GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 22, 2025

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

RE: License #: AL280095116
Investigation #: 2026A0009006
Joy Givers, Inc.

Dear Ms. 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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
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 #:	AL280095116
Investigation #:	2026A0009006
Complaint Receipt Date:	12/02/2025
Investigation Initiation Date:	12/02/2025
Report Due Date:	01/01/2026
LicenseeName:	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, Designee
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:	11/24/2024
Expiration Date:	11/23/2026
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The emergency exits are sometimes blocked.	Yes
The roof has leaked. This happened about eight months ago.	No
There are pipes leaking in the kitchen and utility room that are causing black mold.	No
The facility is too cold in the winter and too hot in the summer.	No
The facility sometimes runs out of food for residents, including milk, butter, and eggs. Sometimes residents do not get to eat lunch and eat leftovers.	No
Residents are left soaked in their own urine. Their bedding is often left wet as well. Some residents are not getting showers due to staff members not wanting to do it.	No
Some medication has been left in resident rooms including a pill found on the floor of a resident room.	Yes
Staff do not always supervise the taking of medication.	No

III. METHODOLOGY

12/02/2025	Special Investigation Intake 2026A0009006
12/02/2025	APS Referral
12/02/2025	Special Investigation Initiated – Document (email) sent to adult protective services worker Adam Bragg
12/02/2025	Contact – Document (email) received from adult protective services worker Adam Bragg
12/03/2025	Contact – Document (email) sent to remaining Grand Traverse County adult protective services workers
12/03/2025	Contact - Document (email) received from adult protective services worker Brandi Fitzgibbon

12/03/2025	Contact – Document (email) received from adult protective services worker Daryl Stallworth
12/04/2025	Contact - Document (email) received from adult protective services worker Kieran Goodman
12/05/2025	Inspection Completed On-site Interview with licensee designee Maegan Giancola Inspection of premises; observation and dialogue with residents
12/09/2025	Contact - Telephone call made to direct care worker Katie Rasch
12/09/2025	Contact - Telephone call made to direct care worker Kimberly Schaipray
12/09/2025	Contact - Telephone call made to direct care worker Katherine Ross
12/22/2025	Exit conference with licensee designee Maegan Giancola

ALLEGATION: The emergency exits are sometimes blocked.

INVESTIGATION: I contacted the four adult protective services workers who cover Grand Traverse County prior to my visit at the Joy Givers adult foster care home. None of them had any investigations involving the facility in recent times. They were positive about the care of the residents and physical state of the home from what they observed during their well-being checks in the home.

I conducted an unannounced site visit at the Joy Givers adult foster care facility on December 5, 2025. Licensee designee Maegan Giancola was present and spoke with me about the report of rule violations I had received. She answered my questions, allowed me to inspect the facility and provided me with documents to assist with my investigation.

I had observed the front door entryway upon my arrival from outside of the facility as well as inside the facility. The front door entryway was free of any obstructions. The area outside of the front door and leading to the parking lot had been recently shoveled of snow and salted. Ms. Giancola confirmed that the front door was one of the emergency exits from the facility. She showed me two other emergency exits, both from the rear of the home. There had been significant snowfall in the days prior to my visit. I observed that both rear emergency exits had not been cleared since the snowfall. There was at least six inches of snow on the ground at that time and more where it had drifted. I did not believe that adults with mobility issues would be able to navigate the snow-covered areas in front of the doors or the ramp in the event of an emergency. Ms. Giancola stated that the staff are supposed to keep

those areas shoveled after it snows. She said that they have been trained to do that but hadn't done so in this case. She said that she would ensure that it was shoveled that day and through the winter months to ensure the safety of the residents.

I spoke with direct care worker Katie Rasch by telephone on December 9, 2025. She said that she was not aware of the emergency exits being blocked. She said that there was one brief period last winter when the roof was being shoveled off that there was snow in front of the exits but they shoveled the exits as soon as that happened. Ms. Rasch said that she shovels and salts the areas in front of the exits so that the residents are able to exit the facility if needed.

I spoke with direct care worker Kimberly Schaipray by telephone on December 9, 2025. She said she was unaware the emergency exits at the facility were blocked. The staff are supposed to shovel in front of all the exits after it snows. Ms. Giancola recently reminded them that they need to do that. Ms. Schaipray said that she has no knowledge of other obstructions in front of the emergency exits from the inside.

I spoke with direct care worker Katherine Ross by telephone on December 9, 2025. She said that she has never known the exits to be blocked or otherwise obstructed. Ms. Ross said that she has shoveled the front exit herself after it has snowed. She did not realize that the back exits also needed to be shoveled. Ms. Ross stated that she was present during my visit on December 5, 2025 and that Ms. Giancola did shovel in front of the back exits before she left that day.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On December 5, 2025, I conducted an unannounced site visit at the facility. I found that both rear emergency exits had not been cleared of snowfall. There was enough snow in front of the exits and on the ramp leading away from the building that would impede exiting for mobility-impaired individuals. It was confirmed through this investigation that the facility was not always maintained to provide adequately for the safety of the occupants.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The roof has leaked. This happened about eight months ago.

INVESTIGATION: When I arrived at the home I noted that the roof was snow-covered and it was not possible to perform any visual inspection of the roof.

I asked licensee designee Maegan Giancola about the report that the roof leaks. She denied that there are any leaks in the roof. The roof is in good repair as far as she knows. They did hire someone to do roof maintenance last year. I asked if there was any documentation from that service. Ms. Giancola stated they used a relative so she did not believe there was any documentation. While inspecting the home I did not see any leaks or any evidence of water damage that might indicate the roof was leaking.

I asked direct care worker Katie Rasch if she had ever known the roof to leak. She replied that there was once last winter when they had received a heavy snowfall. The roof leaked in one spot from all the snow being in one spot. Ms. Giancola called someone immediately to come out and shovel the roof. Ms. Rasch said that she did not know the particulars but that the roof never leaked after that. She knows of no other leaks in the roof.

I asked direct care worker Kimberly Schaipray about the roof leaking. She said that last winter, there was a buildup of ice on one area of the roof. It did leak when that happened. The same evening that the leak was discovered, Ms. Giancola contacted someone to come out and shovel the roof. It was taken care of that night and the next day. There was never any leaking before or after that incident.

I asked direct care worker Katherine Ross about the report of the roof leaking. She said that she had never known the roof to leak during the four months that she had worked at the facility.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(4) Roofs, exterior walls, doors, skylights, and windows must be weathertight and watertight and maintained in good repair.
ANALYSIS:	The roof did leak after significant snowfall and an ice dam in one area of the roof last winter. The roof was cleared the night that the leak was discovered and the next day and the issue was taken care of. There were no reports of leaks before or since that incident. I did not observe any leaks from the roof during the time of my visit or any significant water damage. It was confirmed through this investigation that the roof is weathertight, watertight and in good repair.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There are pipes leaking in the kitchen and utility room that are causing black mold.

INVESTIGATION: I asked licensee designee Maegan Giancola about the report of pipes leaking in the kitchen and in the utility room. She stated that there was a leak underneath the kitchen sink. She has had plumbers into the facility to work on the leak. They did need to return after the initial visit because the leak had not been repaired after the first visit. They had needed to replace all of the piping underneath the sink to take care of the issue. Ms. Giancola went on to say that she planned on remodeling the kitchen at some point but needed to take care of the leak before anything. I checked underneath the kitchen sink during my inspection. I noted that there was new piping underneath the sink. I saw evidence of a leak possibly having been underneath the sink at some point but no current leaking. There was no moisture underneath the sink and no evidence of any mold underneath the sink. I did not detect any odor which might indicate a mold problem underneath the sink.

I also asked Ms. Giancola about the report that there were leaks in the pipes in a utility room. She said that they really don't have a utility room. There are rooms that contain the facility's boilers but she does not know of any leak in any of those rooms. I did check each heat plant room which might have been referred to as a "utility room". This included rooms on the main floor as well as the boiler in the basement of the facility. I did not observe any leakage from the boilers or the pipes leading from them. I did not see any evidence that the boilers were leaking or had been leaking. Ms. Giancola stated that she had recently also had an inspection from her insurance company which was quite comprehensive. They checked the utility areas and did not see anything that concerned them during the time of their inspection.

Direct care worker Katie Rasch stated that the pipes underneath the kitchen sink had leaked but a plumber was called immediately to fix them. It did take him a while to figure out what the issue was. He was there three times before the issue was completely solved. It has not leaked since. She does not know of any other issues with pipes leaking in the facility. She is unaware of other leaks.

I asked direct care worker Kimberly Schaipray about pipes leaking in the facility. She said that there was some leakage underneath the kitchen sink but a plumber came right away to fix it. There is no leaking underneath the kitchen sink now. Ms. Schairpray denied that she knew of any other pipes leaking in the facility.

Direct care worker Katherine Ross denied that there were currently any leaking pipes at the facility. She said that there had been a leak underneath the kitchen sink but that had been fixed. It is not leaking now.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**

	(6) Plumbing fixtures and water and waste pipes must be properly installed and maintained in good working condition.
ANALYSIS:	There had been a leak underneath the kitchen sink recently. It was fixed including new piping installed. There was no evidence of it leaking at this point. I observed the area underneath the sink was dry with no indication of mold growth. There were no reports and no visual evidence of any other leaks from pipes at the facility. The plumbing fixtures and water pipers were in good working condition at the time of the inspection.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility is too cold in the winter and too hot in the summer.

INVESTIGATION: I asked licensee designee Maegan Giancola about the report that the facility is too cold in the winter and too hot in the summer. She stated that it is usually too hot in the winter if anything. She said that the residents do not like to be cold and are often turning up the thermostats during the winter. During the summer, she has air-conditioning for the main areas of the home. Residents are allowed to have individual air-conditioning units placed in their rooms if they desire.

I checked the temperature of the facility in several locations during the time of my inspection. I found that the temperature varied from the mid-70s to the mid-80s. The facility was warmer near the boilers and that was where I found it to be in the mid-80s. The temperature was more moderate in the resident's rooms, in the mid-70's to upper-70s. Ms. Giancola showed me the thermostat in the hallway which she had set at 86 but which read 73 (degrees Fahrenheit). She explained that she needed to have it set higher than the desired temperature. There was no area of the home, either in common areas or resident rooms, which seemed cold to me and none under 68 degrees Fahrenheit during the time of the visit.

Direct care worker Katie Rasch said the facility is a bit warm in the wintertime but that is how the residents like it so that is how they keep it. Ms. Rasch said that she "runs warm" so always thinks it is hot there during the fall and winter. She said that the staff person who was fired was always saying, "I'm freezing" but it was not cold at all. Ms. Rasch has worked there in the summer and did not feel it was too hot for the residents during the summer months.

I asked direct care worker Kimberly Schaipray about the temperature in the facility. She said that she thought that it was "fine". There is a resident who is always "cranking up the heat" but they just turn it down again so it is tolerable. Ms. Schaipray said that she wouldn't say it was ever too hot. It also wasn't too cold.

I asked direct care worker Katherine Ross about the temperature in the facility. She said that it sometimes gets down to 70 degrees but that is the coldest she has ever known it to be. She said that staff always turn the heat up if any of the residents complain of being cold.

APPLICABLE RULE	
R 400.653	**Room temperature.**
	Resident-occupied rooms must be heated at no less than 68 degrees Fahrenheit. While air conditioning is not required, precautions must be taken to prevent prolonged resident exposure to noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations must be based on a resident's health care appraisal and addressed in the resident's assessment plan.
ANALYSIS:	The home's temperature was in the mid-70s during the time of my visit with some areas in the mid-80s near the boiler rooms. It was warm, which is reportedly how the elderly residents prefer it. There was no report that it ever got below 68 degrees and no report that it was too hot in the summer. The facility is equipped with air-conditioning. There was no information or observation that the facility ever reached below 68 degrees or above 90 degrees.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility sometimes runs out of food for residents, including milk, butter, and eggs. Sometimes residents do not get to eat lunch and eat leftovers.

INVESTIGATION: I asked licensee designee Maegan Giancola about the report of them sometimes running out of food for residents and the residents sometimes eating leftovers. Ms. Giancola showed me the pantry, cupboards and refrigerators which contained the resident food. I observed several dry goods and refrigerated and frozen foodstuffs which would support a varied and nutritious menu. This included several cans and boxes of baking ingredients and canned and boxed meals, noodles, crackers, cereals, chips, fruits, vegetables, breads, rolls, milk, nut milks, eggs, butter, frozen meats, frozen breads, waffles and ice cream. I observed a large baking dish with tin foil over it with a note reading "12/5 baked ziti". Ms. Giancola explained that this is a pasta dish using ziti noodles. It was to be served that evening. She also showed me the menu which included recipes for all the cooked items which are on the menu. I read that baked spaghetti with ziti noodles was on the menu for dinner that night along with salad, garlic bread and ice cream

Sandwiches. When I was in the basement of the facility, I checked an additional refrigerator that contained several loaves of bread and gallons of milk.

Direct care worker Katie Rasch said that there is always enough food for residents. There is almost always the ingredients on-hand to serve the items on the menu. The rare exception to this is when there are no peas and they substitute corn. She said, if anything, they make too much food and there are left-overs. The residents then have the choice during subsequent meals to have what is being served or some of the left-overs. If it isn't eaten, the left-overs are thrown out after a couple of days. Ms. Rasch said the facility receives a "huge" food order every week from Walmart and Sam's Club.

I asked direct care worker Kimberly Schaipray about the facility running out of food. She replied that there is always enough food at the facility. She has never known them to "run out of food". She said that the staff are preparing meals all the time. She said that the residents get breakfast and lunch during her shift but can eat anytime they like. Ms. Schaipray stated that she thinks they eat very well. They always have what they need to create the meals on the menu and do have left-overs sometimes. Residents can eat the left-overs if they like.

I asked direct care worker Katherine Ross about the report that they sometimes run out of food. She denied that she has ever known them to run out of food. They might run out of a specific item but they always substitute with a comparable item. The residents do not go without. They always get all three meals and snacks if they want them. The residents are allowed to snack anytime they wish.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	I checked the pantry, three refrigerators and cupboards and observed a substantial amount of foodstuffs at that time including dry goods, frozen items and fresh items. I observed eggs, butter and several gallons of milk during the time of my inspection. The items on the day's menu were present in the facility. The staff reported that there is always sufficient food on hand and residents always receive three meals a day with snacks. I observed that the food on hand could be used to create nutritious and balanced meals for the residents. In consideration of the above information, it is determined that the licensee does provide a minimum of three nutritious meals per day to residents.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are left soaked in their own urine. Their bedding is often left wet as well. Some residents are not getting showers due to staff members not wanting to do it.

INVESTIGATION: I asked licensee designee Maegan Giancola about the report that residents are left soaked in their own urine and not getting showers. She replied that some of the residents do wake up wet in the mornings. All staff know to change them and change their bedding if that is wet as well. Ms. Giancola said that is something all staff know to do. They currently have four residents who wear adult briefs and need to be changed. They are changed upon waking, as needed through the day and before bed. All wet bedding is laundered in the mornings. Ms. Giancola provided me with documentation showing what she has posted for staff in regards to the four residents who require changing. She showed me that each of the four residents has specific instructions regarding their hygiene care needs, specifically for the changing of their adult briefs. She did not know of any instance when any of the four residents were left in wet briefs for any significant amount of time.

Ms. Giancola said that she has some very good midnight staff at the current time. They are also very good at changing any residents who get up in the night who might be wet. They usually do not change sleeping residents unless they receive hospice services and this is part of their treatment plan.

Ms. Giancola also stated that all the residents do get assistance with showering. There is one resident who is able to shower herself but the staff check on her to make sure she is okay during that time. Ms. Giancola provided me with a task list that indicated which residents are showered on what days. She stated that this is the minimal number of showers they receive. They can get assistance with showering anytime they request it. I noted that each resident was on the task list for showering at least once a week and several were on the list more than once a week.

I spoke with three direct care workers who all denied that residents are left in wet briefs or that their bedding is left unchanged when wet. Direct care worker Katie Rasch stated that the only staff who didn't shower residents when they were supposed to was the fired employee. Other than that, all residents are assisted with bathing at least once but usually several times a week. The residents who wear adult briefs are changed first thing in the morning along with their bedding if needed and checked throughout the day.

I spoke with direct care worker Kimberly Schaipray who said it is "a lie" that residents are not being showered or changed. She said that all residents are showered on their "shower day". Sometimes, a resident refuses to take a shower on their shower day. In that case, they ask them the next day if they are ready for their shower and she has always known them to then agree to it. Ms. Schaipray said that for the most

part, they all enjoy being assisted with their showers. She also reported the residents who wear adult briefs are being changed. She has never known them to be “soaked”. Ms. Schaipray typically arrives in the morning and knows that the midnight staff have changed the residents who woke up in the night. If any are wet in the morning, they immediately change them and launder their bedding if needed.

I asked direct care worker Katherine Ross about the complaint of residents not being showered. She said that since she worked a later shift, she did not assist with showering. She said the residents always seem clean to her and she believes that they are assisted with showering regularly. Ms. Ross said that there are only a few residents who need assistance with the changing of their adult briefs and staff assist with changing them throughout the day. She was not aware of them being soaked in urine at any time. Ms. Ross was not aware of their bedding being soaked. She stated that the morning shift would have taken care of any wet bedding as soon as they assisted a resident with getting up in the morning.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(4) A licensee shall ensure the resident receives or has access to all the following: (a) Bathing at least weekly. (b) Toileting as needed. (c) Assistance with resident hygiene as needed.
ANALYSIS:	The licensee designee provided documentation of the resident’s showering schedule for staff to assist them with this task. Each resident showers at least once a week, with most of them being showered several times a week. They can receive assistance with showering anytime they request. Ms. Giancola also provided me with a specific task regarding specific tasks for assisting with changing the residents adult briefs. She did not know of residents being left in soaked briefs. Staff know to change residents when they are wet and to launder any wet bedding. All three staff interviewed confirmed that assistance with showering and changing was being completed by staff. It was confirmed through this investigation that the residents are receiving assistance with bathing at least once weekly and assistance with toileting and resident hygiene as needed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Some medication has been left in resident rooms including a pill found on the floor of a resident room.

INVESTIGATION: I asked Ms. Giancola about the report that medication was found in residents' rooms. She stated that one time a bottle of Tylenol was found on the floor of a resident's room after a family had left it there for him. They did not tell staff that they had brought it and left it in his room. Staff took it and locked it in the facility's medication cabinet as soon as they knew about it.

I inspected the resident's rooms during my visit to the facility. I observed several over-the-counter creams and supplements in the resident rooms at that time. This included: an anti-fungal powder, stool softener, gas relief tablets, cortisone anti-itch cream, vitamins, supplements and several different skin protectants. Three items observed in the rooms: diclofenac sodium topical gel, biofreeze gel and a Benadryl cream had labels from pharmacies corresponding to the residents to whom they had been prescribed. Ms. Giancola stated that she believed some over-the-counter medications or supplements were acceptable in resident rooms but agreed to move them to the medication cabinet.

I asked direct care worker Katie Rasch about medications observed in resident rooms. She said that some over-the-counter creams and supplements were in resident rooms. They sometimes leave protectant creams in the rooms where they assist residents with changing their adult briefs. In regards to any pills being left on the floor of a resident's room, it was only the fired employee who had done that. She was taken off of medication duty after it came out that she wasn't doing it properly.

Direct care worker Kimberly Schaipray stated also confirmed that it was the fired employee who had left pills on the floor of a resident room. She was taken off medication duty immediately following the pills being found.

Direct care worker Katherine Ross disclosed to me that she had actually been fired that morning by text. She had made a medication error which included her leaving a melatonin supplement in a resident's room. Ms. Ross said that it was an accident on her part. She knew there was a cup of pills left in a resident's room by another staff some time ago. Her own experience and her hearing about the other pills being left in a room were the only examples she was aware of regarding medication before left in a resident's room.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily

	accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	I found several over-the-counter medicated products, vitamins and supplements in resident rooms during the time of my inspection. There have been reports of pills and supplements being found unlocked in resident rooms. It was confirmed through this investigation that some over-the-counter medications were left in resident rooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff do not always supervise the taking of medication.

INVESTIGATION: I asked about the report of staff not always supervising the taking of medication by residents. Ms. Giancola had earlier told me that she had needed to terminate a staff's employment for her not doing her job. She felt that the specific complaints I received were related to her firing. This former staff was the only staff there who she had ever known to not supervise the taking of medication. As soon as she found out that this staff had not supervised the taking of medication, she was taken off all medication administration duties. All other staff supervise the taking of medication. This is what they are trained to do and what they observe when shadowing the medication technician. Ms. Giancola showed me the written component of her medication training which read, "*Watch and verify that all medication is completely taken before walking away. Do not leave pill cup unattended*." This direction was bolded.

I asked direct care worker Katie Rasch about the complaint that sometimes staff did not supervise the taking of medication by residents. She said that the only time that has happened was by the staff person who got fired. Ms. Rasch said that she was actually the one who observed the staff put the medication cup down in front of the resident and leave the room. Ms. Rasch said that she told Ms. Giancola about the incident and that the staff person was fired. There have been no other incidents of a staff not supervising the taking of medication by a resident.

I asked direct care worker Kimberly Schaipray about the taking of medication by residents not being supervised by staff. She said that it only happened one time and that she told Ms. Giancola about it. Ms. Giancola immediately took the former employee off medication duty and she was later fired. That was the only time it ever happened as far as she knew. She and all the other staff always supervise the taking of medication by residents.

Direct care worker Katherine Ross said that she has always supervised the taking of medication by residents. This is what she had been trained to do and what she

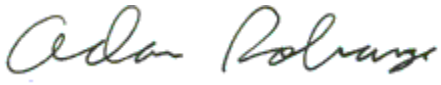
always did. Other staff who administered medication did this as well as far she is aware.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(3) Giving, taking, or applying of prescription medications must be supervised by a licensee, administrator, or direct care staff unless otherwise directed by an appropriately licensed health care professional in writing.
ANALYSIS:	Ms. Giancola and the direct care staff interviewed reported that the giving of medication is supervised by staff at all times. The only time this did not happen, the staff person involved was immediately taken off medication administration duties and later fired. It was confirmed through this investigation that the administration of medication is supervised by staff. The only time this did not happen, the staff involved was taken off of medication administration duty.
CONCLUSION:	VIOLATION NOT ESTABLISHED

An exit conference was conducted with licensee designee Maegan Giancola by telephone on December 22, 2025. She was told of the findings of the investigation and given the opportunity to ask questions.

IV. RECOMMENDATION

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



12/22/2025

Adam Robarge, Licensing Consultant Date

Approved By:

12/22/2025

Jerry Hendrick, Area Manager Date