GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 16, 2024

Linda Perrault
1551 S.Hickory Ridge
Milford, MI 48380

RE: License #: AF630081134
Investigation #: 2025A0991001
Perrault AFC

Dear Linda Perrault:

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:

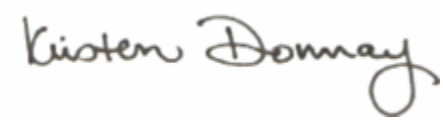
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF630081134
Investigation #:	2025A0991001
Complaint Receipt Date:	10/07/2024
Investigation Initiation Date:	10/07/2024
Report Due Date:	12/06/2024
Licensee Name:	Linda Perrault
Licensee Address:	1551 S. Hickory Ridge Milford, MI 48380
Licensee Telephone #:	(248) 889-3188
Name of Facility:	Perrault AFC
Facility Address:	1551 S. Hickory Ridge Milford, MI 48380
Facility Telephone #:	(248) 889-3188
Original Issuance Date:	08/12/1998
License Status:	REGULAR
Effective Date:	10/26/2023
Expiration Date:	10/25/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
During an audit by Oakland Community Health Network (OCHN) on 09/30/24, a caregiver, Lisa, was on shift at the home. Lisa has not been trained through OCHN or any other community mental health agency.	Yes
On 09/30/24, medications were not locked up. The 7:00am medications had not been passed to one of the residents at 3:00pm.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/07/2024	Special Investigation Intake 2025A0991001
10/07/2024	Special Investigation Initiated - Telephone To assigned Office of Recipient Rights (ORR) worker, Katie Garcia
10/07/2024	Referral - Recipient Rights Received from Office of Recipient Rights (ORR)
10/07/2024	Contact - Document Received Email correspondence from auditor to Office of Recipient Rights
10/10/2024	Inspection Completed On-site Unannounced onsite inspection- no answer/no residents home
10/10/2024	Contact - Telephone call made To licensee, Linda Perrault
10/10/2024	Contact - Telephone call made To Resident A's guardian
10/10/2024	Contact - Telephone call made To responsible person, Christina Johnson
10/11/2024	APS Referral Sent referral to Adult Protective Services (APS) Centralized Intake
10/23/2024	Inspection Completed On-site

	On-site inspection, interviewed staff and residents
11/14/2024	Contact - Telephone call made To Lisa Hixson
11/19/2024	Contact - Telephone call made To Linda Perrault- voicemail box is full
11/20/2024	Contact - Telephone call made To Linda Perrault- voicemail box is full, sent text message
12/02/2024	Exit Conference Via telephone with licensee, Linda Perrault and followed up via telephone with responsible person, Christina Johnson

ALLEGATION:

During an audit by Oakland Community Health Network (OCHN) on 09/30/24, a caregiver, Lisa, was on shift at the home. Lisa has not been trained through OCHN or any other community mental health agency.

INVESTIGATION:

On 10/07/24, I received a complaint regarding Perrault AFC from the Office of Recipient Rights (ORR). The complaint stated that on 09/30/24, Terrance Marble, an audit specialist from Oakland Community Health Network (OCHN), conducted an unannounced site visit at Perrault AFC. During the onsite visit, a caregiver named Lisa was on shift at the home, but she had not been trained through OCHN or any other Community Mental Health (CMH) agency.

I initiated my investigation on 10/07/24 by contacting the assigned ORR worker, Katie Garcia. I received and reviewed email correspondence from the OCHN audit specialist, Terrance Marble, to the Office of Recipient Rights. The information in the email was consistent with the information provided in the complaint. Mr. Marble stated that Lisa informed him that she was not an employee or a family member of any of the residents. She stated that she was not an official employee, but she does help with care at the home. On 10/10/24, I conducted an unannounced onsite inspection at Perrault AFC with Ms. Garcia. There was no response at the home.

On 10/10/24, I contacted the licensee, Linda Perrault, via telephone. Ms. Perrault stated that she was not at the home and that Christina was working at the home today. She did not know where Christina or the residents were at that time. She did not have a phone number for Christina.

On 10/10/24, I contacted Resident A's guardian via telephone. Resident A's guardian stated that Resident A has lived at Perrault AFC since the year 2000. She stated that Christina Johnson is the primary caregiver at the home. She was not aware of any staff person named Lisa working in the home. She stated that Ms. Johnson never mentioned anyone named Lisa. Resident A's guardian stated that she and her husband live a few hours away and they do not come out to the home. Resident A's guardian stated that the licensee, Linda Perrault, was having medical issues and she went to Chicago. She was not sure if Ms. Perrault was still in Chicago. She stated that Christina Johnson is always with the residents. They are very well loved by the family. Ms. Johnson sometimes takes the residents to her house, and Resident A's guardian does not have any issues with that. She stated that they go to the park, to the zoo, and to the movies. The residents are very well loved and well cared for in the home.

On 10/23/24, I conducted an onsite inspection at Perrault AFC with the assigned ORR worker, Katie Garcia. I interviewed Resident A. Resident A stated that he has lived in the home for a long time. He stated that Chrissy is the staff who works in the home. Resident A stated that he knows Lisa. He stated that Lisa comes to the home tomorrow. She comes to the house a lot and watches him.

On 10/23/24, I interviewed Resident B. Resident B stated that Resident A lives in the home with him. Resident B stated that Linda Perrault moved and is not living there anymore. He stated that Chrissy watches them and stays at night. He stated that Lisa hasn't been at the home in a while. He did not know the last time she was there. He stated that only Chrissy works in the home. Sometimes Chrissy leaves and Lisa stays with them. Lisa cooks dinner and gives them medications. He stated that Lisa has worked there for a long time, but she has not been there for a while.

On 10/23/24, I interviewed the responsible person, Christina Johnson. Ms. Johnson stated that she has worked at Perrault AFC for four and a half years. She stated that about six months ago, the licensee, Linda Perrault's health took a downward turn. Ms. Perrault moved to Chicago and is receiving full time care. Ms. Johnson stated that she is residing in the Perrault AFC home with her children, Resident A, and Resident B. She stated that about two and a half weeks ago, she had a medical procedure, and she had "a babysitter", Lisa Hixson, come to the home to watch the residents. Ms. Johnson stated that she had an outpatient procedure at 10:00am and she returned to the home prior to 4:00pm. She stated that the OCHN auditor, Terrance Marble, said he tried to call and email to schedule an onsite inspection, but she did not receive any communication from him. On the date he came to the home unannounced, Ms. Hixson was covering for her. Ms. Johnson stated that Ms. Hixson completed her annual recipient rights training, but she has not completed any other training. Ms. Johnson stated that Ms. Hixson has not been fingerprinted. She stated that Ms. Hixson has only been working in the home for about a month. Ms. Hixson typically only works once a week for two to four hours if Ms. Johnson needs coverage for something, such as going to a conference for her children or a medical appointment.

During the onsite inspection on 10/23/24, I observed a certificate of completion for annual recipient rights training completed by Lisa Hixson on 10/19/24. Ms. Johnson did not have any other employee records for Ms. Hixson.

On 11/24/24, I interviewed the caregiver, Lisa Hixson, via telephone. Ms. Hixson stated that she was previously working at the Perrault AFC home on an on-call basis. She met Christina Johnson through a mutual friend at church. She stated that if Christina Johnson needed someone to cover for her, she would provide coverage. She was not sure how often she worked in the home. She stated that it was sporadic, about once every one to two weeks as needed. Ms. Hixson stated that she had not completed training at the time she was providing coverage, and she is still waiting to complete the required training classes. She stated that she was not fingerprinted. She used to work for a facility in Livingston County, so she took all the required classes, but that was in 2006. She stated that her first aid and CPR training have expired. Ms. Johnson stated that she has not been back to the home since the OCHN auditor came out, as she is not yet trained. She stated that the two residents in the home get more love than anybody. They get home cooked meals and are always happy when she sees them.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas: **(a) An introduction to community residential services and the role of direct care staff.** **(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home.** **(c) Basic interventions for maintaining and caring for a client's health, for example, personal hygiene, infection control, food preparation, nutrition and special diets, and recognizing signs of illness.** **(d) Basic first aid and cardiopulmonary resuscitation.** **(e) Proper precautions and procedures for administering prescriptive and nonprescriptive medications.**

	(f) Preventing, preparing for, and responding to, environmental emergencies, for example, power failures, fires, and tornados. **(g) Protecting and respecting the rights of clients, including providing client orientation with respect to the written policies and procedures of the licensed facility.** **(h) Non-aversive techniques for the prevention and treatment of challenging behavior of clients.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Lisa Hixson did not complete the required training and has worked independently at Perrault AFC while providing coverage for Christina Johnson. The OCHN auditor observed Ms. Hixson working independently in the home on 09/30/24. Ms. Johnson and Ms. Hixson both stated that Ms. Hixson occasionally provides coverage at the home and supervises the residents. They stated that Ms. Hixson did not complete the required training through Oakland Community Health Network (OCHN). At the time of the onsite inspection on 10/23/24, the only training verification on file for Ms. Hixson was for a recipient rights refresher course, which was completed on 10/19/24.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report Dated: 04/11/23; CAP dated: 04/25/23**

APPLICABLE RULE	
R 400.1406	**Ratio of responsible persons to residents.**
	(1) The ratio of responsible persons to residents shall not be less than 1 responsible person to 6 residents and 2 children under the age of 12 years or ratio thereof.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the ratio of responsible persons to residents was less that 1 responsible person to 6 residents when Lisa Hixson was providing coverage at the home. Ms. Hixson does not meet the qualifications for a responsible person, as she has not been fingerprinted and does not have verification of a physical, TB testing, or training on file. On 09/30/24, Ms. Hixson was observed to be alone with the residents in the home by the OCHN auditor, Terrance Marble.

	She told Mr. Marble that she was not an official employee, but she does help with care at the home
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 09/30/24, medications were not locked up. The 7:00am medications had not been passed to one of the residents at 3:00pm.

INVESTIGATION:

The complaint also alleged that on 9/30/24, the OCHN audit specialist, Terrance Marble, observed that medication was not locked up. Mr. Marble also observed that the 7:00am medications for that day were still in the pill pack for one of the residents in the home at the time of the audit at 3:00pm.

On 10/23/24, I interviewed the responsible person, Christina Johnson. Ms. Johnson stated that on the day the OCHN auditor came to the home, she had an outpatient procedure scheduled at 10:00am. She passed medications in the morning at 8:00am before leaving the home. She was back at the home in time to pass the 4:00pm medications. Ms. Johnson stated that the key to the filing cabinet where they store medications was broken, so the medications were being stored on top of the cabinet when the auditor from OCHN came to the home. She stated that the medications were not locked up at that time, but the cabinet is fixed, and the medications are now locked up. Ms. Johnson stated that she was not aware of any medications not being passed on the date that the OCHN auditor came to the home. She stated that in the beginning of September, Resident B's medications were being changed. When the medications were first changed, she did not realize that there were two pill packets for his 7:00am medications. She stated that she did not pass the 7:00am medications at the correct time, because she missed the second packet. The medication was administered to Resident B at 4:00pm that day. Ms. Johnson could not recall what day this occurred.

I reviewed a copy of Resident A and Resident B's medication administration record (MAR) for September 2024. Resident A and Resident B's September MARs had not been initialed at all for the entire month of September. Ms. Johnson stated that Resident B's MAR was not completed because he was having medication changes throughout the month. She stated that she was going to complete Resident A's MAR later.

During the onsite inspection, I observed the medications were being stored in a locked cabinet. I observed Resident A and Resident B's medications. The medications are delivered from the pharmacy in a box that contains a strip of medication packets with all of the pills for each administration in a single packet. The medication packets are torn from the strip on the date and time when they are administered. I observed that Resident A had one packet for 7:00am medications, one packet for 4:00pm

medications, and one packet for 9:00pm medications. I observed that Resident B had two medication packets for his 7:00am medications, one medication packet for his 4:00pm medications, and one packet for 9:00pm medications. The medications for Resident A and Resident B appeared to have been passed in accordance with the date and time during my onsite inspection, as the next packets to be passed were the 4:00pm medications for 10/23/24. Resident A and Resident B's October 2024 MARs were completed indicating medications were passed.

On 11/24/24, I interviewed the caregiver, Lisa Hixson, via telephone. Ms. Hixson stated that she was working when the OCHN auditor came to the home. She stated that he mentioned something about medications not being passed. Ms. Hixson stated that she did not pass medications that morning. Christina Johnson passed the medications before she left the home. Ms. Hixson stated that Resident B started getting two packs of pills for his AM medications, so Ms. Johnson might have only given him one pack that morning. She stated that Ms. Johnson "pretty much always" passed medications, as she was typically only at the home for a couple of hours if Ms. Johnson needed to go to the store, or if she needed to pick up her kids.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that medications were not given pursuant to label instructions. On 09/30/24 at 3:00pm, the OCHN auditor, Terrance Marble, observed that 7:00am medications had not been administered that day. The responsible person, Christina Johnson stated that she was not aware of medications not being passed that day; however, she recalled a time when she did not pass all of Resident B's 7:00am medications, as there was a medication change and she did not realize he had two pill packets for his 7:00am medications. She did not administer the second packet of medications, but she passed them at 4:00pm that day when she noticed the error. Ms. Johnson was not following proper medication procedures, as she did not use the eight rights of medication administration, and she did not initial the medication administration records for the month of September.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the responsible person, Christina Johnson, did not maintain a record as to the time and amount of medications administered. I observed that the September 2024 medication administration records (MARs) for Resident A and Resident B were blank.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report Dated: 04/11/23; CAP Dated: 04/25/23**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(5) Prescription medication shall be kept in the original pharmacy supplied and pharmacy-labeled container, stored in a locked cabinet or drawer, refrigerated if required, and labeled for the specific resident.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that medications were not being stored in a locked cabinet. On 09/30/24, the OCHN auditor, Terrance Marble, observed resident medications that were not locked up during an unannounced onsite visit. The responsible person, Christina Johnson, stated that the key to cabinet was broken, so there was a time period when medications were not being stored in a locked cabinet.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report Dated: 04/11/23; CAP Dated: 04/25/23**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/23/24, I interviewed the responsible person, Christina Johnson. Ms. Johnson stated that about six months ago, the licensee, Linda Perrault's health took a downward turn. Ms. Perrault moved to Chicago and is receiving full time care. Ms. Johnson stated that she is residing in the Perrault AFC home with her children, Resident A and Resident B. The licensee, Linda Perrault, no longer lives in the home. Ms. Johnson stated that as the responsible person, she thought she was allowed to live in the home and provide care to the residents in the absence of the licensee. It was explained to Ms. Johnson that as a family home, the licensee is required to live in the home. Ms. Johnson stated that she would eventually like to apply for a license to provide adult foster care at her own home and move the residents there, but she is not ready to do that yet.

APPLICABLE RULE	
MCL 400.703	**Definitions; A.**
	(5) "Adult foster care family home" means a private residence with the approved capacity to receive at least 3 but not more than 6 adults to be provided with foster care. The adult foster care family home licensee must be a member of the household and an occupant of the residence.
ANALYSIS:	Based on the information gathered during my onsite inspection, there is sufficient information to conclude that the licensee, Linda Perrault, is no longer a member of the household and an occupant of the home. The responsible person, Christina Johnson, stated that Ms. Perrault moved out of the home and is receiving full time care in Chicago. Ms. Johnson is living in the home with the residents and her children at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(8) A licensee shall have an arrangement with a responsible person who is available to provide care in an emergency situation for up to 72 hours.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the responsible person, Christina Johnson, has been providing care for more than 72 hours, after the licensee experienced a decline in her health several months ago and moved out of the home. Ms. Johnson thought she could live in the home and provide care as the responsible person even if the licensee was no longer residing in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/23/24, I interviewed the responsible person, Christina Johson. Ms. Johnson stated that Lisa Hixson covers for her at the home if she needs to go somewhere. Ms. Hixson was at the home alone with Resident A and Resident B when the OCHN auditor, Terrance Marble, came to the home on 09/30/24. Ms. Johnson stated that she did not have an employee file for Ms. Hixon. There was no physical or TB test on file for Ms. Hixson. Ms. Johnson stated that Ms. Hixson had not been fingerprinted through the Michigan Workforce Background Check system.

On 12/02/24, I conducted an exit conference via telephone with the licensee, Linda Perrault. Ms. Perrault confirmed that she is no longer living in the licensed family home, as she is now residing in an assisted living facility near her children in Chicago. Ms. Perrault stated that she is currently dealing with health issues, and she does not believe she will be returning to the licensed family home. She stated that she spoke with her son, Aaron Perrault, and they might try to sell the family home by next summer. Ms. Perrault did not have a clear plan regarding the future of the licensed home or a plan for the residents.

On 12/02/24, I conducted a follow-up exit conference with the responsible person, Christina Johnson. I explained to Ms. Johnson that the home cannot continue to be licensed as a family home if the licensee, Linda Perrault, is not residing in the home. I informed Ms. Johnson that the license cannot be transferred to her name. Ms. Johnson stated that she was planning on eventually applying for a license at her own home, but she needs time to get her home ready. She stated that she would also speak to Oakland Community Health Network (OCHN) to see what the options are for operating the home without a license, as there are only two residents in care and they both receive services through Community Mental Health (CMH). Ms. Johnson stated that they would submit a corrective action plan to address the violations in the report, and they will utilize the provisional period to come up with a plan for her to apply for a license at her own home or transition to providing unlicensed care with oversight from the county CMH.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that a criminal history background check was not completed for the caregiver, Lisa

	Hixson. The responsible person, Christina Johnson, stated that Ms. Hixson had not been fingerprinted. There was no verification on file that fingerprinting was completed through the Michigan Workforce Background Check System at the time of my onsite inspection on 10/23/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(2) A licensee shall have on file with the department a statement signed by a licensed physician or his or her designee with regard to his or her knowledge of the physical health of the licensee and each responsible person. The statement shall be signed within 6 months before the issuance of a license and at any other time requested by the department.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that a physical was not completed for the caregiver, Lisa Hixson. The responsible person, Christina Johnson, stated that Ms. Hixson did not complete a physical. There was no physician statement on file for Lisa Hixson at the time of my onsite inspection on 10/23/24.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report dated: 04/11/23; CAP dated: 04/25/23**

APPLICABLE RULE	
R 400.1405	**Health of a licensee, responsible person, and member of the household.**
	(3) A licensee shall provide the department with written evidence that he or she and each responsible person in the home is free from communicable tuberculosis. Verification shall be within the 3-year period before employment and verification shall occur every 3 years thereafter.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that tuberculosis (TB)

	testing was not completed for the caregiver, Lisa Hixson. The responsible person, Christina Johnson, stated that Ms. Hixson was not tested for TB. There was no verification of TB testing on file for Lisa Hixson at the time of my onsite inspection on 10/23/24.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report dated: 04/11/23; CAP dated: 04/25/23**

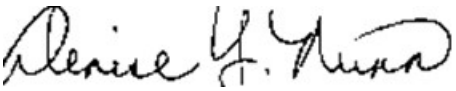
IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license.

12/02/2024

Kristen Donnay Date
Licensing Consultant

Approved By:



12/16/2024

Denise Y. Nunn Date
Area Manager