GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 13, 2025

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

RE: License #: AH610411693
Investigation #: 2026A0627005
The Oasis of Norton Shores

Dear Mr. Khan:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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

I. IDENTIFYING INFORMATION

License #:	AH610411693
Investigation #:	2026A0627005
Complaint Receipt Date:	08/28/2025
Investigation Initiation Date:	09/11/2025
Report Due Date:	10/27/2025
Licensee Name:	The Oasis of Norton Shores LLC
LicenseeAddress:	Ste C 2575 Mcleod Drive North Saginaw, MI 48604
Licensee Telephone #:	(989) 992-4587
Administrator:	Mandi Meza-Cuellar
Authorized Representative/	Tahir Khan, Authorized Repr.
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?
Facility staff sent a resident to the hospital with the wrong identifying information of another resident living at the facility.	No
Additional Findings	No

II. METHODOLOGY

08/28/2025	Special Investigation Intake 2026A0627005
09/11/2025	Special Investigation Initiated - Face to Face
1/14/2026	Exit Conference via email

ALLEGATION: Facility staff sent a resident to the hospital with the wrong identifying information of another resident living at the facility.

INVESTIGATION:

On 08/29/2025, the Bureau of Community and Health Systems received a complaint against The Oasis of Norton Shores. The anonymous complainant alleged that on 08/04/2025 Resident A was sent to the hospital from the memory care unit for hitting her head against the wall, but when the ambulance arrived facility staff sent Resident A with another resident's (Resident B) paperwork, mis-identifying Resident A.

On 09/11/2025, I interviewed SP1 because the Executive Director was off due to illness. SP1 helped but she had limited knowledge of the incident and no access to the Executive Director's office. SP1 reported that Resident A no longer resided at the facility. SP1 reported that she did take report from the hospital when Resident A returned the next day and stated the hospital told her that the mistaken identity of Resident A possibly occurred at the hospital when the Emergency Department unit secretary pulled up the second residents name (Resident B) in their EMR and entered the look alike/sound alike name of Resident B and had no way of knowing where the mistake was made.

On 09/11/2025, I interviewed SP2 who was a Medication Technician to inquire what he knew about the facility's protocol for sending a resident to the hospital. SP2

stated that when a resident has to leave the facility via an ambulance that an incident report needs to be filled out, a call made to the DPOA to notify them, then a call to the resident's primary care physician and get a print out of the of the facility's electronic record "911 Quick Print" which has the residents key information including medications on it for the Hospital. SP2 produced a "911 Quick Report" that included the Medication Administration Record (MAR), and a face sheet. SP2 also reported that each workstation has a binder of with quick reference documents to use and how to fill them out such as Incident/ Accident reports, 911 Quick Print content etc.

On 10/3/2025, I returned to the facility to interview Mandi Meza-Cuellar Executive Director who reported that when Resident A was transferred to the hospital that a 911 Quick Print was sent with Resident A, but there was no evidence of whether the identity on the 911 packet was Resident A's or Resident B (who shares the same first name.) Hospital personnel had told SP1 that they did not have the original 911 packet sent with Resident A as they had destroyed the 911 packet after Resident A was admitted. Hospital personnel reported to the Executive Director that it was possible that their staff had inadvertently had the second residents name (Resident B) come up in their electronic medical record (EMR) and entered Resident B's name for Resident A. The Executive Director reported that there was no disciplinary action taken against the Med Tech sending Resident A due to the possibility the hospital may have entered the Resident B instead of Resident A in their EMR system. The Executive Director reports that they have made it their expectation going forward to have a second staff member verify 911 packet information at the time of transferring any future residents to the hospital.

APPLICABLE RULE	
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.** **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	The hospital admitted to not knowing if the mistaken identity of Resident A lay with their staff selecting the wrong resident in their EMR system. Staff interviewed knew the facility’s expectation for sending correct identifying information with residents when they are transferred to the hospital. The facility was compliant with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

I recommend no change in the status of the license.

11/05/2025

Rick Brummette Date
Licensing Staff

Approved By:

01/13/2026

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