STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2025

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

RE: License #: AH610411693
Investigation #: 2025A1021071
The Oasis of Norton Shores

Dear Tahir Khan:

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) 335-5985.

Sincerely,

Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH610411693
Investigation #:	2025A1021071
Complaint Receipt Date:	08/18/2025
Investigation Initiation Date:	08/19/2025
Report Due Date:	10/17/2025
Licensee Name:	The Oasis of Norton Shores LLC
Licensee Address:	Ste C 2575 Mcleod Drive North Saginaw, MI 48604
Licensee Telephone #:	(989) 992-4587
Administrator/ Authorized Representative	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:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	115
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Medication administration concerns for Resident A.	Yes
Additional Finding	Yes

III. METHODOLOGY

08/18/2025	Special Investigation Intake 2025A1021071
08/19/2025	Special Investigation Initiated - Telephone left message with administrator
08/20/2025	Contact - Telephone call made interviewed SP1
08/25/2025	Contact - Document Received received Resident A documents
09/04/2025	Contact-Telephone Call Made Interviewed Hospice Nurse
09/29/2025	Exit Conference

ALLEGATION:

Medication administration concerns for Resident A.

INVESTIGATION:

On 08/18/2025, the licensing department received a complaint with the facility did not obtain the required medications and Resident A went days without medication. The complainant also alleged Resident A was overdosed on morphine medication on 06/13/2025.

On 08/20/2025, I interviewed staff person 1 (SP1) by telephone. SP1 reported when Resident A first admitted to the facility Resident A was seen by an outside physician and there were changes in medication. SP1 reported that when these medications changes occurred, it was sometimes a dose increase and not new medication. SP1 reported Resident A would then report he was not getting his medications when in fact Resident A was. SP1 reported no knowledge of missed medications. SP1 reported then Resident A was placed on Gentiva hospice company. SP1 reported all

medications were ordered through the hospice company. SP1 reported that the hospice company drew up the syringe for the morphine medication. SP1 reported that when Resident A passed, the facility counted and ensured all morphine medication syringes were accounted for as there was a staff person that was making allegations that Resident A was overdosed.

On 09/04/2025, I interviewed Gentiva hospice care nurse by telephone. The nurse reported that the facility was in constant communication with the hospice company and Resident A's family regarding medication changes and code changes. The hospice nurse reported that Resident A was administered morphine, but that administration was in accordance with the medication orders. The nurse reported no concerns with medication administration, nor the care Resident A received.

I reviewed Resident A's charting notes. The notes read,

"06/12: Resident requested to see me regarding his pain level with his newly prescribed morphine. He explained that his pain has not improved since taking it. I reached out to Gentiva and spoke with his hospice nurse. She visited him today and spoke with him about different options for pain management. At this time, the resident did not want to make any changes. No further concerns at this time.
06/13: Resident had a normal night until staff brought him his 6am pills and observed him shaking, pale, and w decreased LOA. POA and hospice contacted. Resident says he can't stop shaking, lethargic, unable to move.
06/13 7:45am: Resident is not to be given anymore morphine per family request at this time.
06/14: As I was doing my rounds I went into residents apartment to check on him. Resident was fully awake and aware of everything. He woke up and said they are trying to kill me. Resident also stated he didn't want medicine that is going to kill him. Resident also stated that he had about 30 people come in there to tell him goodbye. Resident also said he might be allergic to morphine and that he isn't taking it anymore medicine until he figures out what is going on.
06/14: The resident presented on 06/13am with swollen eyes and verbal communication shallow family and hospice was contacted on behalf of residents presentation. Hospice arrived. Stating they were giving him an oxygen tank etc this is not to be used until Monday as a medicaiton reaction can occur with other meds. The resident that presented around 9am unresponsive vitals were 104/57 O2 77 temp 100.4 the resident then was assisted to their bed for relaxation as they were unable to verbally communicate or open their eyes. The residents family and hospice was contacted. They changes his routine of morphine and time to take the medication. I stated "this looks like to be an allergic reaction as his eyes are swollen shut with a temp." The resident has now presented at 4am 6/14 fully verbal aware of what was stated around him yesterday while he was unable to communicate. He is aware of everything and states "I do not want morphine they are trying to kill me." The residents vitals this morning BP 147/67 O2 94 NO TEMP. The resident is frustrated with hospice and what occurred yesterday. He is doing very well at this time and has drank 40 oz of water no current urination."

I reviewed Resident's A medication administration record (MAR) for June 2025. The MAR revealed this medication was to be stopped on 06/13/2025 at 06/13/2025 at 7:45am. The MAR revealed Resident A was prescribed Morphine Sul Sol with instructions to administer 0.25ml by mouth every four hours as needed for pain or shortness of breath. Resident A was administered for this medication on 06/11-06/13. On 06/11/2025, Resident A received the medication four times and all within the administration parameters. The MAR revealed this medication was requested for pain and was effective. Resident A received this medication on 06/13 at 12:11am and 5:01pm.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	Review of Resident A's chart notes revealed the morphine was to be stopped on 06/13/2025 at 7:45am. Review of Resident A's MAR revealed Resident A received this medication on 06/13/2025 at 5:01pm, even though the order had been stopped at that time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's MAR revealed facility staff did not initial that Resident A received the following medication:

Aspirin Low dose: 06/14/205
Atorvastatin Tab 40mg: 06/13/2025
Bumetanide Tab 2mg: 06/14/2025
Carvedilol Tab 25mg: 06/13-06/14/2025
Doxazosin Tab 2mg: 06/13-06/14/2025
Eliquis Tab 2.5mg: 06/13-06/14/2025
Finasteride Tab 5mg: 06/14/2025
Gabapentin Cap 100mg: 06/13-06/14/2025
Hydralazine Tab 100mg: 06/13-06/14/2025
Iron Tab 325mg: 06/14/2025
Pantoprazole Tab 20mg: 06/14/2025
Sertraline Tab 25mg: 06/14/2025

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Review of Resident A's MAR revealed many instances in which staff did not document medication administration with their initials that Resident A received prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/05/2025

Kimberly Horst
Licensing Staff

Date

Approved By:

09/29/2025

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

Date