopressor or Ritalin from 11/11/2022 to 11/17/2022.

On 11/30/2022, the department received an additional complaint indicating Resident D is not receiving prescribed Seroquel.

On 11/30/2022, I interviewed Ms. Kreklau by telephone. Ms. Kreklau stated she was not aware of the details surrounding Resident B, C and D missing medications. Ms. Kreklau stated she would investigate and provide clarifying information.

On 12/01/2022, I received an email from Ms. Kreklau which included a narrative statement regarding the alleged missed medications for Resident's B, C and D. The email read "included in this narrative for the following residents [Resident D, Resident C and Resident B, is a summary of any medication discrepancies. For [Resident D] we don't have any missed medication. She had all her scheduled medication. [Resident C] was missing her Eliquis and Metoprolol. When I realized she was out of her medication, I got the doctor to write refills for her prescriptions. She received her refills [on] 11/17/2022. [Resident B] was missing Xarelto, Spironolactone, Methimazole, Losartan, 50+occuvite, atorvastatin, and digoxin. When it was brought to our attention that she was out of those meds we were able to get refills. She got the refills on 11/19. Only thing that was still missing is digoxin and 50+occuvite. We were then able to get those refilled as well".

I reviewed November 2022 MARs for Resident's B, C and D, provided by Ms. Kreklau, which read consistently with statements provided within the written statement she 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.
For Reference: R 325.1901	**Definitions**

	(14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all 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 well-being 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.

ANALYSIS:	The initial complaint alleged Resident A was not administered several of her medications for several days as they were missing after the facility transitioned to using a new pharmacy. Additional comoplaints received by the department alleged Resident's B, C and D had also not been administered medications in relation to the change of pharmacy. Reporting from the administrator, Ms. Kreklau, and wellness director, Ms. Black, as well as review of MARS documentation confirmed that at least three of these residents, Residents A, B and C, had in fact missed several doses of several medications for multiple days. Additionally, while the missed medications appear to be predicated on the old pharmacy's poor communication, or lack thereof in some respect, to the new pharmacy, it is the primary responsibility of the facility to pursue adequate pre-emptive communication within such processes in order to ensure residents are protected from the protentional harm of missing medications, and in this case multiple medications, which was not done. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of the facility licensing file revealed no reporting from the facility specific to the medications errors previously noted for Resident's A, B, C and D.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements.
For Reference: R 325.1901	**Definitions**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.

ANALYSIS:	The investigation revealed that several residents were not administered medications between approximately 11/11/2022 and 11/19/2022. Review of the facility licensing file revealed that, despite the potential harm to residents, the facility did not provide an incident report for any of the residents and related missed medications. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that that status of the license remain unchanged.

12/07/2022

Aaron Clum Date
Licensing Staff

Approved By:

12/13/2022

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