GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 2, 2024

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

RE: License #: AL280095116
Investigation #: 2024A0230015
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,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL280095116
Investigation #:	2024A0230015
Complaint Receipt Date:	04/04/2024
Investigation Initiation Date:	04/04/2024
Report Due Date:	06/03/2024
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:	11/24/2022
Expiration Date:	11/23/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medications for over one week. Resident B's medications were discontinued but the medication was still administered.	Yes

III. METHODOLOGY

04/04/2024	Special Investigation Intake 2024A0230015
04/04/2024	Special Investigation Initiated - On Site Interview with staff members Tricia Johnson and Samantha Schaub, observation of Resident A
04/04/2024	APS Referral
04/04/2024	Contact - Telephone call made Shawna Thomas- Nurse Practitioner
04/12/2024	Contact - Telephone call made Licensee Designee Maegan Giancola
04/18/2024	Contact - Face to Face Interview with staff members Samantha Schaub and Tricia Johnson
04/24/2024	Contact - Telephone call made Resident A's daughter
04/24/2024	Exit Conference With Licensee Maegan Giancola

ALLEGATION: Resident A did not receive his medications for over one week. Resident B's medications were discontinued but the medication was still administered.

INVESTIGATION: On 04/04/2024, I conducted an unannounced investigation at the facility and reviewed resident medication logs and interviewed staff members, Samantha Schaub, and Tricia Johnson. I observed the medication logs for Resident A and noted that he had not received his medications from 03/23/2024 through 03/30/2024. These medications included Invokana, vitamins B12, B1, Atorvastatin, Aspirin, Senna, Trulicity, Trazadone, magnesium and acetamin. He had received his

other two prescribed medications during that time period. Those were Metformin and Metoprolol.

Staff members Samantha Schaub and Tricia Johnson stated they were aware of Resident A not receiving these medications and that he had been out of the medications from 03/23/2024 through 03/30/2024. They had tried to communicate with his guardian as her card to pay for the medications wasn't working. They indicated the licensee was aware of this issue. At the time of my inspection Resident A had received his medications and had been taking them since 03/31/2024. I observed Resident A during my inspection but was unable to interview him due to his cognitive limitations.

On 04/12/2024, I spoke with Licensee Maegan Giancola and discussed Resident A. She stated that there had been a problem with Resident A's debit card that the home had on file and it wasn't working during the time period Resident A had not received his medications. She added she had spoken to the guardian and thought everything had been resolved. She felt there had been miscommunication on the part of staff regarding Resident A and his need for the medications. I explained to Ms. Giancola that if any resident is out of medication, she is obligated to make certain the resident gets the medication. She stated she understood.

On 04/24/2024, I spoke with Resident A's daughter who informed me that her bank had switched debit cards for her autopay as the original card had been compromised. The pharmacy had been trying to run the old card and therefore payment was not going through. She indicated the pharmacy now had the new card. She stated she learned through an Adult Protective Service Worker that her father did not have medications for one week in March. She stated her father now had all of his medications at the home.

On 04/04/2024, I spoke with Resident A's nurse practitioner Shawna Thomas who indicated that she had discontinued a medication for Resident B on 03/30/2024 and left a note and told staff members about it. The medication, Furosemide had not been discontinued. Ms. Thomas stated she had been attempting to communicate with Ms. Giancola however she was not receiving an email response. Ms. Thomas indicated Resident A is no longer receiving the discontinued medication and the problem has been resolved.

On 04/04/2024, while at the facility I reviewed medication logs for Resident B and noted the medication, torsemide had been given to Resident B for two days after the date the nurse practitioner told me she discontinued it. The staff members stated they had not seen the order and I was unable to locate it when I was there. They were now clear that they were not give it to Resident A.

On 04/12/2024, Ms. Giancola stated she learned that Resident B had continued to receive her medication for two days after it was discontinued. She stated she

thought staff knew about this order to discontinue but learned there was not enough communication between herself, the staff, and the nurse practitioner.

On 04/18/2024, I made an unannounced inspection at the facility and reviewed medication logs once again. All medications for all residents were accounted for and all orders were in place. The staff members Ms. Schaub and Ms. Johnson both stated that things have been going well and no residents have gone without medications and they are aware of any medications that have been discontinued. Additionally, they reported good communication between themselves, Ms. Kelly, and Ms. Giancola.

On 05/02/2024, I conducted an exit conference with Ms. Giancola and reviewed the findings of the investigation. She stated she had been monitoring all medications herself and double-checking orders. She added that she has given the nurse practitioner her direct number to be able to communicate instructions to her. Additionally, she had arranged for an outside home health company nurse who will be coming to the facility to provide “best practice” medication training for all staff. Ms. Giancola stated she will be providing a plan of correction.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	According to two staff members and Ms. Giancola Resident A did not have ten of his prescribed medications for a one-week period. This was confirmed by his daughter. I observed medication logs for Resident A and noted he did not receive these medications between 03/23/2024 and 03/30/2024. According to two staff members, Ms. Giancola, and Resident A’s nurse practitioner Resident B continued to receive medications for two days after they were discontinued. While on site at the facility I observed that Resident B had continued to receive a medication for two days after it was discontinued.
CONCLUSION:	**VIOLATION ESTABLISHED**

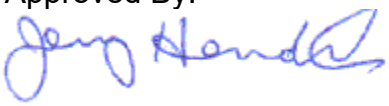
IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction I recommend the status of this license remain unchanged.

05/02/2024

Rhonda Richards Date
Licensing Consultant

Approved By:



05/02/2024

Jerry Hendrick Date
Area Manager