

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

February 9, 2023

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

> RE: License #: AH820409556 Investigation #: 2023A1019013

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff Bureau of Community and Health Systems 611 W. Ottawa Street P.O. Box 30664 Lansing, MI 48909 (810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
License #.	АП020409550
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Investigation #:	2023A1019013
Complaint Receipt Date:	01/17/2023
Investigation Initiation Date:	01/18/2023
Report Due Date:	03/16/2023
Licensee Name:	WestlandOPS, LLC
Licensee Address:	600 Stonehenge Pkwy 2nd Floor
Licensee Address.	Dublin, OH 43017
1 ******* * *!*****	(04.4) 400 0700
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 Tolophone #:	(734) 326-6537
Facility Telephone #:	(734) 320-0337
	00/05/0000
Original Issuance Date:	02/25/2022
License Status:	REGULAR
Effective Date:	08/11/2022
Expiration Date:	08/10/2023
Capacity:	102
Brogram Typo:	AGED
Program Type:	AGED

II. ALLEGATION(S)

Violation Established?

	Established?
Resident B's medications are not administered properly.	Yes
Additional Findings	No

III. METHODOLOGY

01/17/2023	Special Investigation Intake 2023A1019013
01/18/2023	Special Investigation Initiated - Letter Contacted complainant via email for additional information.
01/18/2023	APS Referral Notified APS of the allegations via email referral template.
01/24/2023	Inspection Completed On-site
01/26/2023	Inspection Completed-BCAL Sub. Compliance
01/26/2023	Contact - Telephone call made Called administrator to conduct interview, left message with facility staff who reported that she was in a meeting.
01/27/2023	Contact- Telephone call received Phone interview conducted with administrator.

ALLEGATION:

Resident B's medications are not administered properly.

INVESTIGATION:

On 1/17/23, the department received a complaint that Resident B didn't get her medications as prescribed on 12/28/22 and 12/29/22. The complainant reported that Resident B's Haldol and Hydrocodone were administered late on both dates and that Resident B received the incorrect dose of Seroquel on 12/28/22. The complainant did not witness this and was told by another party that the allegations occurred.

On 1/24/23, I conducted an onsite inspection. Administrator Wanda Kreklau was not present, so Employee 1 was interviewed in her absence. Employee 1 denied knowledge of any medication issues with Resident B. While onsite, I requested Resident B's medication administration record (MAR) for the month of December 2022. Employee 1 stated that the facility utilizes a paper MAR but she was unable to produce the requested records, stating "Our nurse recently quit and I don't know what she did with the files."

In follow up correspondence, Ms. Kreklau stated that the only medication issue that was brought to her attention regarding Resident B was that on one occasion her medications weren't crushed. Ms. Kreklau provided Resident B's MAR and physician's orders for her medications.

Resident B's Haldol order read "give every 6 hours as needed". Resident B's Hydrocodone order read "take one tablet by mouth twice daily". Resident B had two orders for Seroquel, one order was for 25mg and read "take one tablet by mouth at bedtime) and the other order was for 50mg and read "take one tablet by mouth twice daily). Per staff's documentation on Resident B's MAR, Haldol was not administered to Resident B at all on 12/28/22 and administered once to her on 12/29/22. Staff documented on 12/28/22 and 12/29/22 that Resident B received one Hydrocodone tablet instead of two. Resident B also only received one dose instead of two from 12/2/22-12/30/22; two doses of the scheduled Hydrocodone were only administered to Resident B on 12/1/22 and 12/31/22. Per staff's documentation on Resident B's MAR for the 25mg dose of Seroguel, that medication was administered as ordered on 12/28/22 and was documented as administered correctly for that entire month. For the 50mg dose that should be taken twice daily, Resident B received only one dose on 12/28/22. Resident B also only received one Seroquel tablet instead of two from 12/1/22-12/27/22; two doses of scheduled Seroquel were only administered to Resident B on 12/28/22-12/31/22.

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:	Resident B did not receive medication as prescribed on several dates throughout December 2022.
CONCLUSION:	REPEAT VIOLATION ESTABLISHED [for reference, see special investigation report (SIR) 2023A1027007, 2023A0784014 and 2022A1027092]

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend no changes to the status of the license.

01/27/2023

Elizabeth Gregory-Weil Licensing Staff

Date

Approved By:

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02/02/2023

Date

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