GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 15, 2020

Paul Wyman
Retirement Living Management of Fruitport
1845 Birmingham
Lowell, MI 49331

RE: License #:	AM610397644
Investigation #:	2020A0356032
	Chestnut Fields Retirement Community

Dear Mr. Wyman:

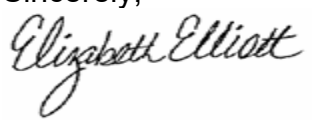
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610397644
Investigation #:	2020A0356032
Complaint Receipt Date:	03/16/2020
Investigation Initiation Date:	03/16/2020
Report Due Date:	05/15/2020
Licensee Name:	Retirement Living Management of Fruitport
Licensee Address:	1845 Birmingham Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Nicole Bradley
Licensee Designee:	Paul Wyman
Name of Facility:	Chestnut Fields Retirement Community
Facility Address:	5467 Chestnut Drive Muskegon, MI 49444
Facility Telephone #:	(231) 798-2220
Original Issuance Date:	08/22/2019
License Status:	REGULAR
Effective Date:	02/22/2020
Expiration Date:	02/21/2022
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed with one staff to four residents.	No
Residents are found in soiled briefs and clothes.	No
Resident B's medication was not administered as prescribed.	Yes
The food served is of poor quality.	No

III. METHODOLOGY

03/16/2020	Special Investigation Intake 2020A0356032
03/16/2020	Special Investigation Initiated - Telephone Complainant.
03/30/2020	Contact - Telephone call made Staff interviews.
03/31/2020	Contact - Telephone call made Staff interview.
04/02/2020	Contact - Telephone call made Administrator, Nicole Bradley.
04/06/2020	APS Referral
04/10/2020	Contact - Document Received
04/14/2020	Contact-Telephone call made Staff interview
04/27/2020	Contact - Telephone call made Amber Fry, Regional Director.
04/28/2020	Contact - Document Received Facility documents received.
04/28/2020	Contact - Telephone call made Relative #1, #2, #3, #5 (no response from #5).

04/29/2020	Contact - Telephone call made Relative #4.
04/29/2020	Contact - Document Sent Ms. Fry and Ms. Bradley.
04/30/2020	Contact - Document Received Facility document.
05/15/2020	Exit Conference-Amber Fry, Regional Director, Per Licensee Designee, Paul Wyman's approval.

ALLEGATION: The facility is understaffed with one staff to four residents.

INVESTIGATION: On 03/16/2020, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that this is a memory care facility with four residents with Alzheimer's and the facility is understaffed with one staff on shift to four "high needs" residents. The complainant reported staff are unable to tend to each resident which leaves them at risk to fall or elope since there is only one staff trying to watch the residents.

On 03/30/2020, I interviewed Staff #1 via telephone. Staff #1 stated there are four residents in the facility with one staff and Resident's A & B would elope if they could get to the door. Staff #1 stated both Resident's A & B are "exit seeking" however, they are not ambulatory without the use of assistive devices such as a walker and a wheelchair, so they are not quick. Staff #1 stated none of the residents have gotten out of the building but it's difficult to keep a close eye on four residents with memory issues that require a higher level of attention and care. Staff #1 stated there have been no falls or elopement of residents during her shifts and all the residents care needs were met.

On 03/31/2020, I interviewed Staff #2 via telephone. Staff #2 stated there are four residents in the facility with one staff and three of the residents tend to "wander." Staff #2 stated it was difficult to toilet Resident A when Resident C wandered off. Staff #2 stated none of the residents have eloped from the facility and no one fell while Staff #2 worked but it was difficult to handle all four residents with memory issues all alone but their care needs were met. Staff #2 stated Resident A, B, C & D all require only one person to assist them.

On 04/02/2020, I interviewed Administrator, Nicole Bradley via telephone. Ms. Bradley stated Resident A, B, C & D do not wander nor are they exit seeking. Ms. Bradley stated two of the residents are up and down moderately throughout the day and the other two residents are not very mobile. Ms. Bradley stated none of the residents require a two person assist and there have been no elopements or falls due to the staff-to-resident ratio.

On 04/10/2020, I reviewed the Resident Assessment Plans and Resident Care Agreements for Resident A, B, C & D. The assessment plans for Resident A, B, C & D are set up with a numbering system and a corresponding explanation for the number given explaining the level of care the resident requires.

- Resident A's assessment plan was signed on 10/17/2019 by former Administrator Jen Owens and by Resident A's designated representative. Resident A's fall risk is documented as a level 3 on the assessment plan, *'one or more in the last 12 months with serious injury.*' Mobility is documented as a level 2 on the assessment plan with no explanation for a level 2, there is no level 2 on the assessment. The assessment has level 1 which is '*mobile by self with assistive device*' and level 3 which is '*verbal cueing needed or standby assist to transfer or ambulate.'* Resident A is documented as *'independent'* with grooming and dressing with no comments of assistance needed. The level of care is documented as 'intermediate' and there is no documentation that Resident A requires a two-person assist.

- Resident B's assessment plan was signed on 12/17/2019 by Ms. Owens and by Resident B's designated representative. Resident B's fall risk is documented as a level 4, '*multiple falls, preventative measures to be put in place*' with no comments documented to explain preventative measures put in place. Mobility is documented as a level 6 with no explanation as to what a level 6 is because there is no level 6 on the assessment plan. There is a level 5 which is a '*one person-assist to transfer or ambulate or wheelchair support*' and a level 7 which is a '*two person-assist to transfer or mechanical lift. Requires wheelchair for mobility cannot maneuver without assistance.*' There are no comments or explanations on the assessment plan to explain the level of assistance Resident B requires with mobility or if Resident B requires a one-person or a two-person assist. Ms. Owens documented on the assessment; Resident B '*will need evacuation assistance.*' Resident B is a total assist with bathing and dressing and resistive with taking medications. Resident B's level of care is documented as '*intermediate.'* There is no documentation that Resident B requires a two-person assist.

- Resident C's assessment plan was signed on 12/19/2019 by Ms. Owens and Resident C's designated representative. Resident C's fall risk is documented as a level 4, *'multiple falls, preventative measure to be put in place'* with comments documented on 12/19/2019 by Ms. Owens that stated, '*several falls but it's when unsupervised*.' There is a slash through the level 4 and a level 0 is written above which means 'none/unknown' with no explanation or date as to when this level of care changed. Resident C is a level 4 for mobility which there is no level 4 on the assessment plan for mobility leaving Resident C in between a level 3 which is 'verbal cueing needed or standby assist to transfer or ambulate' and a level 5 which is 'one person assist to transfer or ambulate or wheelchair support.' Ms. Owens documented '*would need evacuation help.'* Resident C is documented as a level 5 in orientation,

'impairment in all areas; prone to wandering; unable to remember personal information; confused as to time and place.' Resident C is documented as a total assist with grooming and dressing and is incontinent of urine and bowels. Resident C's level of overall care is documented as *'intermediate*.' There is no documentation that Resident C requires a two-person assist.

- Resident D's assessment plan was signed on 02/19/2019 and 08/02/2019 by A. Romanelli, Resident Care Coordinator and by Resident D's designated representative. The assessment was updated again on 02/08/2020 by Amber Fry, Regional Director and Resident D's designated representative. Resident D's fall risk is documented as a level 2, '*two or more in the last 12 months without serious injury.*' Resident D's mobility is a level 1, 'mobile by self with assistive device' and comments written are, '*uses walker, needs assistance with evacuation in the event of a fire.'* Resident D is a level 5 in orientation, '*impairment in all areas; prone to wandering, unable to remember personal information, confused as to time and place'* and Resident D's level of overall care is documented as 'intermediate.' There is no documentation that Resident D requires a two person assist.

- I reviewed Resident's A, B, C and D's Resident Care Agreements that document housekeeping, three meals and snacks daily, medication administration, all ADL's (activities of daily living) as needed, 24-hour supervision and protection, room and board will be provided to the residents.

On 04/14/2020, I interviewed Staff #3 via telephone. Staff #3 stated there was one direct care staff on duty per shift for four memory care residents. Staff #3 stated one resident was a fall risk and to properly care for and monitor all four residents, two staff were needed. Staff #3 stated none of the residents eloped or exit sought, and none fell on her shift.

On 04/27/2020, I interviewed Regional Director Amber Fry via telephone. Ms. Fry stated the residents are provided adequate care per their assessed needs. She also stated that none of the residents in the memory unit have exit seeking behavior or falls due to lack of staffing in the building.

On 04/28/2020, I interviewed Relative #1 via telephone. Relative #1 stated Resident A was able to ambulate around the building and would wander around the facility but would not attempt to elope out of the building. Relative #1 stated falls were not an issue that she was aware of. Relative #1 stated it would take two staff to change Resident A and once they went down to one staff, they were "shorthanded", but she did not note the care of Resident A to be poor.

On 04/28/2020, I interviewed Relative #2 via telephone. Relative #2 stated Resident B was ambulatory but did not ever exit seek or elope. Relative #2 stated Resident B always seemed to be well cared for, did not have falls and had no major concerns about the amount of staff in the facility or the care provided to Resident B.

On 04/28/2020, I interviewed Relative #3 via telephone. Relative #3 stated Resident C needs constant supervision and assistance with ambulation and requires the use of a walker to ambulate. Relative #3 stated Resident C does not wander but poses a fall risk if left alone to ambulate. Relative #3 stated there is one staff to four residents and usually the residents gather in the TV room so staff can monitor them all at once. Relative #3 stated she did not have any issues with the staff-to-resident ratio however the residents are “high need” and she could see a problem if two residents needed assistance at the same time.

On 04/28/2020, I received and reviewed the staff schedule for February and March 2020. The staff schedule documents one direct care worker per shift for 1st, 2nd and 3rd shifts. On March 23, 2020, Resident A, B, C & D were moved from this facility to the assisted living facility temporarily for the enhanced staffing in the larger facility and for the prevention of COVID19.

On 05.15.2020, I conducted an Exit Conference with Ms. Fry via telephone. Ms. Fry stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	While the resident assessment plans are somewhat ambiguous in certain areas, none of the residents are documented as requiring two staff for assistance. In addition, after a review of the Resident Care Agreements, Assessment Plans, interviews with staff and relatives, none of the needs documented in the resident assessment plans or care agreements are reportedly unmet with a staffing ratio of 1:4. Therefore, a violation of this rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are found in soiled briefs and clothes.

INVESTIGATION: On 03/16/2020, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported residents are found in soiled briefs and clothes.

On 03/30/2020, I interviewed Staff #1 via telephone. Staff #1 stated staff conduct rounds every two hours, residents are tended to every two hours and none of the

residents are in soiled briefs or dirty clothes at all during her shift. Staff #1 stated since there are only 4 residents, they mainly sit in the TV area together much of the time so if residents need to change or require assistance with toileting, it is done immediately.

On 03/31/2020, I interviewed Staff #2 via telephone. Staff #2 stated staff conduct rounds every two hours, residents are tended to every two hours and none of the residents have sat in soiled briefs or dirty clothes for any length of time during her shift as she checks the residents regularly and provides the necessary care in a timely manner.

On 04/02/2020, I interviewed Administrator, Nicole Bradley via telephone. Ms. Bradley stated Resident A, B, C & D are on a two-hour check and toileting schedule so none of the residents are in soiled briefs or clothing for any length of time. Ms. Bradley stated the residents' need for toileting is documented on their assessment plan and the resident care plan, but the facility does not track or document when toileting and clothes changes are completed. Ms. Bradley stated skin assessments are done each week and documented when a resident has a shower.

On 04/10/2020, I reviewed Resident Assessment Plans and care plans for Resident A, B, C & D. The assessment plans and care plans for Resident A, B, C & D document the following:

- Resident A for dressing is '*independent, no assistance necessary for dressing, putting on or removing clothing.*' Resident A for continence is '*occasionally incontinent but under control with medication and doctor's supervision or able to manage incontinent products independently' and* Resident A is *'independent, no assistance required-may use assistive/adaptive devices'* for hygiene/grooming.
- Resident B for dressing is *'fully dependent, individual can offer no assistance, requires someone to completely dress. May be resistive.'* Resident B for continence is *'occasionally incontinent but under control with medications and doctor's supervision or able to manage incontinent products independently.'* Resident B *'needs cueing and minor preparation of grooming materials, minimal help'* for hygiene/grooming.
- Resident C for dressing is a *'total assist,'* for hygiene and grooming a *'total assist'* and for continence Resident C is *'incontinent of urine and bowels.'*
- Resident D requires for dressing *'moderate assistance-puts clothing on or takes clothing off with assistance,'* for hygiene and grooming Resident D requires *'physical assistance, can do some on own with extra cueing.'* Resident D's continence is documented as *'occasionally incontinent but under control with medications and doctor's supervision or able to manage incontinent products independently.'*

On 04/10/2020, I reviewed Resident Skin Assessment Forms for Resident A, B, C & D for February and March 2020 and the forms do not document any skin breakdown or marks on the residents' skin that could occur from neglect or lack of care.

On 04/14/2020, I interviewed Staff #3 via telephone. Staff #3 stated she is a 1st shift staff and none of the residents have ever sat in soiled or dirty briefs on her shift. Staff #3 stated Resident B is resistive to changing her clothes and requires staff assistance to get clean clothes on so there have been times that Resident B will remain in the same clothes for a longer length of time.

On 04/27/2020, I interviewed Regional Director Amber Fry via telephone. Ms. Fry stated the residents are provided adequate care by staff per their assessed needs.

On 04/28/2020, I interviewed Relative #1 via telephone. Relative #1 stated she was at the facility "all the time" and never found Resident A in soiled clothing or in wet, soiled pants. Relative #1 stated staff at the facility got Resident A up and assisted her to the bathroom when she needed to go. Relative #1 stated she never saw any of the other residents in the facility soiled, in dirty or wet clothing.

On 04/28/2020, I interviewed Relative #2 via telephone. Relative #2 stated Resident B often gets UTI's (urinary tract infections) and so he asked staff to assist Resident B with going to the bathroom more often to see if it affects the amount of UTI's Resident B gets. Relative #2 stated he does not know if that has anything to do with lack of care or assistance with toileting. Relative #2 stated he has not observed Resident B in soiled or dirty clothes during visits.

On 04/28/2020, I interviewed Relative #3 via telephone. Relative #3 stated Resident C was well cared for and she never saw her or other residents in dirty or soiled clothes or pants. Relative #3 stated she had no concerns about the amount, or level of care provided to Resident C by staff at the facility.

On 05.15.2020, I conducted an Exit Conference with Ms. Fry via telephone. Ms. Fry stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on a review of the assessed needs of the residents, resident care plans, resident skin assessments, as well as staff and relative interviews, there is not a preponderance of evidence to show that the residents are left in soiled clothing and briefs for hours as was alleged. Therefore, a violation of this rule is not established.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident B's medication was not administered as prescribed.

INVESTIGATION: On 03/16/2020, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported Resident B's medication, Ativan was changed, and the new dosage of Ativan was not administered for one week causing Resident B to become violent, biting, hitting, scratching and throwing things.

On 03/31/2020, I interviewed Staff #2 via telephone. Staff #2 stated Resident B's Ativan medication was prescribed as a routine medication to be administered three times daily. Staff #2 stated the medication then was prescribed as a PRN (as needed) but then changed yet again back to routine rather than PRN. Staff #2 stated Resident B received the medication as prescribed and she did not experience Resident B hitting or biting.

On 04/02/2020, I interviewed Administrator, Nicole Bradley via telephone. Ms. Bradley stated Resident B was falling and the facility nurse practitioner, Von Vitto thought Resident B's falls could be from the Ativan, so he slowly decreased the Ativan medication and coincidentally, Resident B became agitated one day during that time. Ms. Bradley explained that Resident B had a fever one day so staff were trying to keep Resident B in her room so as not to pass on whatever she may have had to other residents. Resident B did not want to stay in her room and began biting, hitting, kicking staff and threw a planter in her room and broke it. Ms. Bradley stated the incident was not because Resident B was not given her medication as prescribed and the incident may not have been medication related at all. Ms. Bradley stated the incident could have been because staff attempted to keep Resident B in her room due to the fever when Resident B did not want to stay in her room. Ms. Bradley stated Resident B did not miss a week's worth of Ativan medication and Resident B is given all of her medications as prescribed.

On 04/10/2020, I reviewed Resident B's MAR (Medication Administration Record) for the months of February and March 2020. The February MAR documents that Resident B was prescribed Lorazepam (Ativan) 0.5 mg tablet, take one tablet by mouth twice daily and take one tablet three times daily as needed '*max of 2.5 mg/per day.'* On 02/14/2020 the Lorazepam (Ativan) prescription changed and is documented as Lorazepam 0.5mg, take half tablet (0.25mg) by mouth twice daily. The Lorazepam (Ativan) is documented as administered as prescribed every day except for 02/13/2020 and 02/14/2020 where there are no signatures documenting that the medication was administered. On the MAR under '*scheduled medication notations,*' 02/14/2020 is documented that Resident B's Lorazepam (Ativan) medication was not administered due to '*other problems*' and no further explanation is documented on the MAR. There is nothing documented for 02/13/2020 as to why the medication was not administered. For the month of March 2020, Resident B's Lorazepam (Ativan) medication, is documented as administered as prescribed.

On 04/28/2020, I interviewed Relative #2 via telephone. Relative #2 stated Resident B's medications are administered as prescribed and there have been no issues with Resident B's medications.

On 05.15.2020, I conducted an Exit Conference with Ms. Fry via telephone. Ms. Fry stated she will submit an acceptable corrective action plan regarding this rule violation.

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:	The complainant reported Resident B missed a week's worth of Ativan medication causing Resident B to become violent, biting, hitting, scratching and throwing things. Staff #2 and Relative #2 stated Resident B was administered medications including Ativan as prescribed. Ms. Bradley stated Resident B was administered medications including Ativan as prescribed and the incident when Resident B became agitated may not have had anything to do with not taking her Ativan medication. A review of Resident B's MARs for the months of February and March 2020 document Resident B's Lorazepam (Ativan) medication was administered as prescribed except for 02/13/2020 and 02/14/2020 when the medication was not documented as administered to Resident B. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The food served is of poor quality.

INVESTIGATION: On 03/16/2020, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that the food served at the facility is of poor quality for the price paid to live in the facility.

On 03/30/2020, I interviewed Staff #1 via telephone. Staff #1 stated the meals at the facility include breakfast, lunch, dinner and a snack. Staff #1 stated the food at the facility is of good quality and well balanced.

On 03/31/2020, I interviewed Staff #2 via telephone. Staff #2 stated the meals at the facility include breakfast, lunch, dinner and a snack. Staff #2 stated the food at the facility is good, it is well balanced and if residents do not like what is being served, there is an alternate meal they can pick. Staff #2 stated lunch is a bigger meal and then dinner is light as the residents typically go to bed early. Staff #2 stated she has not had anyone complain about the food at the facility.

On 04/02/2020, I interviewed Administrator, Nicole Bradley via telephone. Ms. Bradley stated residents get breakfast, lunch, dinner and a snack every day. Ms. Bradley stated the meals at the facility are nutritious and well balanced. Ms. Bradley stated if a resident doesn't like the meal being served, they are offered another option.

On 04/14/2020, I interviewed Staff #3 via telephone. Staff #3 stated the meals at the facility include breakfast, lunch and dinner with a snack. The meals tend to be repeated often and the residents have complained to her about the way some of the food is cooked.

On 04/28/2020, I interviewed Relative #1 via telephone. Relative #1 stated she was at the facility "all the time" and the "food was wonderful." Relative #1 stated she ate at the facility six times a week and the food was good. Relative #1 stated every meal was unique and different and consisted of chicken patties made fresh, veggies, fruit, desserts such as cobbler and pudding with special toppings. In addition, the meals consisted of an appetizer, the main meal and a dessert. Relative #1 stated Resident A never complained about the food and there was nothing wrong with the food at this facility.

On 04/28/2020, I interviewed Relative #2 via telephone. Relative #2 stated Resident B had no complaints about the food at the facility.

On 04/28/2020, I interviewed Relative #3 via telephone. Relative #3 stated Resident C never complained about the food at the facility. Relative #3 stated she ate at the facility once and the food was good and included a sandwich and fruit.

On 04/28/2020, I received and reviewed the menus for February and March 2020, The menus depict meals for each day of the week and for breakfast, lunch and

dinner. the meals offer different types of foods including chicken, beef, pork, fruits and vegetables for each meal. The menus include alternate meal options if the residents do not want the main meal featured and hot or cold cereal, fruit cup or yogurt with the daily breakfast that includes eggs, sausage, bacon, toast and pancakes. Milk, juice, coffee or iced tea is available with all meals and snacks and beverages are available between meals. The menus include desserts with lunch and dinner.

On 05.15.2020, I conducted an Exit Conference with Ms. Fry via telephone. Ms. Fry stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15313	**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:	Based on a review of the menus for the months of February and March 2020 along with staff and relative interviews, there is not a preponderance of evidence to show that the meals served at the facility are of poor quality. Therefore, a violation of this rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Elizabeth Elliott

05/15/2020

Elizabeth Elliott Date
Licensing Consultant

Approved By:

05/15/2020

Jerry Hendrick
Area Manager

Date