GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2022

Monica Flagg
Elite Alternatives, Inc.
3330 Primary Rd.
Auburn Hills, MI 48326

RE: License #: AS630274298
Investigation #: 2022A0605033
Avon Group Home

Dear Ms. Flagg:

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 (248) 975-5053.

Sincerely,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630274298
Investigation #:	2022A0605033
Complaint Receipt Date:	05/13/2022
Investigation Initiation Date:	05/16/2022
Report Due Date:	07/12/2022
Licensee Name:	Elite Alternatives, Inc.
Licensee Address:	3330 Primary Rd Auburn Hills, MI 48326
Licensee Telephone #:	(248) 852-2065
Administrator/Licensee Designee:	Monica Flagg
Name of Facility:	Avon Group Home
Facility Address:	275 Lesdale Troy, MI 48085
Facility Telephone #:	(248) 879-6120
Original Issuance Date:	10/10/2005
License Status:	REGULAR
Effective Date:	04/10/2022
Expiration Date:	04/09/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 05/11/2022, DCS Donte Easley was observed sleeping when Macomb-Oakland Regional Center (MORC) supports coordinator arrived at Avon Group Home leaving six residents unattended to.	Yes

III. METHODOLOGY

05/13/2022	Special Investigation Intake 2022A0605033
05/16/2022	Special Investigation Initiated - Letter I emailed Office of Recipient Rights (ORR) worker, Dawn Krull advising her I was investigating these allegations.
05/16/2022	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Novella Jackson and observed Residents A, B, C, D, E, and F.
05/16/2022	Contact - Telephone call made I interviewed the home manager Kim Daniels regarding the allegations.
06/07/2022	Contact - Telephone call made I interviewed DCS Donte Easley and licensee designee Monica Flagg regarding the allegations.
06/08/2022	Contact - Document Received I received an email from Monica Flagg with staff's contact information, May staff schedule and Alternatives Elite, Inc., policy on sleeping on shift.
06/16/2022	APS Referral Adult Protective Services (APS) made a referral and will not be investigating the complaint.
06/16/2022	Contact - Telephone call made I interviewed DCS Rachael Walker and Resident F's guardian regarding the allegations.

06/16/2022	Contact - Telephone call made I followed up with licensee designee Monica Flagg regarding the additional allegations received. I left messages for Resident F's Macomb-Oakland Regional Center (MORC) supports coordinator Crystal Ponce De Leon and Resident F's registered dietician Sadie Riedel.
06/16/2022	Contact - Telephone call received I interviewed Resident F's MORC's supports coordinator Crystal Ponce De Leon and registered dietician Sadie Riedle regarding the allegations.
06/27/2022	Contact - Telephone call made I interviewed acting home manager Terri Speed regarding the allegations. I attempted to call DCS Taylor Speed, but her voice mail box was full, so I texted her to call me to discuss the allegations.
06/27/2022	Contact - Document Sent I emailed acting home manger Terri Speed requesting the recorded voice mail message left by Relative F's guardian and June's staff schedule.
06/28/2022	Contact - Telephone call made I attempted to call DCS Taylor Speed, but her mailbox is still full.
06/28/2022	Contact - Document Sent I emailed licensee designee Monica Flagg.
06/28/2022	Contact - Telephone call received I interviewed DCS Taylor Speed regarding the allegations.
06/29/2022	Exit Conference Left message for licensee designee Monica Flagg with my findings.

ALLEGATION:

On 05/11/2022, DCS Donte Easley was observed sleeping when Macomb-Oakland Regional Center (MORC) supports coordinator arrived at Avon Group Home leaving six residents unattended to.

INVESTIGATION:

On 05/13/2022, intake #187165 was referred by Oakland County Office of Recipient Rights (ORR) regarding Macomb-Oakland Regional Center (MORC) supports coordinator arrived at Avon Group Home on 05/11/2022 and staff were sleeping. During this investigation, I received additional information on 06/16/2022 from Adult Protective Services (APS) regarding Resident F's guardian arrived at Avon Group Home on 06/08/2022 to visit Resident F and observed no staff in the home. After about 45 minutes, the staff member advised the guardian that they were in the home but were laying on the couch.

On 05/16/2022, I emailed ORR worker Dawn Krull advising her that I will be investigating these allegations. Ms. Krull emailed back stating she too was investigating these allegations.

On 05/16/2022, I conducted an unannounced on-site investigation around 10AM. I knocked on the door for about three minutes before direct care staff (DCS) Novella Jackson answered. Ms. Jackson stated she is the only staff on shift with Residents A, B, C, D, E, and F. Ms. Jackson allowed me into the home. Next to the front door was the living room. In the living room was Resident B sitting in a large round fabric chair facing the window with the verticals closed. Resident B was rocking back and forth and non-verbal; therefore, I was unable to interview her. Ms. Jackson stated, "Resident B likes sitting like that." I observed a blanket on the couch in the family room. Ms. Jackson stated, "I was not sleeping, I was sitting on the couch watching TV and had the blanket wrapped around me because I was cold." Ms. Jackson stated all the residents were "chilling," because "it's early." Ms. Jackson stated, "I've been working here since 2016 and I never had this problem. You can't just come and pop up here. I wasn't expecting anyone." I advised Ms. Jackson that Avon Group Home was licensed by the State of MI, Licensing and Regulatory Affairs (LARA) and that any licensing consultant such as myself can conduct "pop up," visits without the group home's knowledge especially for an investigation. I requested to interview the residents, but Ms. Jackson stated all the residents were non-verbal except for Resident E.

I observed Resident C sitting in the living room watching cartoons. I attempted to interview Resident C, but he was not responding to my questions.

I asked to see Resident A, Resident E and Resident F. Ms. Jackson escorted me to the bedrooms. Resident D was in his bedroom in a wheelchair facing the TV. The TV's volume was extremely loud. Resident D is also non-verbal; therefore, I was unable to interview him. Resident A was not in her bedroom and Ms. Jackson did not seem to know where Resident A was. As we walked to towards the back bedroom, I observed Resident A in the bathroom without any pants or underwear on. Resident A was holding her underwear in her hand and she and her underwear were covered in feces. Ms. Jackson stated, "bro, close the door and clean yourself up." Ms. Jackson closed the door leaving Resident A in the bathroom alone. Resident A immediately opened the bathroom door, walked out of the bathroom with her underwear still in her hands. I

advised Ms. Jackson that Resident A will require her assistance. Ms. Jackson then went to grab gloves and assisted in cleaning Resident A up in the bathroom. I observed Resident E lying in bed. Resident E did not want to speak to me; therefore, he was not interviewed. I observed Resident F lying in bed also watching TV with the TV volume loud. Resident F was non-verbal, so I was unable to interview him regarding the allegations.

I interviewed Ms. Jackson regarding the allegations. Ms. Jackson stated she was not working on 05/11/2022 when MORC's supports coordinator arrived at Avon Group Home and staff was asleep. Ms. Jackson stated DCS Donte Easley was working that shift. She stated there should always be two DCS on shift, but because they are short staffed, there is only one DCS per shift. Ms. Jackson stated staff have been working close to 16-hour shifts, but she denied she sleeps during her shift. Ms. Jackson stated she monitors the residents and "makes sure they're healthy and safe," when she was asked how she meets the residents' needs as all the residents living at Avon Group Home have significant medical and mental health needs. Ms. Jackson stated she has no further details as to Mr. Easley sleeping during his shift.

I reviewed Resident A's individual plan of service (IPOS) completed by MORC on 04/13/2022. Resident A is non-verbal. Staff should be within hearing range of Resident A; staff will conduct visual checks every 15 minutes during waking hours and every 2-hour bed checks during sleeping hours. Resident A requires assistance with bowel movements (BM).

I reviewed Resident B's IPOS completed by MORC on 10/01/2021. Resident A is non-verbal and is dependent on staff for all their personal care needs and safety. Staff will conduct visual checks every 15 minutes during waking hours and every 2-hour bed checks during sleeping hours.

I reviewed Resident C's IPOS completed by MORC on 07/01/2021. Resident A is verbal but speaks in a low tone. Resident A requires visual checks every 30 minutes during waking hours and every 2-hour bed checks during sleeping hours.

I reviewed Resident D's IPOS completed by MORC on 02/01/2022. Staff should be within hearing range of Resident D; staff will conduct visual checks every 15 minutes during waking hours and every 2-hour bed checks during sleeping hours. Resident D wears adult briefs and should be checked every 2-hours to ensure he is dry.

I reviewed Resident E's IPOS completed by MORC on 12/01/2021. Staff will conduct visual checks every 30 minutes and staff should accompany Resident E when he is outside unless he is in the backyard or front porch. If he is in the backyard, visual checks will be completed every 10 minutes and when on the front porch, visual checks will be completed every 5 minutes to ensure safety.

I reviewed Resident F's IPOS completed by MORC on 01/01/2022. Resident F is totally dependent on staff for all his personal needs. Resident F is a two person assist and requires 2-hour bed checks during sleeping hours.

Note: After leaving Avon Group Home, I observed Resident E come out of the door from the backyard, walked to the driveway and brought in the trash cans. I did not observe Ms. Jackson accompanying Resident E while he was in the driveway.

On 05/16/2022, I interviewed the home manager Kim Daniels via telephone regarding the allegations. Ms. Daniels has worked for this corporation since 2015. She is the home manager between three homes and stated she has been working with the licensee designee Monica Flagg in closing one of their group homes located in Macomb County due to staff shortage. Ms. Daniels stated there should be two DCS at Avon Group Home but due to staff shortage, there is only one DCS. She stated on 05/11/2022, MORC supports coordinator arrived at Avon Group Home for their monthly visit and found DCS Donte Easley sleeping. Mr. Easley was the only DCS on shift that day. Ms. Daniels stated that all the staff working at Avon Group Home have been working long hours, sometimes 16-hour shifts because they are "very short staffed." Ms. Daniels believes once the Macomb County group home is closed, the staff will be transferred to Avon Group Home so this will help with the staff shortage. Ms. Daniels stated she believes this was an isolated incident with Mr. Easley sleeping on his shift because there have not been any other complaints. She stated she has not spoken to Mr. Easley about the incident.

On 05/16/2022, I left a detailed voice mail message for licensee designee Monica Flagg informing her of the concerns regarding DCS Novella Jackson sitting on the couch covered with a blanket while Resident A had been in the bathroom covered in feces after Resident A had a BM.

On 05/16/2022, I interviewed DCS Donte Easley regarding the allegations via telephone. Mr. Easley has worked for this corporation for three years. He works all shifts; 7AM-11PM and 3PM-7AM but on 05/11/2022, he worked 7AM-11PM. Around 10AM, MORC supports coordinator, Crystal Ponce De Leon arrived at Avon Group Home around 10AM. He stated, "Resident A answered the door like Resident A does every time someone knocks on the door," and "Resident A let Crystal inside." Mr. Easley stated, "I was sitting on the couch with all the residents, and I dosed off a little bit, but I wasn't sleeping." Mr. Easley stated, "I only dosed off for a couple of minutes once all the work was done and I began watching SpongeBob Square Pants with the residents and must have dosed off." Mr. Easley stated he had worked 16-hour shifts when he worked alone, but now that there are two DCS per shift, he is only working eight-hour shifts. Mr. Easley stated this was the first time he "dosed off," and that he made sure all the residents were sitting in the living room with him.

On 06/07/2022, I interviewed licensee designee Monica Flagg regarding the allegations via telephone. Ms. Flagg stated she was made aware of the incident with DCS Donte Easley sleeping during his shift on 05/11/2022 and received the voice mail message

regarding DCS Novella Jackson that was left by me on 05/16/2022. Ms. Flagg stated on 05/11/2022, Mr. Easley was the only DCS on shift that day and due to short staff, Mr. Easley may have worked 16 hours. Ms. Flagg stated Mr. Easley advised her he was "resting his eyes," but not sleeping when MORC supports coordinator arrived at Avon Group Home. Ms. Flagg stated she is closing one of her group homes in Macomb County which will allow her to staff two DCS per shift at Avon Group Home. Ms. Flagg stated she understands the concerns and agrees that staff should not be sleeping during their shift, but that she has no other staff to put in the home. Ms. Flagg stated she has another home manager, Terri Speed who will be filling in at Avon Group Home to ensure there are always two DCS on shift. Ms. Flagg stated she is also offering "double time pay," for any DCS who fills in a shift. She stated she will also be making daily visits to Avon Group Home to ensure DCS are not sleeping and/or sitting on the couch watching TV and taking care of the residents. Ms. Flagg will email me all DCS names and contact numbers, May staff schedule and policy on sleeping during shifts.

On 16/16/2022, I received additional information from APS regarding Resident F's guardian arriving at Avon Group Home on 06/08/2022 and there was no staff present. The guardian was in the home for 45 minutes and stated loudly, "I'm going to dial 911," before DCS Taylor Speed came out of the living room. Taylor had been laying on the couch in the living room.

On 06/16/2022, I contacted Avon Group Home and spoke with DCS Rachael Walker. Ms. Walker was interviewed regarding the allegations. She has been working with this corporation on and off for seven years. She works 7AM-3PM. Ms. Walker stated there should be two staff per shift, but she is working alone today. Ms. Walker stated she was not present on 05/11/2022 when MORC supports coordinator arrived at Avon Group Home and DCS Donte Easley was sleeping. She stated she heard about it from MORC supports coordinator Crystal Ponce De Leon. Ms. Walker has not observed Mr. Easley or any other staff sleeping, nor has she ever slept during her shift. Ms. Walker stated she was not working on 06/08/2022, when Resident F's guardian arrived at Avon Group Home and there was no staff around for about 45 minutes. Ms. Walker stated that the registered dietician (RD) informed her what happened that Resident F puked, and the guardian had to change him because staff was just "sitting on the couch."

On 06/16/2022, I interviewed MORC supports coordinator regarding the allegations. MORC supports coordinator stated she arrived at Avon Group Home on 05/11/2022 around 10AM for her monthly visit. She knocked on the door for about five minutes before Resident A answered the door. MORC supports coordinator came inside and found DCS Donte Easley sleeping on the couch. She stated, "I said hi and as soon as I said something, Donte jumped up off the couch." MORC supports coordinator called the home manager Kim Daniels advising her what happened. Ms. Daniels called Mr. Easley while MORC supports coordinator was present as Mr. Easley could be heard complaining on the phone to Ms. Daniels.

MORC supports coordinator stated she received a call from Resident F's guardian who advised her that Resident F had puked himself and there was no staff around for 45

minutes. Only after the guardian stated, “I’m going to call 911,” did DCS Taylor Speed come out of the living room saying, “I’ve been here for an hour.” The guardian told MORC supports coordinator that Taylor was laying on the couch. MORC supports coordinator stated that Resident F was a two person assist but now is a one person assist after a Hoyer lift was prescribed to him on 05/16/2022.

On 06/16/2022, I interviewed Resident F’s guardian via telephone regarding the allegations. The guardian stated she arrived at Avon Group Home around 4:30PM, knocked on the door and Resident A answered the door. She stated all the residents were present, but she did not see any staff. The guardian was with her friend, and both went straight into Resident F’s bedroom which is in the back of the hallway. The guardian stated she observed vomit on Resident F’s shirt, so she and her friend changed Resident F’s shirt. The guardian stated after 45 minutes, she and her friend wanted to leave, but because she did not observe any staff, she called the number she had for the group home. The guardian stated that a child answered the phone and then hung up. She stated she attempted a couple more times to call the number she had and each time a child answered and then hung up. The guardian stated she did not feel comfortable leaving the residents alone, so she walked to the kitchen and loudly said, “I’m going to call 911,” and then a female staff (Taylor Speed) “popped up from the living room.” Taylor told the guardian, “I was here the entire time. I was laying on the couch.” The guardian stated the staff did not say anything the entire time the guardian and her friend were in the home. The guardian informed Taylor that Resident F had vomited on his shirt and that the guardian changed his shirt and then the guardian and her friend left. The guardian stated this was an isolated incident.

On 06/16/2022, I interviewed the RD regarding the allegations via telephone. The RD stated she was told about the DCS sleeping during his shift by MORC supports coordinator when the supports coordinator was making her monthly visits at Avon Group Home. The RD stated she was then informed about the guardian arriving at Avon Group Home and there was no staff around for about 45 minutes. The RD expressed her concerns about Resident F vomiting and no staff being around. The concern is that Resident F could have aspirated on his vomit as Resident F has “silent aspirations.” The RD stated she should have been contacted by staff after learning that Resident F had vomited but reported that she received no calls from staff, nor did she receive any incident reports regarding Resident F vomiting. The RD visited Avon Group Home last week to pick up the in-service for recommendations she had for all the residents she visits in the home; however, the home manager Kim Daniels had not signed the in-service sheet. The RD stated in the past, there was a home manager specifically for Avon Group Home that was on top of everything, and the staff was great, but now the RD stated with the new home manager having to manage three different group homes, there is no one overseeing staff to ensure staff are following RD’s recommendations for these residents.

On 06/16/2022, I contacted licensee designee Monica Flagg via telephone. Ms. Flagg was advised of the allegations regarding Taylor Speed not being around for 45 minutes when Resident F’s guardian was at Avon Group Home on 06/08/2022. Ms. Flagg stated

she was informed of the allegations and that she talked to Taylor who informed Ms. Flagg that she (Taylor) was in the bathroom and came out immediately after seeing the guardian at the home. Ms. Flagg is also concerned about staff at Avon Group Home if staff are continuing to sleep and not around for 45 minutes when the guardian was present. Ms. Flagg was unaware that there is only one DCS on shift today at Avon Group Home. Ms. Flagg stated that the home manager Kim Daniels is on personal leave until next week, but that she was heading to Avon Group Home to find out why there is only one staff there. Ms. Flagg called me stating she was informed that the second staff that was on the schedule did not show up. Ms. Flagg stated the acting home manager Terri Speed will be working the shift.

On 06/27/2022, I interviewed acting home manager Terri Speed regarding the allegations. Ms. Speed stated Taylor Speed is her daughter. She dropped her daughter off to work the morning of 06/08/2022 and stated that her daughter had worked more than 16 hours. Ms. Speed reported that shortly after the incident, Ms. Speed heard that Resident F's guardian arrived at Avon Group Home and there was no staff in the home and that the police were called. Then a week later, Ms. Speed heard that the police were not called because Taylor was at the home. Ms. Speed stated there was a voice mail left by the guardian and Ms. Speed could hear Taylor talking to the guardian in the background. Ms. Speed stated she asked Taylor what happened. Taylor told Ms. Speed that the guardian was not there for 45 minutes and that when Ms. Speed asked Taylor about Resident F vomiting, Ms. Speed stated, "Taylor seemed surprised about the vomit." Ms. Speed stated that Taylor did not admit to sleeping, but it would not surprise Ms. Speed because of the many hours Taylor worked. Ms. Speed stated, "if Taylor sleeps, she really sleeps.

On 06/28/2022, I interviewed DCS Taylor Speed via telephone regarding the allegations. Taylor stated on 06/08/2022 she worked the morning shift but had been there for close to 16 hours. She is not sure what time the guardian arrived but stated that Resident A answered the door and Taylor did not get up off the couch to see who was at the door. Taylor stated Resident A let the guardian in and that the guardian and her friend were there to visit with Resident F. Taylor stated she was on the couch the entire time the guardian was present. Taylor stated she did not know how long but stated "it was a while they were with Resident F." Taylor stated she got up off the couch when the guardian came into the kitchen saying, "I'm calling 911." Taylor stated she got up and told the guardian, "I was here the entire time. I was laying on the couch watching TV." Taylor stated Resident F did not vomit because the last time she checked on him was when she passed his 2PM medications. Taylor stated she was on the couch since she passed Resident F's medication at 2PM.

On 06/29/2022, I left a detailed message for licensee designee Monica Flagg via telephone with my findings.

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:	Based on my investigation and information gathered, there was insufficient DCS on 05/11/2022, when DCS Donte Easley was observed sleeping during his shift by MORC supports coordinator leaving insufficient DCS on duty at all times to provide for the supervision, personal care, and protection of Residents A, B, C, D, E, and F.
CONCLUSION:	**VIOLATION ESTABLISHED**

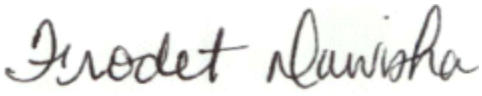
APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and information gathered, DCS Novella Jackson did not provide supervision, protection, and personal care as defined in Residents A's IPOS completed by MORC on 04/23/2022 and Resident E's IPOS completed by MORC on 12/01/2022. On 05/16/2022, during my unannounced on-site investigation, Ms. Jackson was sitting on the couch, wrapped up in a blanket watching TV when Resident A had a bowel movement and was trying to clean herself in the bathroom. Resident A's IPOS dated 04/23/2022, indicated that Resident A requires assistance whenever she has a bowel movement. Instead of Ms. Jackson assisting Resident A, Ms. Jackson closed the bathroom door and told Resident A to clean herself. Ms. Jackson did not assist in cleaning Resident A up until I advised her that Resident A needed her assistance. In addition, Ms. Jackson did not accompany Resident E outside the home on 05/16/2022, when I observed Resident E come out of Avon Group Home and pull in the trash cans from the driveway without any staff. Resident E's IPOS stated that staff

	should accompany Resident E when he is outside unless he is in the backyard or the front porch, which Resident E was not. DCS Taylor Speed did not provide supervision, protection, and personal care as defined in Resident A's, B's, C's, D's, E's, and F's crisis plans completed by MORC. On 06/08/2022, Resident F's guardian arrived at Avon Group Home around 4:30PM and did not observe staff around for at least 45 minutes. Resident F had vomited, the guardian and her friend changed his shirt because staff was nowhere to be found until the guardian stated loudly, "I'm calling 911." Taylor stated she was present, but that she was laying on the couch watching TV soon after she passed Resident F's medications at 2PM. If Taylor would have conducted her well checks, she would have observed the vomit on Resident F's shirt. Also, according to the registered dietician, staff at Avon Group Home were in-serviced regarding Resident F's silent aspiration and that staff must contact the registered dietician when Resident F vomits, which Taylor did not do. In addition, Taylor did not conduct her 15 minutes well checks for Resident A, Resident B, and Resident D as stated in their IPOS's nor did she conduct her 30 minutes well checks for Resident C and Resident E as stated in their IPOS's.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation and information gathered, DCS Donte Easley was sleeping while on his shift on 05/11/2022, DCS Novella Jackson was sitting on the couch, wrapped in a blanket watching TV on 05/16/2022 and DCS Taylor Speed was also sitting on the couch watching TV on 06/08/2022, not attending to at all times for the personal needs, including protection and safety of Residents A, B, C, D, E, and F.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

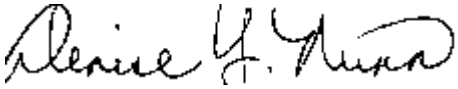
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



06/30/82022

Frodet Dawisha — Date
Licensing Consultant

Approved By:



06/30/2022

Denise Y. Nunn — Date
Area Manager