GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 11, 2023

Dianne Penfold
05295 Cedarview Rd.
Charlevoix, MI 49720

RE: License #: AF150394238
Investigation #: 2023A0009028
Penfold AFC

Dear Dianne Penfold:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF150394238
Investigation #:	2023A0009028
Complaint Receipt Date:	06/28/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	07/28/2023
Licensee Name:	Dianne Penfold
Licensee Address:	05295 Cedarview Rd. Charlevoix, MI 49720
Licensee Telephone #:	(231) 547-5784
Administrator:	N/A
Name of Facility:	Penfold AFC
Facility Address:	05295 Cedarview Rd. Charlevoix, MI 49720-
Facility Telephone #:	(231) 547-5784
Original Issuance Date:	07/30/2018
License Status:	REGULAR
Effective Date:	02/01/2023
Expiration Date:	01/31/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The licensee gave Resident A a discontinued medication.	Yes

III. METHODOLOGY

06/28/2023	Special Investigation Intake 2023A0009028
07/03/2023	Special Investigation Initiated – Telephone call made to Community Mental Health (CMH) supervisor Nina Martenson
07/05/2023	APS Referral
07/05/2023	Contact - Telephone call made to CMH caseworker Andrea Rose
07/05/2023	Contact - Telephone call made to CMH nurse Megan Scott
07/05/2023	Inspection Completed On-site Interview with licensee Dianne Penfold and Resident A
07/05/2023	Contact - Telephone call received from Adult Protective Services worker Lane Stopher
07/05/2023	Contact - Telephone call made to Resident A's Guardian
07/10/2023	Exit conference with licensee Dianne Penfold

ALLEGATION: The licensee gave Resident A a discontinued medication.

INVESTIGATION: I spoke with Community Mental Health (CMH) supervisor Nina Martenson by phone on July 3, 2023. She said that Ms. Penfold had reported giving Resident A medication that had previously been prescribed to him but was discontinued before she gave it to him. Ms. Penfold reportedly admitted that she knew that the medication had been discontinued but had given it anyway because she thought it would help him through a difficult time. She told this to both Resident A's caseworker as well as the CMH nurse who works with Resident A. She did give differing accounts, telling one that she had given the discontinued medication "once or twice" and the other that she had given it on "several occasions". We also discussed Resident A using marijuana in the home with Ms. Penfold being aware of the usage. I told Ms. Martenson that marijuana must be treated as a medication and asked licensees to obtain a prescription for the marijuana from the resident's primary physician or psychiatrist. This is to ensure that it will not have a detrimental effect on the resident.

I spoke with CMH caseworker Andrea Rose by phone on July 5, 2023. She told me that Resident A was originally prescribed Zyprexa to bridge the gap between anti-psychotic injections he receives. He is now on the maximum dosage of the anti-psychotic and no longer needs the Zyprexa so it was discontinued. Ms. Rose went on to say that when she was at the home last week, Ms. Penfold admitted that she had been giving Resident A the discontinued Zyprexa up to twice a day. Ms. Rose said she spoke with the nurse who sees Resident A. She expressed concern about Ms. Penfold knowingly administering a discontinued medication to Resident A. The nurse called Ms. Penfold and told her she needed to stop doing that. She also stated that Resident A uses marijuana and that he has told her that Ms. Penfold has obtained the marijuana for him on occasion.

I then spoke with CMH nurse Megan Scott by phone on July 5, 2023. Ms. Scott reported that after the caseworker had told her about the situation, she called Ms. Penfold to tell her to stop administering the Zyprexa. Ms. Penfold reportedly admitted that she had given Resident A the Zyprexa even though she knew it had been discontinued. Ms. Penfold reportedly explained that she had done this because he had started to "deteriorate". Ms. Penfold told her she had only given the Zyprexa once per day to Resident A when she had administered it. Ms. Scott stated that is significant because the Zyprexa, when it was prescribed, was only to be given once per day. I asked Ms. Scott when Ms. Penfold would have been made aware that the Zyprexa was discontinued. Ms. Scott reported that she verbally told Ms. Penfold the medication was discontinued on April 26, 2023 and had also sent paperwork back with Resident A on that date that indicated the Zyprexa was discontinued. I asked Ms. Scott what the risk to Resident A was by being giving the Zyprexa after it was discontinued. She said that it increased the risk of Resident A experiencing side effects and that the Zyprexa is not an appropriate medication for the symptoms that Resident A exhibits. Ms. Scott said that she is also concerned because Ms. Penfold refuses to share Resident A's medication administration records with her.

I then made an unannounced home visit at the Penfold AFC home on July 5, 2023. Ms. Penfold was present at the time of the visit and spoke with me at that time. She seemed to have an idea of why I was there and said that Resident A had been in "bad shape" in regard to his mental health. She explained that Resident A was a daily marijuana user when he moved into the home and that usage has continued since he has lived there. She said that the person Resident A usually uses marijuana with has been unavailable in the last few weeks and that Resident A hasn't been able to use marijuana during that time. Ms. Penfold stated Resident A has gotten "loud" and swears profusely at those times. When it got really bad, she kept asking him if he felt he needed to be assessed at the hospital, but he kept telling her he didn't need to go to the hospital. Ms. Penfold said that CMH was not available due to a lot of it occurring over the weekend. She went on to say that she has taken Resident A to the hospital to be assessed in the past for similar issues but they always send him back with no new medication.

Ms. Penfold acknowledged that she decided to give Resident A some of the left-over

Zyprexa which had previously been prescribed for him. She said that she still had some because the Zyprexa had not been discontinued at the pharmacy and they kept sending it to her each month. Ms. Penfold admitted that she was aware that the Zyprexa had been discontinued. She stated she was told that verbally, but denied receiving any paperwork indicating that it was discontinued. She said that it had originally been prescribed for three months but was discontinued after Resident A had taken it only 4 days. More recently, she had given Resident A one Zyprexa tablet on some days and two tablets on others. She said that she knew that it was wrong for her to give Resident A the discontinued medication, but she did it because he was having such a difficult time.

Ms. Penfold stated that she hasn't given Resident A anymore Zyprexa after she spoke to CMH about it last week. Ms. Penfold said that she will not give him a discontinued medication again. I spoke with Ms. Penfold about Resident A using marijuana. I told her that he should have a prescription for the marijuana from his primary physician or CMH psychiatrist. If the primary physician did prescribe marijuana for him, the psychiatrist should be made aware and be in support of it. This is so they can ensure that it is safe for him to use with his other medications and it does not have any other detrimental effect on him. Ms. Penfold said that CMH is aware that Resident A uses marijuana and that she has discussed it with them on many occasions. She said that the CMH prescriber is also aware of Resident A's marijuana usage. I asked Ms. Penfold about her not providing the CMH nurse with Resident A's medication administration records. She replied that she didn't think that she needed to give her actual copies. Ms. Penfold said that she has no problem telling a CMH nurse verbally what she has administered and has done that in the past. I told her that the CMH nurse needed to ensure that Resident A was in good health and if she felt she needed the records to do that, then that was the best practice.

I asked to see Resident A's medication administration record. Ms. Penfold provided me with Resident A's medication administration record for May, June and July of 2023. On the medication administration record for June of 2023, it read, "Olanzapine 5mg, sub for Zyprexa, dissolve 1 tablet by mouth daily. "DC" was written at the right of this label information. Further to the right was written "PRN". The record had initials "DP" written on June 23, 24, 25, 26, 27 and 28, indicating that the medication had been administered on those days. It indicated that Resident A had been given one Olanzapine (Zyprexa) pill on the days June 23, 24 and 28. It also indicated that Resident A was administered two tablets on June 25, 26 and 27. Below the last administration on June 28, "DC" was written again. There was no indication that Resident A had been administered the Zyprexa after those dates according to the record.

I then spoke with Resident A in his room. I asked him if I could have a look around. He said that I could. He said that he had marijuana paraphernalia but no marijuana. Resident A pointed to two pipes on his dresser which looked to have been used to smoke something, likely marijuana. He said that the marijuana helps calm him and

control his anxiety. He said that the shot they had been giving him helps some but that it “doesn’t suffice”. I asked him if Ms. Penfold had given him Zyprexa recently. He said yes, that she had given him one or two for a few days when he was having a difficult time. Resident A said that he thought the Zyprexa had also helped him at that time. He said that he is doing better now. Resident A seemed calm during our discussion.

I received a telephone call from adult protective services worker Lane Stopher on July 5, 2023. He said that he was also investigating the matter and had received the same complaint information. I told him that I had just been to the Penfold AFC home and shared with him what I found at that time. Mr. Stopher said that he also planned on visiting the home and speaking with Resident A that day.

I spoke with Resident A’s Guardian by phone on July 5, 2023. She said that she has been Resident A’s guardian for several years. Resident A’s Guardian said that Resident A can be quite difficult at times. She was aware that he uses marijuana and he has used marijuana as long as she has known him. Resident A has reportedly informed her that the marijuana helps him. She could not say whether it actually helps him or not. I asked her what she knew about Ms. Penfold administering a discontinued medication to Resident A. She said that she found out about it after the fact. Ms. Penfold did not consult her beforehand. Resident A’s Guardian said that she found out about it after the fact from the CMH caseworker and then Ms. Penfold called her to discuss the situation. Ms. Penfold told her that she had tried to get help with Resident A from CMH but was not getting the support she thought she needed from them. Ms. Penfold reportedly told her that she had given Resident A medication that had been previously prescribed to him. She said that it had “only just been discontinued”. Resident A’s Guardian said that she did feel that Resident A is safe at the Penfold AFC home. She said that Ms. Penfold is typically much more careful than this. Resident A’s Guardian said that she did remind Ms. Penfold that she has a licensed home and that she needs to follow the rules.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being (33.1101 et. seq. of the Michigan Compiled Laws.
ANALYSIS:	It was confirmed through this investigation that the licensee administered medication to Resident A that was no longer

	prescribed for him. Although it had previously been prescribed for him, it was discontinued. The medication had been given over a period of six days according to the medication administration record. When the medication had been prescribed to Resident A, the dosage was one pill per day. On three of the afore- mentioned days, the licensee gave Resident A two pills according to the record. Resident A confirmed this when he told me that Ms. Penfold had given him one or two (Zyprexa pills) for a few days when he was having a difficult time. CMH nurse Megan Scott reported that Resident A receiving the Zyprexa when not prescribed to him increased the risk of him experiencing side effects. She also said that it is not an appropriate medication for the symptoms that he exhibits. Resident A's Guardian was not consulted beforehand about Resident A being given a discontinued medication and was told this information initially from his CMH caseworker.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference by telephone with licensee Dianne Penfold on July 10, 2023. I told her of the findings of my investigation and the recommendation for a provisional license. I gave her the opportunity to ask questions at that time.

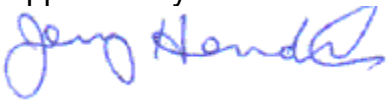
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend a six-month provisional license for the above summarized quality of care violation.

07/10/2023

Adam Robarge — Date
Licensing Consultant

Approved By:



07/10/2023

Jerry Hendrick — Date
Area Manager