RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 7, 2018

Christopher McCoy
108 West Street
Battle Creek, MI 49017

RE: License #: AM130095549
Investigation #: **2018A0462023**
Rhema Home AFC

Dear Mr. McCoy:

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 feel free to 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) 356-0183.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM130095549
Investigation #:	2018A0462023
Complaint Receipt Date:	03/08/2018
Investigation Initiation Date:	03/12/2018
Report Due Date:	05/07/2018
Licensee Name:	Christopher McCoy
Licensee Address:	108 West Street Battle Creek, MI 49017
Licensee Telephone #:	(616) 965-4837
Administrator:	Christopher McCoy
Licensee Designee:	N/A
Name of Facility:	Rhema Home AFC
Facility Address:	108 West Street Battle Creek, MI 49017
Facility Telephone #:	(269) 339-3714
Original Issuance Date:	01/10/2003
License Status:	REGULAR
Effective Date:	08/08/2016
Expiration Date:	08/07/2018
Capacity:	7
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Licensee Christopher McCoy used an inappropriate crisis intervention technique on Resident A, causing Resident A to sustain injuries.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/08/2018	Special Investigation Intake 2018A0462023
03/12/2018	Special Investigation Initiated – Telephone with APS specialist Karla Evans.
03/16/2018	Contact- Telephone interview with Resident A and Resident A's legal guardian Toby Pumphreys.
03/19/2018	Unannounced investigation at the AFC facility. Interviews with DCW Randy Roberson and Residents B and C. Requested police report from the Battle Creek Police Department.
03/21/2018	Document received- Police report from Battle Creek Police Department.
03/29/2018	Contact- Telephone interview with licensee Christopher McCoy.
05/02/2018	Contact- Second telephone interview with Resident A's legal guardian Toby Pumphreys.
05/07/2018	Exit conference with licensee Christopher McCoy.

ALLEGATION:

Licensee Christopher McCoy used an inappropriate crisis intervention technique on Resident A, causing Resident A to sustain injuries.

INVESTIGATION:

On 03/09/2018 Calhoun County adult protective services forwarded a complaint to the Bureau of Community and Health Systems (BCHS) through the BCHS on-line complaint system. The written complaint indicated that according to the facility's house rules, residents are to be upstairs in their bedrooms by 9:00 PM every evening. On 03/07/2018 licensee Christopher McCoy threatened to "throw [Resident A] out" if Resident A did not go to his bedroom. When Resident A refused, Mr. McCoy physically assaulted Resident A. The written complaint indicated that law enforcement was contacted and Resident A sustained injuries due to the assault.

On 03/12/2018 I conducted a telephone interview with Calhoun County adult protective services (APS) specialist Karla Evans who stated that this complaint was also assigned to her for investigation. Mrs. Evans informed me that Resident A was no longer residing at the facility.

On 03/16/2018 I conducted a telephone interview with Resident A's legal guardian Toby Pumphrey, who worked for the agency Guardian Inc. Mr. Pumphrey stated that while Resident A had a history of medication non-compliance, Resident A did not have a history of physical violence. Mr. Pumphrey stated that according to Resident A, on 03/07/2018 Resident A came back to the facility shortly after the facility's curfew of 9:00 PM. Mr. Pumphrey stated that a direct care worker (DCW) by the name of "Randy" immediately instructed Resident A to go to his bedroom. When Resident A refused, a verbal altercation between "Randy" and Resident A occurred. "Randy" called licensee Christopher McCoy who told Resident A via telephone that Resident A could either go to his bedroom immediately or leave the facility. When Resident A refused to do either, Mr. McCoy reported to the facility and confronted Resident A in person. Mr. Pumphrey stated that a physical altercation ensued whereas, according to Resident A, Mr. McCoy shoved Resident A to the ground and "jumped" on him. Mr. Pumphrey stated that Resident A received a number of injuries to his face, neck, and back that where consistent with a physical altercation of some kind. However, Mr. Pumphrey stated that the injuries were no longer visible. Mr. Pumphrey stated that the police were called to the facility and Resident A was transferred to the local hospital where he was treated and released. Mr. Pumphrey stated that pending a police investigation, Resident A was considering pressing legal charges against Mr. McCoy. Mr. Pumphrey stated that Mr. McCoy would not allow Resident A to return to the facility and confirmed that Resident A had moved out of the facility and was currently living with friends. However, Mr. Pumphreys stated that he never received a written emergency discharge notice for Resident A from the facility. Mr. Pumphreys stated that Resident A did not have access to a telephone but physically checked in with Mr. Pumphrey at Guardian Inc. daily. Mr. Pumphrey

agreed to contact me via telephone when Resident A was at his office so that I could conduct a telephone interview with Resident A.

Later that day I conducted a telephone interview with Resident A. Resident A confirmed the information provided to me by Mr. Pumphrey. Resident A stated that at one point during the altercation, Mr. McCoy head butted, punched and kicked him. Resident A stated that initially the police only listened to Mr. McCoy's side of the story, and he was transferred to the local hospital to be assessed for admission into their psychiatric unit. However, Resident A stated that he refused the assessment and left the hospital. Resident A stated that he was eventually able to provide the police with his "side of the story" and confirmed that he was considering pressing charges against Mr. McCoy.

On 03/19/2018 I met APS specialist Karla Evans at the facility and together we conducted an unannounced investigation. We interviewed DWC Randy Roberson. Mr. Roberson stated that per the facility's house rules, the residents had to be upstairs and in their bedrooms by 9:00 PM every evening. Mr. Roberson confirmed that Resident A returned to the facility around 9:00 PM on 03/07/2018 and refused to go upstairs to his bedroom. Mr. Roberson stated that when Resident A began using profanity, he called Mr. McCoy who attempted to speak with Resident A via telephone. However, Resident A hung up on Mr. McCoy. Mr. Roberson confirmed that Mr. McCoy reported to the facility and told Resident A that if he didn't go upstairs to his bedroom, he would need to leave the facility. Mr. Roberson stated that Resident A became "defiant" so Mr. McCoy instructed Mr. Roberson to call the local community mental health agency Summit Pointe's crisis hotline, as well as 911. Mr. Roberson stated that while he was on the telephone in the other room he heard a "scuffle" ensue between Resident A and Mr. McCoy. Mr. Roberson stated that he entered the facility's kitchen and observed Mr. McCoy on top of Resident A. Mr. Roberson clarified that Mr. McCoy was not assaulting Resident A but was "holding Resident A down". Mr. Roberson stated that according to Mr. McCoy, Resident A had run into the kitchen to grab a butter knife that was lying on the counter. Mr. McCoy grabbed Resident A before he could get the knife and held Resident A down until the police arrived. Mr. Roberson stated that the other residents were upstairs in their bedrooms when the incident occurred, and that they did not witness the altercation.

Mrs. Evans and I interviewed Residents B and C who both confirmed that they did not witness the altercation between Resident A and Mr. McCoy the evening of 03/07/2018. Both Residents B and C stated that Mr. McCoy had never physically assaulted them, and they had never witnessed Mr. McCoy physically assault other residents in the facility. Resident B stated that "Chris" had good intensions. However, he (Mr. McCoy) was very strict. Resident B stated that when residents broke the house rules, Mr. McCoy would speak "harshly" and with "authority."

I reviewed a copy of the facility's house rules which read, in part:

"Residents are expected to be in their room and quiet by 9:00 PM. Lights will be turned out or dimmed no later than 10:00 PM. All radios, televisions, CD players or videos must be turned off by 10:00 PM. Curfew times are 9:00 PM on weekends and 9:00 PM on weekdays."

I reviewed a copy of Resident A's written resident care agreement which was signed by both Mr. McCoy and Mr. Pumphrey on 05/02/2017. Resident A's written resident care agreement indicated that Resident A and/or Mr. Pumphreys received a copy of the house rules and agree to follow them.

On 03/29/2018 I conducted a telephone interview with Mr. McCoy who stated, "we run a structured home and we will not allow guys to just be up in the general area past 9:00 PM to do whatever they want." Mr. McCoy provided me with the same information Mr. Roberson relayed to me during my interview with Mr. Roberson. Mr. McCoy further explained that Resident A threatened to stab him. Mr. McCoy stated that he saw a butter knife laying on the kitchen counter so he "took [Resident A] down before he could grab the knife." Mr. McCoy stated that he told Resident A that he would not let him up until Resident A made the decision to either go to his bedroom or to leave the facility. Mr. McCoy stated that he eventually allowed Resident A to get up, but then immediately placed Resident A in a "bear hug" because Resident A began "going crazy." Mr. McCoy stated that he held Resident A in a bear hug until the police arrived, and once an officer responded, Resident A broke down crying. Mr. McCoy confirmed that Resident A was taken to the local hospital for psychiatric evaluation and that Resident A was not allowed to return to the facility. However, Mr. McCoy stated that Resident A made it clear that he did not want to reside in the facility anyway.

I reviewed a copy of the facility's discharge policy which was located in their department file. The facility's discharge policy read in part:

"Rhema Home AFC will provide a resident and his or her designated representative with a 30-day notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude Rhema Homes AFC from providing other legal notice as required by law.

Rhema Homes AFC will discharge a resident before the 30-day notice when the following is determined and documented:

(A) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.
(B) Substantial risk, or an occurrence, of self-destructive behavior.
(C) Substantial risk, or an occurrence, of serious physical assault.
(D) Substantial risk, or an occurrence, of the destruction of property.

Rhema Home AFC will take the following steps before discharging the resident:

A) Rhema Homes shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:

1) The reason for the proposed discharge, including the specific nature of the substantial risk.
2) The alternatives to discharge that have been attempted by Rhema Homes AFC
3) The location to which the resident will be discharged, if known.

B) Rhema Homes AFC shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:

1) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.
2) The resident shall have the right to file a complaint with the department.
3) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home."

I reviewed a copy of a *Battle Creek Police Department's (BCPD) Incident/Investigation Report* that was drafted by BCPD officer, Officer Henley, on 03/08/2018. Documentation on the report indicated that on 03/07/2017 Officer Henley was dispatched to the facility and discovered that a physical altercation had occurred between an "AFC homeowner and AFC patient." Documentation on the report indicated that Officer Henley gathered both parties' statements and also spoke to Mr. Roberson. Documentation on the report indicated that both parties' statements were different and both parties wanted to pursue charges on each other for assault. Documentation on the report regarding the statements made to Officer Henley by Resident A, Mr. Roberson and Mr. McCoy were similar to the information they all provided to me during my interviews with them.

Documentation on the report indicated that according to Mr. McCoy, Resident A threatened to stab Mr. McCoy, so he used proper techniques to restrain Resident A in self-defense. During the altercation, Resident A kicked and punched Mr. McCoy several times. Documentation on the report indicated that Officer Henley observed a

red mark on Mr. McCoy's nose. Documentation on the report indicated that according to Mr. McCoy, after allowing Resident A to get up, Resident A tried to head butt Mr. McCoy. Mr. McCoy then used his body weight to push Resident A up against the corner of the kitchen wall.

Documentation on the report indicated that according to Resident A, Mr. McCoy punched Resident A twice. When Resident A told Mr. McCoy that he was going to call the police, Mr. McCoy grabbed the phone away from Resident A and tackled him to the ground. Documentation on the report indicated that according to Resident A, Mr. McCoy punched and kicked Resident A several more times and tried to head butt Resident A. Documentation on the report indicated that Officer Henley observed a small scratch on the left side of Resident A's neck.

Documentation on the report indicated that according to Mr. Roberson, while Mr. McCoy was speaking with Resident A, Mr. Roberson had left the area and was upstairs when he heard a large crash in the kitchen. Documentation on the report indicated that according to Mr. Roberson, Mr. Roberson came running downstairs and observed Mr. McCoy on top of Resident A restraining him. Documentation on the report indicated that according to Mr. Roberson, Mr. Roberson witnessed Resident A kicking and punching Mr. McCoy, but witnessed nothing further.

Documentation on the report indicated that warrant requests were submitted on both Resident A and Mr. McCoy.

I reviewed a copy of an additional *BCPD Incident/Investigation Report* that was drafted by Officer Henley on 03/09/2018. Documentation on the report indicated that Officer Henley responded to the agency Guardian Inc. on 03/09/2018 to observe injures on Resident A that were allegedly obtained during the physical altercation between Resident A and Mr. McCoy on 03/07/2018. Documentation on the report indicated that Office Henley observed redness on the left side of Resident A's neck, scratches on the lower part of Resident A's right neck, and scratches near Resident A's ribs, on his left side.

On 05/02/2018 I conducted a second interview with Mr. Pumphreys who stated that the last information he had received regarding this incident was that warrant requests were submitted by the BCPD on both Resident A and Mr. McCoy. Mr. Pumphrey informed me that he had reached out to the BCPD a few weeks ago to get an update on their investigation. However, he had not heard back from them. Mr. Pumphrey stated that Resident A was currently residing in a licensed AFC facility in Ionia County.

APPLICABLE RULE	
R 400.14309	**Resident behavior interventions prohibitions.**
	(1) Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to

	develop a specialized intervention plan to reduce the behavior causing the crisis. If the resident requires the repeated or prolonged use of crisis intervention procedures, the licensee shall contact the resident's designated representative and the responsible agency or, in the absence of a responsible agency, a professional who is licensed or certified in the appropriate scope of practice to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan. **(3) Crisis intervention shall be used to the minimum extent and the minimum duration necessary and shall be used only after less restrictive means of protection have failed.** **(4) Crisis intervention shall be employed to allow the resident the greatest possible comfort and to avoid physical injury and mental distress.**
ANALYSIS:	On 03/07/2018 Resident A violated the terms of his written resident care agreement when he broke the house rules by refusing to go to his bedroom at 9:00 PM. While at the facility, licensee Christopher McCoy gave Resident A the option to either follow the house rules by going to his bedroom or to leave the facility. Based upon interviews with Resident A, Resident A's legal guardian, DCW Randy Roberson and licensee Christopher McCoy, it has been determined that Mr. McCoy's continuous threats to make Resident A leave the facility if Resident A didn't go to his bedroom caused Resident A's behavior to escalate and for a physical altercation to ensue. Resident A and Mr. McCoy gave different accounts of what occurred, and both expressed wanting to pursue charges against the other for assault. According to Mr. McCoy, he used "proper techniques" to restrain Resident A in an act of self-defense. However, Mr. McCoy also stated that while restraining Resident A, he told Resident A that he would not release him until Resident A agreed to either go to his bedroom or to leave the facility. Documentation on *Battle Creek Police Department Incident/Investigation Reports* indicated that after the incident occurred, Officer Henley observed a red mark on Mr. McCoy's nose. Officer Henley also observed redness on the left side of Resident A's neck, scratches on the lower part of Resident A's right neck, and scratches near Resident A's ribs, on his left side. It has been established that on the evening of 03/07/2018, Mr. McCoy did not use a crisis intervention technique on Resident A

	to the minimum extent and to the minimum duration necessary. As evidenced by the injuries that Resident A sustained, the crisis intervention employed by Mr. McCoy did not allow Resident A the greatest possible comfort to avoid physical injury and mental distress.
CONCLUSION:	**VIOLATION ESTABLISHED.**

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.**
ANALYSIS:	A licensee may choose to issue a resident a 30-day discharge notice for violating the terms of their written resident care agreement. On 03/07/2018 licensee Christopher McCoy threatened several times that Resident A had to leave the facility before 30 days if he did not go to his bedroom. While Resident A's refusal to go to his bedroom was a violation of the facility's house rules, his refusal did not meet the department's criteria, as well as the criteria indicated on the facility's written discharge policy, for an emergency discharge. It has been determined that Mr. McCoy's continuous threats to make Resident A leave the facility if he didn't go his bedroom caused Resident A's behavior to continue to escalate, ending with a physical altercation.
CONCLUSION:	**VIOLATION ESTABLISHED.**

ADDITIONAL FINDINGS:

During my interview with Resident B on 03/19/2018, Resident B stated that one DCW was scheduled to work at the facility on each shift. Every Sunday and Wednesday evening, as well as every Saturday morning, the scheduled DCW took residents to church. Resident B stated that because he didn't want to attend church, he was forced to go to the public library or to a friend's house until the scheduled DCW and other residents returned to the facility, as the facility was locked. Resident B stated that breakfast was served at church every Saturday morning. Therefore, on Saturday mornings, no breakfast was served at the facility. Because he didn't attend church, Resident B stated that he did not eat breakfast on Saturday mornings.

During my interview with DCW Randy Roberson on 03/19/2018, Mr. Roberson confirmed this information.

During my interview with licensee Christopher McCoy on 03/29/2018, Mr. McCoy confirmed that one DCW was scheduled to work in the facility at all times. Mr. McCoy denied the allegations made by Resident B and stated that if a resident or residents did not want to go to church, the scheduled DCW did not take any residents to church and stayed back at the facility.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(p) The right of access to his or her room at his or her own discretion.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Although denied by licensee Christopher McCoy, according to both Resident B and DCW Randy Roberson, the facility is locked when the scheduled DCW on duty takes residents to church every Sunday and Wednesday evening, as well as every Saturday morning. Because Resident B did not want to attend church, he was forced to go to the public library or to a friend's house until the scheduled DCW and other residents returned to the facility. It has been established that Resident B was denied the right of access to his room at his own discretion when the scheduled DCW on duty took other residents to church on Sunday and Wednesday evenings, as well as Saturday mornings, because the facility was locked.

CONCLUSION:	**VIOLATION ESTABLISHED.**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	According to both Resident B and DCW Randy Roberson, the scheduled DCW on duty took residents to church on Saturday mornings, where breakfast was served. Therefore, breakfast was not served in the facility on Saturday mornings. Because Resident B did not attend church, he did not eat breakfast on Saturday mornings.
CONCLUSION:	**VIOLATION ESTABLISHED.**

INVESTIGATION:

Licensee Christopher McCoy failed to submit a written report to the adult foster care division within 48 hours of the physical altercation that occurred between him and Resident A on 03/07/2018.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	It has been established that licensee Christopher McCoy failed to submit a written report to the adult foster care division within 48 hours of the physical altercation that occurred between him and Resident A on 03/07/2018.
CONCLUSION:	**VIOLATION ESTABLISHED.**

INVESTIGATION:

I reviewed a copy of Resident A's written assessment plan, which indicated that licensee Christopher McCoy last conducted Resident A's assessment on 04/26/2016.

I reviewed a copy of Resident A's written resident care agreement which was signed and dated by both DCW Randy Roberson and Resident A's legal guardian Toby Pumphreys on 05/02/2017.

Renewal licensing study report dated 08/08/2016 indicated that the facility was in violation of administrative rule 400.14301(4) when it was discovered that one resident's written assessment plan was last completed in the year 2012. According to Mr. McCoy's approved plan of correction, dated 08/19/2016, monthly internal file reviews would be conducted by the facility's management team to ensure all file requirements were satisfied and current.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home. **(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.**
ANALYSIS:	Resident A's written assessment plan was dated 04/26/2016. There was nothing in Resident A's record to document that Resident A's written assessment plan was reviewed by his guardian and/or licensee Christopher McCoy. Therefore, it has been established that licensee Christopher McCoy did not conduct a written assessment on Resident A at least annually. According to the date on Resident A's written resident care agreement, the agreement was reviewed with Resident A's legal guardian at least annually. However, Resident A's written resident care agreement was signed by DCW Randy Roberson and not by Mr. McCoy. When updating and/or reviewing residents' written resident care agreements annually, the form must be signed by all required parties during the annual review.

	It has been established that Mr. McCoy did not sign Resident A's current written resident care agreement.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED.** Renewal LSR dated 08/08/2016 Corrective action plan dated 08/19/2016.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

05/04/2018

Michele Streeter — Date
Licensing Consultant

Approved By:

05/04/2018

Dawn N. Timm — Date
Area Manager