GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

November 27, 2024

RE: License #: AH820409556
Investigation #: 2024A1022076
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 authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara Zabitz, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 296-5731

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820409556
Investigation #:	2024A1022076
Complaint Receipt Date:	08/12/2024
Investigation Initiation Date:	08/30/2024
Report Due Date:	10/11/2024
Licensee Name:	WestlandOPS, LLC
Licensee Address:	2nd Floor 600 Stonehenge Pkwy Dublin, OH 43017
Licensee Telephone #:	(614) 420-2763
Administrator:	Michele White
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:	08/11/2024
Expiration Date:	07/31/2025
Capacity:	102
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents do not receive appropriate care.	Yes
Medications are administered late.	Yes
The facility is short of staff.	No
The facility is poorly maintained.	No
Additional Findings	Yes

III. METHODOLOGY

08/12/2024	Special Investigation Intake 2024A1022076
08/30/2024	Special Investigation Initiated - On Site
08/30/2024	Inspection Completed On-site
10/14/2024	Contact - Document Received Email exchange with the DON
10/25/2024	Contact - Document Received Email exchange with administrator
11/07/2024	Exit Conference
11/26/2024	Contact - Document Received Email exchange with administrator

ALLEGATION:

Residents do not receive appropriate care.

INVESTIGATION:

On 08/12/2024, the Bureau of Community and Health Systems (BCHS) received an anonymous complaint that read, “My (family member) is unable to receive the proper care she needs because the aide that’s assigned to her room is also assigned to other floors and also more than two medication carts. Agency (employees) walk out

when they see the residents due to no proper care. Residents unable to walk or even move, there is no way they can have two person assist when there's nobody here to help."

On 08/30/2024, at the time of the onsite visit, I interviewed the interim administrator, the interim assistant administrator, and the director of nursing (DON). The authorized representative (AR) was not in the building, but he joined the interview via videoconference.

The facility identified 3 residents who required total care from caregivers, Resident A, Resident B, and Resident C. According to the DON, these three residents had the most extensive care needs of the resident population. They each needed the assistance of two caregivers and were assisted last. Usually, the medication technicians (med techs) who had completed their medication administration passes earlier would assume this task.

Resident A was lying in bed in her room with her eyes closed. Caregiver #1 and caregiver #2 asked Resident A if she was ready to get dressed for the day. Resident A nodded in agreement but was unenthusiastic. The two caregivers first checked her incontinence brief, and it was dry, indicating that she had received care earlier. The caregivers then preceded to wash Resident A's upper body and help her put clothes on. After she was dressed, caregiver #1 asked her if she wanted to get out of her bed and that she (caregiver #1) would help her (Resident A) brush her teeth when she was sitting in a chair. Resident A replied that she wanted to stay in bed a while longer and caregiver #1 replaced Resident A's blanket over her. According to her service plan, Resident A needed assistance from caregivers to complete her activities of daily living (ADLs), although Resident A was able to participate when cued by a caregiver. Her service plan indicated that Resident A's strength varied from day to day, and that when she felt weak, she needed the assistance of 2 caregivers to transfer in and out of bed and chair. If Resident A was feeling strong, she could stand with support of a walker.

Resident B was also in her room in bed. Caregivers #1 and #2 asked her if she was ready to get dressed, and Resident B replied that she was. Like Resident A, the two caregivers uncovered Resident B and prepared to provide her with incontinence care. Resident B's brief was moderately wet and there were traces of pink tinged zinc oxide moisture barrier in the brief. Resident B was observed to have marked redness of her buttocks. After cleaning Resident B's genital area and her buttocks, caregiver #2 applied a generous amount of zinc oxide moisture barrier to these area before placing a clean brief on Resident B. Resident B expressed that she did not feel well and was in pain. According to the DON, Resident B was in hospice care and was scheduled to be administered pain medication as soon as caregivers #1 and #2 had finished. According to her service plan, Resident B needed extensive assistance for the completion of her ADLs, including the assistance of 2 caregivers for transfer in and out of bed and chair. She was incontinent and wore an

incontinence brief. Her service plan noted that Resident B received hospice benefits since 11/02/2023.

Like Resident A and Resident B, Resident C was also lying in bed. Although she told caregiver #1 that she was ready to be dressed, just as soon as the two caregivers, she began to resist their efforts to remove her gown to wash and dress her. According to the two caregivers, Resident C was usually resistive to care and was known to become combative. According to the DON, Resident C was receiving hospice care. As the two caregivers removed Resident C's brief, Resident C began to say that "it (her buttocks) hurts!" Resident C's buttocks were observed to be reddened and on her left buttock, there was an area about the size of a quarter, that appeared to be missing the top layer of skin. Before caregiver #2 was able to react, Resident C began to scratch and dig at the opened area. With much coaxing and with the caregivers reapproaching the resident, they were able to change Resident C's brief, wash her upper body, and assist her to put on a clean shirt. Resident C also requested to remain in bed. According to her service plan, Resident C needed assistance from caregivers for completion of her ADLs, but she was noted to be "reluctant to accept care" from her caregivers. She was known to become combative with caregivers and others. Caregivers were instructed to stop when Resident C displayed resistance to receiving care and to reapproach later.

On 06/07/2024, according to an incident report, the caregiver providing Resident C's care "observed a skin tear on her lower back right side." The nurse documented, "observed with skin tear to buttock and right side of buttock. Site cleaned, barrier cream applied, all responsible parties notified. No new orders or interventions at this time…" On 06/10/2024, Resident C's service plan for toileting and peri-care was updated with the instruction to "notify nursing staff of any changes in skin condition or odor, including redness and irritation." Otherwise, the service plan did not address the skin breakdown observed at the time of the onsite visit.

On 10/14/2024, via an email exchange, the DON was asked to explain the absence of this care need on the service plan. The DON acknowledged that a section for skin condition was added to the service plan on 09/06/2024, after my onsite visit. Resident C's behavior of scratching her buttocks was noted and caregivers were instructed to "apply (zinc oxide moisture barrier) ointment with each brief change." The DON was unable to provide any documentation regarding observed changes in Resident C's skin from June 2024 until September 2024, other than to say that Resident C was on hospice care. The DON did not say how hospice interventions for skin breakdown affected the facility's care for Resident C.

At the time of the exit conference, the administrator and the AR requested an opportunity to submit additional information to demonstrate that the facility was in compliance regarding the care of Resident C. The facility asserted that "The skin issue that was identified and treated in June (2024) healed in July (2024)" and that further interventions were unnecessary. The facility further provided notes maintained by Resident C's hospice provider that documented wound care was

provided by the hospice nurse to Resident C on 06/06/2024 and on 06/20/2024. On 07/05/2024, the hospice provider documented, “buttock wound healed.” However, on 07/19/2024, the hospice provider documented, “RN helped pt (patient) with her meal and provided companionship and wound care. Wound unchanged.” There was no further hospice documentation on Resident C’s wound until 09/10/2024, when the hospice nurse assessed Resident C’s skin, noting that her buttocks were red and irritated. The hospice nurse made visits to Resident C on 08/29/2024 and on 09/04/2024, but on neither occasion did the nurse note the impaired skin that I observed at the time of the onsite visit, on 08/30/2024.

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: **(e) A patient or resident is entitled to receive adequate and appropriate care**
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of 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.**

ANALYSIS:	Hospice documentation noted that Resident C's buttock wound had been healed on 07/05/2024. On 07/192024, hospice notes document that wound care was provided and the wound condition was unchanged. This lack of clarity in documentation makes it difficult to know the status of the buttock wound. However, an area of skin impairment was observed at the time of the onsite visit on 08/30/2024. The facility was unaware of the change in Resident C's skin condition and had not sought any wound care for this change in skin condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications are administered late.

INVESTIGATION:

According to the anonymous compliant, "Medications are always missed or late due to caregivers having to be on every medication cart by themselves."

According to the DON, the facility utilized an electronic medication administration system whereas a bar code on each medication was scanned with a bar code reader as it was passed to the resident and ensure to the extent possible that all administration passes were recorded.

The facility provided the August 2024 medication administration records (MARs) for Resident A, Resident B, and Resident C. Review of the MARs revealed no evidence that medications were skipped for any of these residents, however, the documentation did reveal that medications were often administered more than 1 hour after the time prescribed for administration by both the morning shift med tech and by the overnight med tech.

Resident A was prescribed Dorzolamide-Timolol Eye Drops 1 drop each eye twice daily, scheduled by the pharmacy for 8 am and 8 pm. The 8 am administration was administered late on multiple occasions in August 2024 including on 1 occasion when it was administered at 12:15 pm. She received the overnight shift dose as late as 11:50 pm. Resident B was prescribed Hydralazine 50 mg tablet twice daily, scheduled by the pharmacy for 8 am and again at 8 pm. For the 8 am dose, Resident B also received the medication as late as 12:15 pm. For the 8 pm dose, it was administered as late as 11:30 pm. Resident C was prescribed Eliquis 5 mg tablet, take one every 8 hours by mouth, scheduled by the pharmacy at 8 am and again at 8 pm. For the 8 pm dose, Resident C was administered the medication as late as 10:46 pm.

Further review additionally revealed that medications were administered more than 1 hour early. Resident A received her 8 am eye drops as early as 6:20 am; Resident B received her 8 pm Hydralazine as early as 6:06 pm, and Resident C received her 8 am Eliquis as early as 5:55 am.

According to the facility policy, Medication Administration, “Medications can be administered within a two-hour time frame (one hour before to one hour after the time prescribed by the Physician). Administering medications too early or too late is considered a medication error (if it could result in significant harm) and must be followed by an incident report…”

On 10/25/2024, via an email exchange with the newly hired administrator, the administrator was asked to explain the medication administration times. The administrator stated, “Prior to my (the newly hired administrator) employment, The Westland House hired a consultant group to strengthen the Medication Administration program. Unfortunately, this group informed staff that medications could be given during a much broader time frame (than what was specified in the Medication Administration policy). Staff was instructed that Morning medication could be passed between 5:00am and 11:59am; Afternoon Medications could be passed between 12:00pm and 4:59pm; Bedtime Medications could be passed between 5:00pm and 10:59pm; and Nighttime medications could be passed between 11:00pm and 4:59am… the pharmacy had a kept the set schedule for each medication and that schedule is what should have been followed… I am currently working with the pharmacy and the physicians to stagger the administration times when able.”

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:	Based on the review of medication administration records, medications were not administered according to the prescribing health care professional’s order.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is short of staff.

INVESTIGATION:

According to the written complaint, “The facility is always short staffed…”

When asked about staffing, the AR explained that the facility did not have a large census, and few residents needed more than supervision. They expected all employees to “work as a team,” to help each other out. There were not that many medications to be administered and so the med techs also provided care. At the time of the onsite visit, caregivers and med techs worked 12-hour shifts and the morning shift was staffed the same as the overnight shift. Five employees were scheduled for each shift comprised of 2 med techs and 3 caregivers. One med tech covered floors #1 and #4. One med tech covered floors #2, #3, and #5. Likewise, 1 caregiver covered floors #1 and #4. Another caregiver covered floors #3 and #5. The caregiver who was assigned to floor #2 had the heaviest assignment and was not assigned to another floor. The AR went on to explain that staffing was determined by the acuity score of the residents living in the facility as well as the number of medications that needed to be administered to residents and was subject to change as the facility’s needs changed. Additionally, for the overnight shift, he did not believe that 5 total caregivers were necessary after midnight, and the facility was working towards changing their staffing schedule from two 12-hour shifts to three 8-hour shifts to reflect the need for fewer staff after midnight.

The facility provided their staffing schedule for the week of 08/11/2024 through 08/17/2024. Review of the schedule revealed that there were only 4 employees working for the following overnight (6 pm to 6 am) shifts: 8/11/2024; on 08/12/2024; on 8/15/2024; and on 8/15/2024.

At the time of the exit conference, the AR indicated that he had misspoke when he initially described the number of caregivers needed. According to the email exchange on 11/26/2024, “Our staffing standards consist of five RAs (caregivers) for the morning shift and four RAs for the evening shift, which aligns with our resident census of 53 to 54. This results in a staffing ratio of 1 RA for every 10 residents in the morning and 1 RA for every 13 residents in the evening…”

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
For Reference: R325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the

	specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The facility's staffing was sufficient to meet their staffing ratio formula.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is poorly maintained.

INVESTIGATION:

According to the written complaint, maintenance issues include "unclean building, roaches all on the floor, doors (are) broken."

When asked about broken doors and other equipment issues, both the AR and the interim administrator explained that the facility had just had its HUD (Federal Department of Housing and Urban Development) inspection on 08/28/2024 for their physical plant. Review of the inspection report provided by the facility revealed that the inspection had identified 4 of 25 units inspected had malfunctioning doors as well as the presence of other physical plant deficiencies categorized as "severe," "moderate," and "low." According to the interim administrator, the facility had been mandated to correct the violations within HUD specified timeframes: 24-hours for "high," as well as 30-day and 60-day timeframes for the less severe deficiencies. The deficiencies identified as needing correction within 24 hours had been completed and they were confident that they would meet the timeframes for the remaining violations.

When asked about "roaches on the floor," the AR stated that the facility's pest control company was making routine preventive maintenance, but no one had reported the presence of cockroaches.

At the time of the onsite visit, observation did not indicate that the interior of the building, furnishings, or equipment was unclean, broken, or unmaintained in any manner.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observation indicated that the facility was clean and in good repair.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of the MAR for Resident C revealed that she had a prescriber's order for Hydralazine, 25 mg tablet, take 1 tablet by mouth every 8 hours for blood pressure. The pharmacy scheduled the medication to be given at 6 am, 2 pm, and at 10 pm. On 08/26/2024, Resident C she was administered the medication at 7:32 am, 2:30 pm, and at 6:44 pm. When the administrator was asked if the health care professional who prescribed the medication had been notified that the medication had been administered in a timeframe much less than every 8 hours, the administrator replied that she was unable to find an incident report for this event.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**
ANALYSIS:	The facility did not contact the prescribing health care professional when Resident C's medication, Hydralazine, was not administered according to the order.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/27/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

11/27/2024

_____

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