GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 25, 2023

Dianne Penfold
05295 Cedarview Rd.
Charlevoix, MI 49720

RE: License #: AF150394238
Investigation #: 2023A0009034
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 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,

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 #:	2023A0009034
Complaint Receipt Date:	09/05/2023
Investigation Initiation Date:	09/06/2023
Report Due Date:	10/05/2023
Licensee Name:	Dianne Penfold
Licensee Address:	05295 Cedarview Rd. Charlevoix, MI 49720
Licensee Telephone #:	(231) 547-5784
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:	1ST PROVISIONAL
Effective Date:	08/10/2023
Expiration Date:	02/09/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The licensee did not give Resident A a prescribed medication for six weeks.	Yes

III. METHODOLOGY

09/05/2023	Special Investigation Intake 2023A0009034
09/05/2023	Contact – Telephone call received from Megan Scott, Community Mental Health (CMH) nurse
09/06/2023	Special Investigation Initiated - On Site Interview with licensee Dianne Penfold
09/06/2023	Exit conference with Dianne Penfold
09/06/2023	Contact – Telephone call made to Megan Scott, CMH nurse

ALLEGATION: The licensee did not give Resident A a prescribed medication for six weeks.

INVESTIGATION: I spoke with Community Mental Health (CMH) nurse Megan Scott by phone on September 5, 2023. Ms. Scott stated it just came to their attention that Resident A had not received a prescribed medication for six weeks while living at the Penfold AFC home. The prescription for the medication, Invega, was sent to the Charlevoix Rite-Aid pharmacy on July 21, 2023 at 2:53 p.m. Ms. Scott stated that it would have been filled and Ms. Penfold would have received a "robo-call" that it was at the pharmacy for her to pick up. They do not believe that Ms. Penfold ever picked it up and it was likely put back on the shelf by the pharmacy. Ms. Penfold has not been attending the medication reviews with Resident A lately or she would have known that the medication had changed. As it is, Resident A was sent home with paperwork indicating the change. Ms. Penfold is welcome to attend the medication reviews in person if Resident A is okay with her being present.

I made an unannounced site visit at the Penfold AFC home on September 6, 2023. I spoke with Ms. Penfold during my time there. I asked her about Resident A not receiving his Invega that was prescribe to him. She said that she "felt really bad" about him not getting his pills. Ms. Penfold explained that Resident A was having a difficult time with his behavior during that time and now she knows why. She had not realized that he had been prescribed a new medication. That was why she had given Resident A a medication that was previously prescribed to him (see Special

Investigation 2023A0009028). I asked her if she had been notified that Resident A had a medication change on July 21, 2023. She admitted that Resident A was sent home with paperwork that showed the medication change. She showed me Resident A's Medication Log Summary dated July 21, 2023. The log summary instructed, *"Add Invega 1.5 mg. Take 1 tablet by mouth every morning.*" Ms. Penfold stated that it was a bit confusing because the new log summary listed an, *"Add*", "*Discontinued*" and "*Change*" all on the same sheet. It was difficult to determine what was really going on. I asked her about her understanding of how the pharmacy receives a prescription from CMH. She said that CMH calls it into the pharmacy following a medication review. Ms. Penfold said that then the pharmacy calls her with an automated message to let her know the medication is there for pick up. She did not know if she got the automated message to remind her to pick it up. Ms. Penfold admitted that she did receive the new Medication Log Summary and should have followed through on it, making sure that Resident A received the new medication. She showed me a more recent Medication Log Summary she had received from CMH. Medication changes had been highlighted on the new summary. She said that CMH highlighting the changes helped her to see that changes were made. I asked Ms. Penfold if it would be helpful for her to attend the medication reviews with Resident A so she was aware when changes were made to his medication. She indicated that it would be helpful, but she would rather wait in the parking lot in her vehicle and have someone come out and tell her about the changes. When I asked her why she would not just attend the review in person, she replied that since the Covid (pandemic) restrictions were put in place, she has not attended those in person. She is now used to waiting in the parking lot. Ms. Penfold would not commit to attending the meetings but said that she would be okay being out in the parking lot during the meetings. They could come out and talk to her in the parking lot about any changes.

I spoke with CMH nurse Megan Scott by phone on September 6, 2023. I asked her if there was documentation that Resident A's prescription had been sent to the pharmacy. She said that their system indicates that it was sent to the Rite-Aid pharmacy on July 21, 2023. Ms. Scott said that even if it hadn't for some reason, it was Ms. Penfold's responsibility to make sure it was filled after receiving the paperwork indicating the change in his medication. She said that Ms. Penfold knows that she can always call her if there are any issues with a resident's medication. I asked her if it would help if Ms. Penfold was present during medication reviews. She said it would be but she could only be present if Resident A gave his permission. I asked Ms. Scott if she would be willing to speak with Ms. Penfold in the parking lot of the CMH office after medication reviews. She agreed that it might help ensure that medication changes were noted by Ms. Penfold if she was told of them face to face.

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:	On July 21, 2023, Ms. Penfold received documentation that Resident A had a medication change instructing that Invega be given to him once daily. This prescription was sent directly to the pharmacy by CMH. Ms. Penfold admitted that she received the paperwork which indicated this change. Ms. Penfold stated that she knows CMH sends prescriptions to her pharmacy and that the pharmacy calls her with an automated message. She did not remember receiving the automated message. The CMH nurse involved stated that the new prescription was sent to the pharmacy on July 31, 2023, and it would have been there for Ms. Penfold to pick up. It was her responsibility to pick up the medication and administer it to Resident A. It was confirmed through this investigation that the licensee did not administer Resident A his Invega for six weeks after being notified of the medication change on July 21, 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee Dianne Penfold in person on September 6, 2023. I told her of the findings of the investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of a corrective action plan, I recommend no change in the license status. The current violation occurred prior to the license being modified to First Provisional status. It involves the same resident with the new medication replacing the medication involved in the previous investigation (SIR #2023A0009028).

9/25/2023

Adam Robarge Date
Licensing Consultant

Approved By:

9/25/2023

Jerry Hendrick Date
Area Manager