GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 19, 2025

Jason Muriithi
Oasis Care Services LLC
3749 Ivy Drive
Grand Rapids, MI 49525

RE: License #: AS410321061
Investigation #: 2025A0583019
Ivy Home

Dear Mr. Muriithi:

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 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 (616) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410321061
Investigation #:	2025A0583019
Complaint Receipt Date:	02/10/2025
Investigation Initiation Date:	02/12/2025
Report Due Date:	03/12/2025
Licensee Name:	Oasis Care Services LLC
Licensee Address:	3749 Ivy Drive, Grand Rapids, MI 49525
Licensee Telephone #:	(616) 550-3982
Administrator:	Jason Muriithi
Licensee Designee:	Jason Muriithi
Name of Facility:	Ivy Home
Facility Address:	3749 Ivy Drive, Grand Rapids, MI 49525
Facility Telephone #:	(616) 550-3982
Original Issuance Date:	12/06/2013
License Status:	REGULAR
Effective Date:	07/08/2023
Expiration Date:	07/07/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is being administered Tylenol without a physician's order.	No
Additional Findings	Yes

III. METHODOLOGY

02/10/2025	Special Investigation Intake 2025A0583019
02/12/2025	APS Referral
02/12/2025	Special Investigation Initiated - On Site
02/19/2025	Exit Conference Licensee Designee Jason Muriithi

ALLEGATION: Resident A is being administered Tylenol without a physician's order.

INVESTIGATION: On 02/06/2025 the above complaint allegation was received from LARA-BCHS-Complaints and was assigned for investigation on 02/10/2025. The complaint alleged that Resident A is being administered "Tylenol/Aleve every day multiple times" and the licensee designee Jason Muriithi reported that he did not have a physician's order for that medication.

On 02/12/2025 I emailed the complaint allegation to Adult Protective Services Centralized Intake.

On 02/12/2025 I completed an onsite investigation at the facility and privately interviewed staff David Nganga. Mr. Nganga stated that Resident A is prescribed Tylenol PRN. Mr. Nganga stated that licensee designee Jason Muriithi would have the actual physician's order.

Resident A stated that he is prescribed Tylenol and to his knowledge, he is receiving his medication as prescribed.

While onsite I observed Resident A's Medication Administration Record (MAR) for the time frame of 02/01 until 02/12/2025. Resident A's MAR states that Resident A is prescribed Acetamin ER 650 MG take two tablets by mouth every four hours as needed RX 3267320 start date 08/14/2024.

On 02/13/2025 I interviewed licensee designee Jason Muriithi via telephone. Mr. Muriithi stated that Resident A is prescribed Tylenol PRN and Mr. Murithi has a physician's order. Mr. Muriithi stated that he would email a copy of the medication order.

On 02/14/2025 I received an email from licensee designee Jason Muriithi. The email contained Resident A's Tylenol prescription script. The script was written by Stephanie Owen NPI 1184263105 08/14/2024 for Tylenol Arthritis 650 MG ST TAB dispensed as Acetaminophen ER 8 Hour 650 MG SA TAB and administered take two tablets every four hours as needed with a max of 4000 MG (6 tablets) per day.

On 02/19/2025 I completed an exit conference via telephone with licensee designee Jason Muriithi. Mr. Muriithi stated that he agreed with the finding.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was discovered through this investigation that Resident A had a Tylenol prescription script. The script was written by Stephanie Owen NPI 1184263105 08/14/2024 for Tylenol Arthritis 650 MG ST TAB dispensed as Acetaminophen ER 8 Hour 650 MG SA TAB and administered take two tablets every four hours as needed with a max of 4000 MG (6 tablets) per day.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Facility staff are administering an incorrect dosage of Resident A's prescribed Tylenol.

INVESTIGATION: While onsite on 02/12/2025, I privately interviewed staff David Nganga. Mr. Nganga stated that Resident A is prescribed Tylenol PRN. Mr. Nganga provided me with Resident A's prescribed Tylenol bottle. I observed the bottle was "Good Sense" brand and stated "Acetaminophen" as compared to "Tylenol" 500 MG caplets. The bottle displayed Resident A's handwritten name on it.

Mr. Nganga stated that the caplets contained in the bottle were the supply utilized by staff to administer to Resident A.

While onsite I observed Resident A's Medication Administration Record for the time frame of 02/01 until 02/12/2025. I observed that Resident A's MAR states that Resident A is prescribed Acetamin ER 650 MG take two tablets by mouth every four hours as needed RX 3267320 start date 08/14/2024.

On 02/13/2025 I interviewed licensee designee Jason Muriithi via telephone. Mr. Muriithi stated that Resident A is prescribed Tylenol PRN and Mr. Murithi confirmed that Resident A is administered the "Good Sense" brand Acetaminophen 500 MG caplets that I had observed at the facility on 02/12/2025.

On 02/19/2025 I completed an exit conference via telephone with licensee designee Jason Muriithi. He stated that he did not dispute the finding and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Staff David Nganga stated that Resident A is prescribed Tylenol PRN. Mr. Nganga provided me with Resident A's prescribed Tylenol bottle. The bottle was "Good Sense" brand and stated "Acetaminophen" as compared to "Tylenol" 500 MG caplets. The bottle displayed Resident A's handwritten name on it. Mr. Nganga stated that the caplets contained in the bottle were the supply utilized by staff to administer to Resident A. While onsite I observed Resident A's MAR for the time frame of 02/01 until 02/12/2025. Resident A's MAR states that Resident A is prescribed Acetamin ER 650 MG take two tablets by mouth every four hours as needed RX 3267320 start date 08/14/2024. I observed that the email contained Resident A's Tylenol prescription script. The script was written by Stephanie Owen

	NPI 1184263105 08/14/2024 for Tylenol Arthritis 650 MG ST TAB dispensed as Acetaminophen ER 8 Hour 650 MG SA TAB and administered take two tablets every four hours as needed with a max of 4000 MG (6 tablets) per day. A preponderance of evidence was discovered to support that a violation of the applicable rule occurred. Resident A is prescribed Acetamin ER 650 MG however staff are administering an incorrect dosage of 500 MG without an extended release.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident As' Medication Administration Record does not contain the dosage, label instructions for use, time to be administered of Resident A's Melatonin.

INVESTIGATION: While onsite on 02/12/2025, I observed Resident A's MAR for the time frame of 02/01 until 02/12/2025. Resident A's MAR states that Resident A is prescribed Melatonin in handwritten font. I observed that Resident A's MAR does not indicate the dosage, the label instructions for use, or time to be administered. Resident A's MAR states that Resident A has been administered "Melatonin" on 02/02/2025, 02/04/2025, and 02/11/2025.

On 02/19/2025 I completed an exit conference via telephone with licensee designee Jason Muriithi. He stated that he did not dispute the finding and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(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 administers 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:	While onsite on 02/12/2025, I observed Resident A's MAR for the time frame of 02/01 until 02/12/2025. Resident A's MAR states that Resident A is prescribed Melatonin in handwritten font. Resident A's MAR does not indicate the dosage, the label instructions for use, or time to be administered. Resident A's MAR states that Resident A has been administered "Melatonin" on 02/02/2025, 02/04/2025, and 02/11/2025. A preponderance of evidence was discovered to support that a violation of the applicable rule occurred. Resident A's Medication Administration Record lacks the dosage, label instructions for use, and time to be administered for Resident A's Melatonin.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff David Nganga administers Resident A's Tylenol PRN but fails to document the reason for each administration.

INVESTIGATION: While onsite on 02/12/2025, I observed Resident A's MAR for the time frame of 02/01 until 02/12/2025. Resident A's MAR states that Resident A is prescribed Acetamin ER 650 MG take two tablets by mouth every four hours as needed RX 3267320 start date 08/14/2024. Resident A 's MAR indicates that on 02/04/2025 at 8:00 AM, 02/04/2025 at 5:00 PM, 02/11/2025 at 8:00 AM, and 02/12/2025 at 8:00 AM Mr. Nganga administered Resident A's Tylenol PRN but failed to document the reason for each PRN administration.

Staff David Nganga stated that he did not document the reason for each Tylenol PRN administration because he was unaware that the medication was a PRN medication.

On 02/19/2025 I completed an exit conference via telephone with licensee designee Jason Muriithi. He stated that he did not dispute the finding and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**

ANALYSIS:	While onsite on 02/12/2025, I observed Resident A's MAR for the time frame of 02/01 until 02/12/2025. Resident A's MAR states that Resident A is prescribed Acetamin ER 650 MG take two tablets by mouth every four hours as needed RX 3267320 start date 08/14/2024. Resident A 's MAR indicates that on 02/04/2025 at 8:00 AM, 02/04/2025 at 5:00 PM, 02/11/2025 at 8:00 AM, and 02/12/2025 at 8:00 AM. Mr. Nganga administered Resident A's Tylenol PRN but failed to document the reason for each PRN administration. Staff David Nganga stated that he did not document the reason for each Tylenol PRN administration because he was unaware that the medication was a PRN medication. A preponderance of evidence was discovered to support that a violation of the applicable rule occurred. Staff David Nganga failed to document the reason for Resident A's Tylenol PRN medication of 02/04/2025 at 8:00 AM, 02/04/2025 at 5:00 PM, 02/11/2025 at 8:00 AM, and 02/12/2025 at 8:00 AM.
CONCLUSION:	**VIOLATION ESTABLISHED**

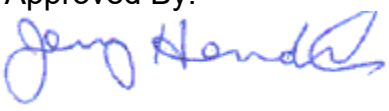
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

02/19/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



02/19/2025

Jerry Hendrick Date
Area Manager