GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2023

Sharleen Nash
Nash Manor LLC
21086 W 638 Hwy
Onaway, MI 49765

RE: License #: AM710327772
Investigation #: 2023A0360023
Nash Manor

Dear Ms. Nash:

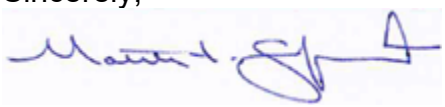
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM710327772
Investigation #:	2023A0360023
Complaint Receipt Date:	04/07/2023
Investigation Initiation Date:	04/07/2023
Report Due Date:	06/07/2023
Licensee Name:	Nash Manor LLC
Licensee Address:	21086 W 638 Hwy Onaway, MI 49765
Licensee Telephone #:	(989) 733-8647
Administrator:	Sharleen Nash
Licensee Designee:	Sharleen Nash
Name of Facility:	Nash Manor
Facility Address:	21085 W 638 Hwy Onaway, MI 49765
Facility Telephone #:	(989) 733-8647
Original Issuance Date:	01/11/2013
License Status:	REGULAR
Effective Date:	01/02/2023
Expiration Date:	01/01/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has missing prescription medication.	Yes

III. METHODOLOGY

04/07/2023	Special Investigation Intake 2023A0360023
04/07/2023	Special Investigation Initiated - Telephone Licensee Shar Nash
04/12/2023	Inspection Completed On-site Licensee Shar Nash, Resident A
04/17/2023	APS Referral online
06/05/2023	Contact - Telephone call made DCS Amanda Mustachia
06/05/2023	Contact - Telephone call made DCS Ginger Nash
06/05/2023	Contact - Telephone call made APS Sarah Purol
06/05/2023	Contact - Telephone call made McLaren Hospice Supervisor Tracy Bunker
06/07/2023	Exit Conference With licensee Sharleen Nash

ALLEGATION: Resident has missing prescription medication.

INVESTIGATION: On 4/07/2023 I was assigned a complaint from the LARA online complaint system.

On 4/12/2023 I conducted an unannounced onsite inspection at the facility. The licensee Sharleen Nash stated it was discovered on 4/07/2023 by direct care staff Ginger Nash that Resident A was missing 9 Norco, 15 Lorazepam 1 mg, and 7 Lorazepam .5mg. She stated direct care staff Amanda Mustachia was the direct care staff who received the new shipment of medication the day prior and was the last staff to administer the medication, although she did not document that she had administered the medication on 4/06/2023. She stated Ms. Mustachia was immediately contacted and terminated and a police report was made. She stated

McLaren Hospice was notified and licensing. She stated the Presque Isle County Sheriff came to the facility and interviewed direct care staff Ginger Nash on 4/07/2023. Ms. Nash provided me with a copy of the April 2023 medication administration record. Resident A's 8 p.m. medications were not documented as administered including Lorazepam 1mg, Norco 5/325mg. Ms. Nash stated the Lorazepam .5mg is a PRN. She stated Ms. Mustachia worked the afternoon shift on 4/06/2023 and was the only one to administer any medications before Ginger Nash came in on 4/07/2023 and discovered the medications were missing. She stated they do not do regular narcotic medication counts during shift change however when Ms. Nash went to administer the morning medications, she noticed the bottle looked like it was missing medications since it was just filled. She stated the Hospice nurse also does a full medication count weekly. She stated Resident A does not have a legal guardian.

While at the facility on 4/12/2023 I interviewed Resident A. Resident A stated she receives her medications as prescribed, and the facility handles them for her.

On 4/17/2023 I completed an adult protective services referral.

On 6/05/2023 I contacted APS worker Sarah Purol. Ms. Purol stated the complaint was not assigned for an investigation.

On 6/05/2023 I contacted direct care staff Amanda Mustachia. Ms. Mustachia stated she received a new shipment of medications for Resident A on 4/06/2023 that included Norco, Lorazepam 1 mg, and Lorazepam .5mg. She stated she did not count them when she received them. She stated the facility does not do regular medication counts at shift change. She stated she administered all of Resident A's medications as prescribed on 4/06/2023 however she forgot to document that she administered them. She stated she was going to do it the next day however she was notified by the licensee Sharleen Nash that she was fired. She stated the Presque Isle County Sheriff did interview her, but she has not heard from them since. She stated she did not take any medications and does not know why they were missing.

On 6/05/2023 I contacted direct care staff Ginger Nash. Ms. Nash stated she came to work on 4/07/2023 and noticed the newly filled prescriptions for Resident A's Norco, Lorazepam 1mg, and Lorazepam .5mg looked low for just being filled the day prior. She stated she counted the medications and discovered there were 9 missing Norco, 15 missing Lorazepam 1mg and 7 missing Lorazepam .5mg. She stated she then contacted Hospice and the police. She stated the police came to the facility the same day and took her statement and contact information for Amanda Mustachia. She stated Ms. Mustachia only worked at the facility for a few weeks. She stated Hospice refilled Resident A's medications early and replaced the missing pills so she did not miss any medication administration.

On 6/05/2023 I contacted McLaren Hospice supervisor Tracy Bunker. Ms. Bunker stated she was notified of the missing medications, received a copy of the police

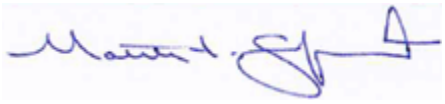
report, and replaced the missing medications knowing that the direct care staff who was suspected of taking the medications was terminated.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The complaint alleged Resident A has missing prescription medication. The licensee Ms. Nash stated Resident A had 9 Norco, 15 Lorazepam 1mg, and 7 Lorazepam .5mg come up missing during direct care staff Amanda Mustachia's shift on 4/6/2023. She filed a police report and contacted hospice. Ms. Mustachia's employment was terminated immediately. Ms. Mustachia denied taking any of the medications. There is a preponderance of evidence that Resident A's medication Norco and Lorazepam were missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/07/2023 I conducted an exit conference with licensee Sharleen Nash. Ms. Nash stated she disagreed with the rule violation because she contacted all necessary parties when the incident occurred and immediately terminated Ms. Mustachia. She stated she will submit a corrective action plan for approval.

IV. RECOMMENDATION

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



06/07/2023

Matthew Soderquist Date
Licensing Consultant

Approved By:

06/07/2023

Jerry Hendrick Date
Area Manager