GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 29, 2025

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

RE: License #: AS410321061
Investigation #: 2025A0583053
Ivy Home

Dear Mr. Muriithi:

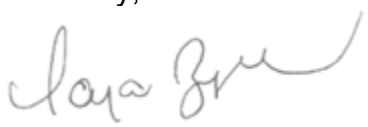
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0100.

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 #:	2025A0583053
Complaint Receipt Date:	08/06/2025
Investigation Initiation Date:	08/07/2025
Report Due Date:	09/05/2025
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:	07/08/2025
Expiration Date:	07/07/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff do not administer Resident A's medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/06/2025	Special Investigation Intake 2025A0583053
08/07/2025	Special Investigation Initiated - On Site
08/22/2025	APS Referral
08/29/2025	Exit Conference Licensee Designee Jason Muriithi

ALLEGATION: Staff do not administer Resident A's medication as prescribed.

INVESTIGATION: On 08/06/2025 the above complaint allegation was received via a US mailed letter. The complaint alleged that facility staff are not administering Resident A's Tylenol as prescribed.

On 08/06/2025 I interviewed Relative 1. Relative 1 stated that staff are not administering Resident A's MAPAP (Tylenol) as prescribed. Relative 1 stated that staff are administering this medication three times daily, rather than the prescribed four times daily (every six hours).

On 08/07/2025 I completed an unannounced onsite investigation at the facility and privately interviewed Solange Murekatete and Resident A.

Ms. Murekatete stated that Resident A is prescribed MAPAP 500 MG take two capsules three times per day and a fourth dose can be administered as a PRN.

Resident A stated that staff are administering MAPAP 500 MG three times daily.

While onsite I observed Resident A's MAPAP medication blister pack states that since 07/18/2025 Resident A is prescribed MAPAP CAP 500 MG, take two capsules (1000 MG) by mouth every six hours by Dr. Louis Praamsma.

While onsite I observed that Resident A's August 2025 medication Administration Record (MAR) states in handwritten text that Resident A is prescribed MAPAP CAP 500 MG (1000 MG) take two capsules by mouth every six hours at 8 AM, 2 PM, and 8 PM. The MAR indicated that from 08/01/2025 until 08/07/2025, Resident A was administered MAPAP CAP 500 MG take two capsules three times daily at 8 AM, 2 PM, and 8 PM.

On 08/07/2025 I interviewed staff Beryl Ali via telephone. Ms. Ali stated that she contacted Dr. Praamsma's office and spoke to Eric Hamman, RN. Ms. Ali stated that she informed Mr. Hamman that it was difficult to administer Resident A's fourth dose of MAPAP because he was usually asleep. Ms. Ali stated that she requested Dr. Praamsma modify the fourth dose to PRN. Ms. Ali stated that Mr. Hamman agreed to forward the request to Dr. Praamsma for his approval. Ms. Ali stated that staff began administering the fourth dose as a PRN even though the facility never received an order to modify the dosage. Ms. Ali stated that she has since contacted the facility's pharmacy, and the pharmacy has no record of a new order from Dr. Praamsma's office. Ms. Ali agreed that the facility should not have modified Resident A's MAPAP without receiving a new order from the prescribing physician.

On 08/22/2025 I interviewed Eric Hamman, Registered Nurse. Mr. Hamman stated that he is employed at Dr. Praamsma's office. Mr. Hamman stated that on 06/17/2025 he received a telephone call from facility staff who reported that Resident A often refused his fourth dose of Tylenol because it was ordered to be administered during Resident A's sleeping hours. Mr. Hamman stated that the facility staff requested that Resident A's fourth dose be modified to administration as a PRN. Mr. Hamman stated that he sent the request to Dr. Praamsma as requested but never observed that Dr. Praamsma approved the modification.

On 08/22/2025 I completed an online Adult Protective Services Complaint.

On 08/22/2025 I completed a LARA file view. I observed that according to Special Investigation 2025A0583019 the facility was found in violation of R 400.14312 (1). According to the Special Investigation (02/19/2025), Resident A was prescribed Acetamin ER 650 MG. However, staff were administering an incorrect dosage of 500 MG without an extended release. A Corrective Action Plan was approved to rectify the violation on 03/10/2025. Additionally, I observed that according to the most recent licensing renewal inspection on 05/19/2025, the facility was found in violation of R 400.14312 (1). According to the licensing study report, it was observed that staff were administering Resident A's PRN Banophen 25 MG and MAPAP 500 MG as regularly scheduled medications and staff were administering the medications too frequently. A Corrective Action Plan was approved to rectify the violation on 06/03/2025.

On 08/29/2025 I completed an exit conference via telephone with licensee designee Jason Muriithi. He stated that he does not dispute the special investigation findings and will 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:	Resident A is prescribed MAPAP two 500 MG CAPs every six hours. A review of Resident A's MAR indicates that from 08/01/2025 until 08/07/2025 facility staff administered this medication three times daily, instead of the prescribed four times daily. A preponderance of evidence was discovered to support that a violation of the applicable rule occurred. Staff did not administer Resident A's MAPAP as prescribed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2025A0583019** **Renewal Inspection 05/19/2025**

ADDITIONAL FINDINGS: Staff Tehuti Ali worked at the facility independently with residents despite not completing a background check.

INVESTIGATION: On 08/07/2025 I interviewed staff Beryl Ali via telephone. Ms. Ali stated that staff Tehuti Ali was hired to work at the facility on 07/20/2025 and Mr. Ali has worked independently with residents despite not completing a background check. Ms. Ali stated that Mr. Ali did not show up to complete his scheduled fingerprinting check. She reported that he no longer works at the facility.

On 08/29/2025 I completed an exit conference via telephone with licensee designee Jason Muriithi. He stated that he does not dispute the special investigation findings and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**

ANALYSIS:	Staff Beryl Ali stated that Tehuti Ali failed to complete his scheduled background check. She stated that Mr. Ali worked independently with residents despite not completing his background check. Multiple phone calls and voicemail messages were left for Tehuti Ali however he has failed to return my messages. A preponderance of evidence was discovered to support that a violation of the applicable rule occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff Tehuti Ali worked at the facility independently with residents despite not completing the required training.

INVESTIGATION: On 08/07/2025 I interviewed staff Beryl Ali via telephone. Ms. Ali stated that staff Tehuti Ali was hired to work at the facility on 07/20/2025 and Mr. Ali worked independently with residents despite not completing all required trainings. Ms. Ali stated that Mr. Ali completed CPR and First Aid training but failed to complete any other required training. She reported that he no longer works at the facility.

On 08/12/2025 I received an email from staff Beryl Ali which contained verification that staff Tehuti Ali completed CPR and Faire Aide training on 02/05/2025.

On 08/29/2025 I completed an exit conference via telephone with licensee designee Jason Muriithi. He stated that he does not dispute the special investigation findings and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**

ANALYSIS:	Staff Beryl Ali stated that staff Tehuti Ali was hired to work at the facility on 07/20/2025 and Mr. Ali has worked independently with residents despite not completing all required trainings. Ms. Ali stated that Mr. Ali completed CPR and First Aid training but failed to complete any other required training. A preponderance of evidence was discovered to indicate that a violation of the applicable rule occurred. Staff Tehuti Ali failed to complete required training prior to working independently with residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff Tehuti Ali left Resident A unattended in the community on a 93-degree day.

INVESTIGATION: On 08/06/2025 I interviewed Relative 1. Relative 1 stated that on 07/23/2025 she spoke with staff at the facility, and it was agreed that staff would transport Resident A to her home located in Allegan County for a visit. Relative 1 stated that staff Tehuti Ali was "running late" on the afternoon of 07/23/2025 and instead of delivering Resident A to her home, Mr. Ali left Resident A at Relative 2's home which is located ten minutes closer to the facility. Relative 1 stated that Mr. Ali left Resident A outside of Relative 2's home and drove away before verifying that Relative 2 was home. Relative 1 stated that Relative 2 was not home and Mr. Ali never contacted Relative 2 before leaving Resident A at her home. Relative 1 stated that no staff from the facility contacted Relative 1 or Relative 2 to alert them that Resident A was dropped off at Relative 2's home. Relative 1 stated that Resident A was left outside and the temperatures reached approximately 90 degrees. Relative 1 stated that Resident A was also left in procession of his medications. Relative 1 stated that Resident A telephoned her and requested that Relative 1 come to Relative 2's home to pick him up. Relative 1 stated that it took her ten minutes to reach Relative 2's home to retrieve Resident A and his medications.

On 08/07/2025 I completed an unannounced onsite investigation at the facility and privately interviewed Resident A. Resident A stated that on 07/23/2025 he was supposed to be transported to Relative 1's home by staff Tehuti Ali. Resident A stated that Mr. Ali was running late and instead dropped Resident A off at Relative 2's home because it was closer to the facility. Resident A stated that Mr. Ali left Resident A at Relative 2's home without checking to make sure that Relative 2 was home. Resident A stated that he knocked on Relative 2's door and found that she was not home, but Ms. Ali had already driven away. Resident A stated that he telephoned Relative 1 and she drove to pick up Resident A within ten minutes. Resident A stated the temperature was approximately 90 degrees outside, and Mr. Ali left Resident A's medications in Resident A's procession.

On 08/07/2025 I interviewed staff Beryl Ali via telephone. Ms. Ali stated that on 07/23/2025 staff Tehuti Ali was assigned to transport Resident A to Relative 1's home. Ms. Ali stated that she was never alerted that Mr. Ali left Resident A and his medications at Relative 2's home.

On 08/12/2025 I received an email from staff Byrle Ali which contained Resident A's Assessment Plan, signed 11/08/2024. The document indicates that Resident A can move freely within the community.

On 08/29/2025 I completed an exit conference via telephone with licensee designee Jason Muriithi. He stated that he does not dispute the special investigation findings and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A and Relative 1 both stated that on 07/23/2025 staff agreed to transport Resident A to Relative 1's home for a visit. Instead, staff Tehuti Ali left Resident A at Relative 2's home and Relative 2 was not home. As a result, Resident A was left outside in 90-degree heat until Resident A contacted Relative 1. A preponderance of evidence was discovered to support that a violation of the applicable rule occurred. On 07/23/2025, staff Tehuti Ali left Resident A alone outside of Relative 2's home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Resident A and Relative 1 both stated that on 07/23/2025 staff transported Resident A to Relative 2's home and left Resident A

	before verifying that Relative 2 was present. Staff Tehuti Ali left Resident A at Relative 2's home and Relative 2 was not home. Resident A was left by staff unattended in Relative 2's drive way with his personal medication unsecured. A preponderance of evidence was discovered to support that a violation of the applicable rule occurred. On 07/23/2025, staff Tehuti Ali left Resident A unattended and in procession of his personal medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

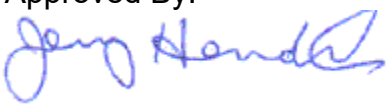
IV. RECOMMENDATION

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

08/29/2025

Toya Zylstra — Date
Licensing Consultant

Approved By:



08/29/2025

Jerry Hendrick — Date
Area Manager