GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 20, 2024

Tahir Khan
The Oasis of Norton Shores
6025 Harvey Street
Norton Shores, MI 49444

RE: License #: AH610411693
Investigation #: 2025A1010003
The Oasis of Norton Shores

Dear Licensee:

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.

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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH610411693
Investigation #:	2025A1010003
Complaint Receipt Date:	10/08/2024
Investigation Initiation Date:	10/08/2024
Report Due Date:	12/07/2024
Licensee Name:	The Oasis of Norton Shores LLC
Licensee Address:	Ste C 2575 Mcleod Drive North Saginaw, MI 48604
Licensee Telephone #:	(989) 992-4587
Authorized Representative/Administrator:	Tahir Khan
Name of Facility:	The Oasis of Norton Shores
Facility Address:	6025 Harvey Street Norton Shores, MI 49444
Facility Telephone #:	Unknown
Original Issuance Date:	06/26/2024
License Status:	TEMPORARY
Effective Date:	06/26/2024
Expiration Date:	12/25/2024
Capacity:	115
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff Person 1 (SP1) administered the incorrect dose of Resident A's prescribed liquid morphine. Resident A was hospitalized and given Narcan due to being overdosed.	Yes

III. METHODOLOGY

10/08/2024	Special Investigation Intake 2025A1010003
10/08/2024	Special Investigation Initiated – Telephone Received telephone call regarding incident from administrator
10/08/2024	Contact - Telephone call received Telephone call from the administrator received regarding the medication error
10/09/2024	Contact - Telephone call made The administrator reported the medication error and agreed to email the incident report and staff statements regarding the incident
10/09/2024	Contact - Document Received Email with incident report received from administrator
10/14/2024	Inspection Completed On-site
10/14/2024	Contact - Document Received Received all internal investigation facility documents, including staff statements, resident service plan, and staff medication administration training documents
10/21/2024	Contact - Telephone call made Telephone call with assigned Norton Shores Police Dept Detective Jared Passchier
10/21/2024	Contact - Document Received Police report received from Det. Passchier
11/01/2024	Contact - Telephone call made Telephone message left for SP5, a telephone call back was requested

11/20/2024	Exit Conference

ALLEGATION:

Staff Person 1 (SP1) administered the incorrect dose of Resident A's prescribed liquid morphine. Resident A was hospitalized and given Narcan due to being overdosed.

INVESTIGATION:

On 10/8/24, the Bureau received the allegations from the online complaint system. The complaint read Resident A "was supposed to receive a certain amount of medication but received the wrong amount. [Resident A] was sent to Trinity Hospital in Muskegon and treated for an overdose and sent back to the facility. The next day [Resident A] was found with a significant condition change." The complaint also read Resident A "did pass away, was found at 10:40 a.m."

On 10/8/24, I reviewed an email I received from the administrator on 10/4/24. The email dated 10/4/24 read,

> "One of our employees mistakenly administered the wrong dosage of medication to one of our residents. Fortunately, our RCC quickly noticed that the resident was unusually quiet and dizzy, prompting further investigation. It was then discovered that the wrong dosage of medication had been given.
>
> The employee responsible has been terminated, and the necessary incident reports have been filed. After consulting with Hospice, the resident was sent to the hospital as a precautionary measure, and the family has been notified of the situation.
>
> To prevent this from happening again, we will be conducting an in-service training for all employees. This training will be a part of our upcoming mandatory meeting and will focus on ensuring proper medication administration and reducing the risk of future errors."

On 10/8/24, I received a telephone voicemail from the administrator regarding Resident A's medication error.

On 10/9/24, I interviewed the administrator by telephone. The administrator's statements were consistent with the email I received on 10/4/24 regarding the incident. The administrator agreed to email a copy of the incident report for my review.

On 10/9/24, I received a copy of the incident report via email from the administrator for my review. The *Explain What Happened/Describe Injury* section of the report

read, “Staff gave resident wrong dose.” The *Action Taken by Staff/Treatment Given* section of the report read, “Called Hospice resident sent to trinity Health and family was called.” The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section of the report read, “Staff was terminated. She was told to leave after it happened.” The report read Gentiva Hospice was notified on 10/4/24 at 1:30 pm and Resident A’s responsible persons were notified on 10/4/24 at 1:30 pm.

On 10/14/24, I interviewed SP2 at the facility. SP2 reported SP1 administered 2.5 mL of liquid morphine to Resident A on 10/4/24. SP2 stated Resident A is prescribed .25 mL of liquid morphine, therefore Resident A was overdosed. SP2 said after SP1 administered the incorrect amount of liquid morphine to Resident A, Resident A began to experience adverse side effects. SP2 reported at this time, SP1 admitted she administered 2.5 mL of liquid morphine to Resident A.

SP2 reported SP1 was not supposed to administer resident medications by herself when the incident occurred on 10/4/24. SP2 stated SP1 had not completed her medication administration training. SP2 explained staff who are training to administer resident mediations must complete a “competency checklist” on the floor under the supervision of the facility’s resident care coordinator (RCC). SP2 said when the “competency checklist” is completed, the RCC signs off on it and the staff person can begin to administer resident medications independently.

SP2 stated on 10/4/24, SP1 contacted her on the two-way radio staff carry during their shift. SP2 said SP1 told her over the two-way radio that she had a question regarding Resident A’s Morphine. SP2 reported she told SP1 to wait until she was done assisting a resident in their room in memory care. SP2 explained that while she was assisting the resident in memory care shortly after SP1 contacted her on the two-way radio, SP1 approached her with a medication cup that had a liquid medication in it. SP2 said SP1 held up the medication cup and asked, “is this enough?” SP2 reported she did not know what was in the medication cup, so she asked SP1 if it was cough syrup for Resident B. SP2 reported SP1 said “yes” it was cough syrup for Resident B. SP2 explained she then instructed SP1 to not administer the medication until she was done assisting the resident in memory care. SP2 stated SP1 did not listen to her instructions and administered the medication to Resident A.

On 10/14/24, I interviewed SP3 at the facility. SP3’s statements regarding the incident were consistent with SP2. SP3 said after the incident, Resident A was transported to the hospital and did receive Narcan. SP3 stated Resident A returned to the facility the same day she went out on 10/4/24. SP3 reported Resident A was at the facility when she died on 10/7/24. SP3 stated after the incident on 10/4/24, SP1 was sent home immediately and terminated on 10/5/24.

SP3 explained written statements from staff who were present and involved in the incident on 10/4/24 were obtained and are part of the incident report. SP3 provided

me with copies of the written statements from SP1, SP2, SP5, and SP6 for my review.

On 10/14/24, I interviewed SP4 at the facility. SP4's statements regarding the incident were consistent with SP2 and SP3.

SP4 reported prior to staff going on the floor to complete their medication administration competency check list, they must complete a "classroom" medication administration training with her. SP4 said staff must complete and pass a written medication administration competency test before they can go on the floor to complete their competency checklist with the RCC. SP4 stated the staff in training must complete 40 hours on the floor completing their competency checklist with the RCC before the RCC can sign off on it.

SP4 stated SP1 completed the classroom training and passed the medication administration competency test. SP4 provided me with a copy of SP1's written *MEDICATION ADMINISTRATION COMPETENCY TEST* that she passed for my review. The test was dated 9/24/24.

SP4 reported Resident A had her prescribed liquid morphine in sealed bottles, and some were in predawn syringes. SP4 stated SP1 took morphine from a sealed bottle and poured 2.5 mL in a medication cup rather than using a syringe. SP4 said she was present in the building during the incident on 10/4/24. SP4 stated she notified the Gentiva Hospice nurse regarding the incident and monitored Resident A's vitals after the incident. SP4 reported she contacted 911 when Resident A's "respirations dropped."

On 10/14/24, I was not able to interview SP1 as she is no longer employed at the facility. SP3 reported a written statement was obtained from SP1 before she was terminated. SP3 provided me with a copy of SP1's written statement for my review. The statement read, "I was told [Resident A] wanted mophen [sic] for pain. I went to med cart. Looked up her morphen [sic]. It said .25 mL. I looked at the med cup. Thought to myself no way that's too much. So not knowing to use the seringe [sic]. I put 2.5 mL in the med cup. I took it to [SP2] in memorie [sic] care and she asked me if that was for [Resident C]. Me not sure who it was for I took it to [Resident A]. Not being sure what I've been doing all day. I kept asking for help and not sure of a lot of things. First day on meds."

On 10/21/24, I contacted the assigned Norton Shores Police Department detective Jared Passchier by telephone. Detective Passchier reported he is investigating the incident and will present his case to the county prosecutor's office. Detective Passchier stated from there, the prosecutor's office will determine whether criminal charges will be pursued.

On 10/21/24, I received a copy of Detective Passchier's police report via email.

On 11/1/24, I attempted to interview SP5 by telephone. I left a telephone message and requested a telephone call back. I reviewed SP5's written statement regarding the incident. The statement read, "with the issues concerning [Resident A] I was with [SP2] when [SP1] called over the walkie saying [Resident A] wanted morphine. [SP2] said 'okay just give me a minute I'm with [Resident D].' Shortly after we got [Resident D] on the toilet [SP1] came into the room with a medicine cup asking if that was enough. Looking at the medicine cup [SP2] and I assumed it was cough medicine. Prompting [SP2] to ask if it was for [Resident B] [SP1] said yes it was for [Resident B] and so [SP2] said yeah that's fine."

As of 11/14/24, I have not received a telephone call back from SP5.

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:	The interviews with SP2, SP3, SP4, along with review of Resident A's incident report and staff written statements on 10/4/24, revealed SP1 incorrectly administered 2.5 mL of liquid morphine to Resident A when Resident A was prescribed .25 mL. This medication error caused Resident A to need medical attention and resident was transported to the hospital for treatment. Resident A did return to the facility; however, she died on 10/7/24. The facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility's licensee authorized representative on 11/20/24.

IV. RECOMMENDATION

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

11/14/2024

Lauren Wohlfert Date
Licensing Staff

Approved By:

11/20/2024

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