STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

November 4, 2021

Maegan Giancola
Joy Givers, Inc.
7438 N Long Lake Rd
Traverse City, MI 49684

RE: License #: AL280095116
Investigation #: 2022A0870004
Joy Givers, Inc.

Dear Mrs. Giancola:

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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL280095116
Investigation #:	2022A0870004
Complaint Receipt Date:	10/18/2021
Investigation Initiation Date:	10/18/2021
Report Due Date:	12/17/2021
Licensee Name:	Joy Givers, Inc.
Licensee Address:	7438 N Long Lake Rd Traverse City, MI 49684
Licensee Telephone #:	(231) 922-5974
Administrator:	Maegan Giancola
Licensee Designee:	Maegan Giancola
Name of Facility:	Joy Givers, Inc.
Facility Address:	7438 N Long Lake Road Traverse City, MI 49684
Facility Telephone #:	(231) 922-5974
Original Issuance Date:	02/12/2001
License Status:	REGULAR
Effective Date:	11/24/2020
Expiration Date:	11/23/2022
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On October 15, 2021, it was discovered that Resident A's prescription medication Norco had been "switched out" with over-the-counter Tylenol.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/18/2021	Special Investigation Intake 2022A0870004
10/18/2021	Special Investigation Initiated - Telephone Telephone interview with LD Maegan Giancola.
10/20/2021	Inspection Completed On-site Interview with LD Maegan Giancola and staff.
11/01/2021	Inspection Completed-BCAL Sub. Compliance
11/01/2021	Exit Conference Completed with LD Maegan Giancola.
11/01/2021	Corrective Action Plan Requested and Due on 11/16/2021

ALLEGATION: On October 15, 2021, it was discovered that Resident A's prescription medication Norco had been "switched out" with over-the-counter Tylenol.

INVESTIGATION: On October 18, 2021, Licensee Designee Meagan Giancola informed me that staff member Kimberley Schopieray had discovered that Resident A's prescription medication Norco had been "switched out" with Tylenol. Ms. Giancola noted that this was discovered on October 15, 2021. She further noted that the "shift change med count" sheet notes that on October 15, 2021, Resident A had seven Norco pills remaining. Ms. Giancola stated she had spoken with all of her staff members, and no one could explain the discrepancy. I informed Ms. Giancola that I would be opening a special investigation and would meet with her at the facility on October 20, 2021. I instructed Ms. Giancola to contact law enforcement and make a report of this incident.

On October 20, 2021, I conducted an on-site special investigation. I met with Licensee Designee Meagan Giancola. Ms. Giancola noted that Resident A's Norco prescription of 24 Norco pills was filled on September 16, 2021. She explained that she maintains a "shift change med count" log and requires that both on-coming, and off-going, staff jointly count narcotic medications and log the "count" on this document. She provided me with a copy. I noted this document notes that on October 6, 2021, the count of Norco was nine pills, on October 7, 2021, the count was eight pills and on October 8 to present, the count was seven pills. Ms. Giancola stated she has six staff members who work for her at this facility. I noted that the "shift change med count" log contained the initials of all of her staff. Ms. Giancola again noted that she had spoken with all of her staff, and no one could explain the discrepancy. Ms. Giancola noted she maintains an electronic medication log, which I requested access to Resident A's medication log (record). I noted that there was no documentation in the electronic medication record for Resident A being provided with Norco. Ms. Giancola explained that her electronic record does not document "as needed" medications, and the Norco, prescribed to Resident A, is an as needed medication. She further stated she uses the shift change med count log and staff shift notes to record when Resident A has been provided her Norco. It is noted that the "shift change med count" log does not contain Resident A's name, nor does it contain all the required information per licensing rule. Ms. Giancola stated staff member Kimberly Schopieray is the staff member who informed her of the discrepancy when she went to dispense a Norco to Resident A on October 15, 2021. Ms. Giancola confirmed that she did contact law enforcement on October 18, 2021 and made a report to State Police trooper Korzek. The complaint number is 71-4012-21

On October 20, 2021, I conducted a private, in-person interview with staff member Kimberly Schopieray. Ms. Schopieray stated she worked the day shift, beginning at 7:00 a.m. on October 15, 2021. She stated that she identified the pills that were labeled for Resident A as Norco, but actually were Tylenol, at approximatly1:45 p.m. that day, October 15, 2021. I showed Ms. Schopieray the "shift change med count" log provided to me by Ms. Giancola. Ms. Schopieray identified her initials on this document which I note states "7am" and "10/15" next to her initials. I asked Ms. Schopieray to explain the discrepancy which occurred between 7:00 a.m., when she identified, and documented, that Resident A had seven Norco pills remaining, and 1:45 p.m. when she identified that the Norco pills were actually Tylenol. Ms. Schopieray stated, "it was a busy morning" and that she and off going, overnight, staff member Katie Francisco, did not actually conduct a count of the medication, just documented that they did. Ms. Schopieray denied taking the Norco, denied switching the Norco with Tylenol and denied knowledge of who may have taken the Norco and/or switched it out with Tylenol.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Documentation provided by Licensee Meagan Giancola states that seven prescription medication Norco pills are unaccounted for and their location is unknown. The Licensee failed to maintain Resident A's prescription medication in the original pharmacy supplied container.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

During this special investigation, Ms. Giancola noted she maintains an electronic medication log. I noted that there was no documentation in the electronic medication record for Resident A being provided with Norco. Ms. Giancola explained that her electronic record does not document "as needed" medications, and the Norco, prescribed to Resident A, is an as needed medication. She further stated she uses the shift change med count log and staff shift notes to record when Resident A has been provided her Norco. It is noted that the "shift change med count" log does not contain Resident A's name, nor does it contain label instructions for use, the time the medication was administered or the initials of the person who administered the medication.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff members supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(b) Complete an individual medication log that contains all of the following information: **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	The Licensee failed to ensure that facility staff completed a medication log, for Resident A, which contained the instructions for use, the time the medication was administered or the initials of the person who administered Resident A's Norco medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

On November 1, 2021, I conducted an exit conference with Licensee Designee Maegan Giancola. I explained my findings as noted above. Ms. Giancola stated she understood and had begun to implement corrective measures shortly after my on-site investigation. She noted she would submit a written corrective action plan to address the above findings and had no further questions pertaining to this special investigation.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

November 3, 2021

Bruce A. Messer Date
Licensing Consultant

Approved By:

November 4, 2021

Jerry Hendrick Date
Area Manager