GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 28, 2025

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS330311852
Investigation #: 2025A0622024
Willoughby Home

Dear Ms. Bhaskaran:

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 (517) 284-9727.

Sincerely,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330311852
Investigation #:	2025A0622024
Complaint Receipt Date:	03/05/2025
Investigation Initiation Date:	03/05/2025
Report Due Date:	04/04/2025
Licensee Name:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jennifer Bhaskaran
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Willoughby Home
Facility Address:	5343 Willoughby Road Lansing, MI 48911
Facility Telephone #:	(517) 394-9699
Original Issuance Date:	07/01/2011
License Status:	REGULAR
Effective Date:	01/21/2024
Expiration Date:	01/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is missing activities which are in her assessment plan.	Yes
Resident A was confined to her room when she was sick.	No
Additional Findings	Yes

III. METHODOLOGY

03/05/2025	Special Investigation Intake 2025A0622024
03/05/2025	Special Investigation Initiated – Telephone call made to AFC Consultant Jennifer Browning.
03/11/2025	Inspection Completed-BCAL Sub. Compliance
03/17/2025	Contact - Telephone call made- Interview with Guardian A1.
03/18/2025	Contact - Telephone call made- direct care worker (DCW) Michelle Stewart, DCW Emily Santos, DCW Michelle Scott and DCW Malaysia Aldridge
03/18/2025	Contact - Document Received- Tamie Stevens sent over paperwork for Resident A.
03/20/2025	Contact- Telephone call made- Interview with Resident A.
03/21/2025	Contact - Document Received- Tamie Stevens sent over paperwork for Resident A.
03/28/2025	Exit conference with licensee designee, Jennifer Bhaskaran.

ALLEGATION: Resident A is missing activities which are in her assessment plan.

INVESTIGATION:
On 03/05/2025, I received this complaint through a phone call received from an anonymous source to the assigned AFC Consultant. According to the complaint, Resident A has been missing her in-person MSU music therapy class through the fall and into the spring. The complaint stated that Resident A has been attending this class for years and it's documented in her plan. The complaint reported that the music teacher has reached out to the home and requested that she be transported to the class. Resident A pays substantially for both the in-person and online class but has not been attending the in-person class on Wednesday. According to the

complaint, Resident A has also missed a recent "sister's coffee " with family which is once monthly. The complaint stated that the reason given was that the home van was being used by another staff member to drive the van to another AFC home because she could not use her personal vehicle. The complaint stated that the previous month, Resident A missed the “sisters’ coffee” because the manager was sick, and no other staff were available to transport her. The complaint reported Resident A has also missed planned special needs church services which was amended to her plan last year with the schedule.

On 03/05/2025, I interviewed AFC Licensing Consultant Jennifer Browning who received the complaint and provided the information. Ms. Browning also provided Resident A’s resident paperwork from 2024.

On 03/11/2025, I completed an unannounced onsite investigation to Willoughby AFC. During the unannounced onsite investigation, I interviewed Resident A and two direct care workers.

On 03/11/2025, I interviewed Resident A in person. Resident A stated she goes out with staff members and went to Meijer yesterday. Resident A reported that she goes to her music class on Wednesdays and staff transport in the van. She stated that currently the class is on break for spring break. Resident A also reported that once a month she goes to Panera Break for her sister’s coffee. Resident A reported that she has not been lately but was unsure why.

On 03/11/2025, I interviewed direct care worker (DCW) Malaysia Aldridge in person. She stated that she has been employed since September 2024. DCW Aldridge reported that Resident A has an in-person class weekly on Wednesday at 3:30pm at MSU. DCW Aldridge reported that she can’t recall the last time Resident A has attended the in-person class. She explained that many staff have quit or been fired, and they have not been fully staffed. DCW Aldridge stated that when they are fully staffed, Resident A meets monthly with her sisters at Panera Bread and attends Mass every other Sunday. DCW Aldridge reported that staff usually take Resident A out in the community twice weekly during first shift and they take her to the mall, haircuts, movies, shopping and to get coffee.

On 03/11/2025, I interviewed direct care worker Michelle Scott in person. She reported that she started in February 2025 and works first shift. DCW Scott stated that there has been staffing issues since she started. DCW Scott reported that Resident A has not been attending her in person class at MSU due to staffing issues, as there is not a second person for second shift. DCW Scott reported that staff do take Resident A out in the community during first shift to Meijer, Dollar Tree, the mall and Hobby Lobby.

At the time of the unannounced onsite investigation, Resident A’s resident paperwork was not available and the direct care workers working did not have access to her paperwork.

Resident A's resident paperwork was reviewed from 2024 and 2025. According to Resident A's *AFC-Resident Care Agreement* her basic fees include the following transportation services: medical appointments and community inclusion.

According to her *Assessment Plan for AFC Residents* for 2024 and 2025, it states the following:

"Moves independently in the community: *must be monitored and supported in the community for health and safety.*
Walking/mobility: *Requires wheelchair, needs staff assistance, transferring, using gait belt or Hoyer.*
Use of assistive devices: *sit to stand lift, Hoyer lift as needed, wheelchair, gait belt for transfers, commode, shower chair, harness for transport safety.*
Participates in religious practice: *no, chooses not to attend.*
Hobbies/Special Interests: *Bingo, coloring, crafts, singing, coffee, stickers, MSU music class in person and zoom, nails painted and TV.*
Recreation: *MSU Music therapy, out to eat, getting coffee and shopping.*
Friends/family: *sisters come to visit regularly at the home."*

On 03/17/2025, I interviewed Guardian A1 via phone. Guardian A1 reported each year she completes the assessment plans; she discusses Resident A's music class and the importance of having her attend in-person. Guardian A1 reported that she has talked with the home manager, Bonnie Snider, another manager, Tamie Stevens, and previous assistant home managers Hope Wiseman and Daniel Farlin regarding the importance of Resident A attending in-person. Guardian A1 reported that staff will often give excuses on being short staffed or tell her they will get her there. She reported that staff have the schedule and it's every Wednesday at 4:15-5pm. Guardian A1 reported that Resident A pays $750 a semester to attend the class. Guardian A1 stated that the last time Resident A attended in-person was August 7th, 2024. Guardian A1 reported that Resident A was unable to attend the sister's coffee in February and March 2025. Guardian A1 reported that the special needs mass is twice a month and Resident A did attend the last one. Guardian A1 reported that Resident A is taken out into the community twice a week to get fresh fruit/veggies, craft supplies, coffee and music in the park during the summer.

On 03/17/2025, I interviewed direct care worker, Amber Delisle via phone. She reported that she has worked at the home for 6 years. DCW Delisle stated that Resident A attends a zoom music class on Monday evenings and then every Wednesday, she attends an in-person class around 3:30pm. DCW Delisle explained that she thinks the last time she attended in person was October or November but was not sure. She stated that they have not had enough staff to provide transportation for Resident A to her in person music class. DCW Delisle reported that Resident A is taken out in the community twice weekly to go shopping, get her hair cut or get coffee. She explained that once a month she attends St. Franics Mass and then also has a sister's coffee once a month. DCW Delisle reported that Resident A was unable to attend the sister's coffee in February or March 2025 due

to no van available or staff available to take her. DCW Delisle reported that she is a lead direct care worker and has reminded the managers, Bonnie Snider and Hope Wiseman that Resident A has her in person music class, but staff have not been made available to transport her on Wednesdays during second shift.

On 03/17/2025, I interviewed direct care worker, Michelle Stewart via phone. She reported that she has worked at the home for five months and works first shift. DCW Stewart reported that Resident A goes to her music class after she leaves, so she is unsure if she has attended. DCW Stewart stated that she does take Resident A out in public to go shopping or eat at least weekly.

On 03/20/2025, I interviewed direct care worker, Emily Santos via phone. She reported that she has worked at the home for four months and works first shift. She stated that Resident A goes to her music class after she leaves, therefore she is unaware if she attends. DCW Santos stated that she does assist with taking Resident A out in the community to eat and shop twice weekly.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.**

ANALYSIS:	Based on the review of the *AFC-Resident Care Agreement and Assessment Plan for AFC Residents* for Resident A, Willougby AFC agreed to provide transportation for Resident A for community inclusion which includes Resident A's MSU in-person music class. All direct care workers confirmed that she was unable to attend the class due to lack of staff available to transport her. Guardian A1 reported that she has attempted to address her lack of attendance to the paid MSU music class with management and discussed this service yearly at her assessment planning meeting. Guardian A1 reported that the last time she attended her in person MSU music class was on August 7th, 2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was confined to her room when she was sick.

INVESTIGATION:
According to the complaint, on 02/16/2025, Resident A had influenza A, which was diagnosed by an urgent care. The complaint stated that she was quarantined to her room including some meals. Complainant reported that the following Friday, Complainant requested Resident A be released from her room, as Resident A's counselor stated that she seemed fine and was complaining about being in her room. Complainant reported that she talked with Bonnie Snider via phone and requested that a six-foot distance be used in the common room for Resident A. According to the complaint, a phone call was received on Friday at 9pm, that Resident A was released out of her room. Complainant reported that she visited the home on Sunday 2/23/25 and found Resident A in her room with a mask on. The complaint stated that she requested that staff bring Resident A out and her room be cleaned as it had an odor.

On 03/11/2025, I interviewed DCW Malaysia Aldridge and Michelle Scott in person during an unannounced onsite investigation. DCW Aldridge reported that Resident A caught the flu from her roommate, but her roommate has been out of the home for about a month. Both, DCW Aldridge and Scott reported that Resident A was very sick the first three days and didn't want to leave her room. They stated as she improved, she came out for meals and could come out of her room at any time. DCW Aldridge and Scott reported that they continued to check on Resident A, toilet her and shower her. DCW Aldridge and Scott stated that Resident A was coughing and weak from the sickness, therefore she preferred to be in her room. DCW Aldridge and Scott denied Resident A needing to be quarantined to her room.

On 03/17/2025, I interviewed Guardian A1 via phone. Guardian A1 stated that she received contact from Resident A's counselor that she was feeling better and wanted to leave her room because she was bored. Guardian A1 reported that Resident A

often spends a lot of time at the kitchen table. She stated that she found Resident A in her room on Sunday the 23rd at 12:30pm with a mask on. Guardian A1 explained that she requested staff to bring her out of her room, and they followed the request.

On 03/18/2025, I interviewed DCW Michelle Stewart via phone. She reported that Resident A was quarantined for seven days, and she received this information from third shift. DCW Stewart reported that Resident A was fed separately in the dining room and taken out of her room for the bathroom and showers. DCW Stewart reported that if Resident A wanted to come out of her room, she could have and she stated that she does not recall seeing Resident A have a mask on.

On 03/18/2025, I interviewed DCW Emily Santos via phone. She reported that Resident A was very sick the first few days and wanted to be in her room. DCW Santos reported that Resident A would come out to go to the bathroom and eat and then would want to go back to her room. DCW Santos reported that if Resident A wanted to come out of her room, she could have, and no staff was stopping her.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	Based on interviews with direct care workers, inconsistent information was received regarding Resident A being confined to her bedroom during her sickness. It was reported that Resident A was brought out for meals, bathroom use and showers. No direct care workers reported keeping Resident A confined to her room or stopped her from leaving her room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 03/11/2025, I completed an unannounced onsite investigation to Willoughby AFC. During the unannounced onsite investigation, I requested to view Resident A's resident paperwork. DCW Scott and Aldridge were working and reported that they did not have access to Resident A's paperwork. DCW Aldridge called the manager, Bonnie Snider and reported that Ms. Snider would provide me with all the paperwork on 3/12/2025. During interviews with DCW Scott and Aldridge, they were unsure if

Resident A required one direct care staff member or two direct care staff members to assist her personal care and/or transferring. Due to not having access to Resident A's paperwork, they were unable to determine the answer. Before leaving the unannounced onsite investigation, I left my business card, and a list of paperwork needed.

On 03/13/2025, I emailed manager, Bonnie Snider to request copies of paperwork for Resident A which was received via email on 03/13/2025.

APPLICABLE RULE	
R 400.14209	**Home records generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(d) Resident records.**
ANALYSIS:	Resident A's resident records were not available to direct care workers or this consultant during the unannounced onsite investigation. Direct care workers were unsure if Resident A was a one person, or two persons assist and were unable to verify due to not having access to the paperwork. DCW Aldridge reported that management would email the paperwork over to me on 3/12/2025. On 03/13/2025, I had to reach out to management for Willoughby AFC and re-request the documents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 03/11/2025, I completed an unannounced onsite investigation to Willougby AFC and requested to view Resident A's resident paperwork. During the unannounced onsite investigation, the paperwork was unavailable. On 03/13/2025, I sent a follow-up email to Willougby AFC and received Resident A's paperwork. I requested to view Resident A"s *Health Care Apprisal*. Direct Care Worker Bonnie Snider reported via email, that the doctor's office failed to fill out the state paperwork and they are attempting to get it completed. She provided a Community Mental Health medical visit form, that was filled out for the date of 01/17/2024 for an annual visit and stated see AVS. No AVS paperwork or documentation was attached. The document was signed by a doctor on 01/17/2025. A blank *Health Care Apprisal* was also attached to the email.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	During the unannounced onsite investigation and during review of documents sent via email a current *Health Care Apprisal* for Resident A was not available for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 03/17/2025, I interviewed Guardian A1 via phone and she reported that third shift staff are refusing to change or assist Resident A with going to the bathroom and they are waiting for the morning staff to come in to care for Resident A's toileting needs. Guardian A1 stated that she has witnessed first shift fighting with third shift for not changing Resident A and her being soaked with urine. Guardian A1 reported that she has arrived at the home at 11am and has found Resident A to be in bed and was soaked with urine, along with her bed.

On 03/17/2025, I interviewed Amber Delisle via phone and she reported that three days a week she comes into her first shift and finds Resident A soaked in urine. DCW Delisle reported that Resident A will occasionally wear briefs, and she will be soaked through her briefs. DCW Delisle explained that Resident A will wake up and request to go to the bathroom but is unable to get out of bed by herself. DCW Delisle reported that Resident A has a loud voice and can be heard when she yells from her room to use the bathroom. DCW Delisle explained that third shift staff should be checking on residents every couple of hours during third shift. DCW Delisle reported that on 03/12/2025, Resident A had a colonoscopy, therefore she had pills for the preparation on the night of 03/11/2025. Third shift was asked to check on Resident A every 30 minutes. DCW Delisle stated that when first shift arrived on 03/12/2025, they found Resident A to be laying in feces and with feces all over her.

On 03/18/2025, I interviewed DCW Michelle Stewart via phone. She reported that when she comes in on first shift, she will find Resident A to be wet with urine 2-3 times a week. DCW Stewart reported that the staff is young and are stating that they were not trained to care for residents overnight. DCW Stewart reported that they were recently trained the last few weeks.

On 03/18/2025, I interviewed DCW Michelle Scott via phone. She reported that every morning she works, she finds Resident A to be soaked with urine and along with her bed, therefore she must shower her and wash her bedding. DCW Scott reported that staff should be checking on Resident A every two hours during third shift. DCW Scott stated that Resident A will wake up and can yell to use the bathroom. DCW Scott reported that she had left a note for third shift on 03/11/2025, that Resident A was doing a preparation for a colonoscopy and would need to be helped more on third shift. DCW Scott reported that when she arrived on 03/12/2025, she found Resident A awake in her bed with feces all over her and her bed. DCW Scott reported that third shift staff states that they are not trained to help Resident A on third shift.

On 03/18/2025, I interviewed DCW Malaysia Aldridge via phone. She reported that when she comes in for first shift, she finds that all residents are soaked with urine. DCW Aldridge stated that sometimes, Resident A will wear a brief and it's usually her decision if she wants to wear one. DCW Aldridge reported that third shift should be checking on all residents every two hours and that Resident A is very good at communicating when she needs to use the bathroom. DCW Aldridge also confirmed that Resident A was laying in her own feces on the morning of 03/12/2025.

On 03/18/2025, I interviewed DCW Emily Santos via phone. She reported that Resident A is often wet and her whole bed is soaked in urine when she arrives for her first shift. DCW Santos reported that Resident A will not have an incontinence accident unless staff are not assisting her, and Resident A will often be calling for assistance when she arrives for first shift to use the bathroom again or be changed due to being wet. DCW Santos reported that she has no idea if third shift is helping Resident A during the middle of the night, but Resident A would only wet herself if she were not receiving assistance.

On 03/20/2025, I interviewed Resident A via phone. Resident A reported that she will call for help if she needs to use the bathroom during nighttime hours, and direct care staff help her. Resident A reported that sometimes she has accidents, but she calls for staff first. Resident A reported the following: "sometimes I do have problems with them not helping." Resident A also mentioned that the doctor prescribed her a new cream for a rash.

On 03/20/2025, I requested documentation via email for documentation regarding Resident A's most recent doctors' appointment. Documentation was reviewed on 03/21/2025 from Resident A's doctors' appointment on 03/17/2025. According to the documentation, the appointment was a follow up for her flu and thyroid. During the

medical visit a skin irritation was found and addressed. The documentation stated the following:

"Skin Irritation: *not likely to be a pressure sore given the location is not in a pressure dependent location. May be due too infrequent changes in depends. Recommend more frequent changes in patients depends and continuing to monitor site worsening in skin irritation.*

Skin Redness: *Caregiver noted that patients daughter noticed redness around patients posterior thigh when patient is showering. Caregiver noted that the patients depend is ideally changed every couple of hours.*

Skin: *comments-Erythematous rash noted on R posterior thigh in gluteal fold. Skin is dry at area of rash."*

According to Resident A's assessment plan the following was documented regarding her toileting:

"Toileting: *Needs staff assistance with transferring on and off the toilet and help with wiping for bowel movements.*

Bathing: *Requires full assistance from staff for all bathing needs, uses a shower bench.*

Personal hygiene: *Requires staff assistance for thoroughness."*

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 interviews and documentation reviewed it was determined that briefs are being used occasionally during nighttime hours although it's not documented in Resident A's *Assessment Plan for AFC Residents.* It was also found during interviews with direct care staff that the third shift staff members are not providing personal care to Resident A during sleeping hours, which has caused an Erythematous rash to develop on Resident A's posterior thigh in her gluteal fold. Resident A also reported calling for assistance from third shift staff but not receiving timely before an incontinence accident occurs.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 03/17/2025, I interviewed Guardian A1 via phone. She reported that staff take Resident A out in the community twice weekly. She stated that she gives the home $75 monthly for her outings, but recently on March 2nd staff did not have access to the cash and had to just walk the mall. Guardian A1 reported that on 3/12/2025,

Resident A had a colonoscopy appointment, and she gave the staff member $10 because she did not have access to cash before their appointment.

On 03/17/2025, I interviewed DCW Amber Delisle via phone. She reported that she must request money for Resident A ahead of time from a manager. She reported that Resident A does not have immediate access to $20 and it could take a few days for a manger to provide access to the money.

On 03/18/2025, I interviewed DCW Michelle Stewart via phone. She reported that she does not have access to the Residents money, and it needs to be requested. She reported that she recently took Resident A to McDonalds and didn't have any cash for Resident A, therefore she bought the meal for her. DCW Stewart explained that managers only have access to the cash and currently there are no managers in the home.

On 03/18/2024, I interviewed DCW Malaysia Aldridge via phone and she reported that she has to get money from management, therefore if she plans to take Resident A out for an activity, she will have to call a manager and request the money.

On 03/18/2025, I interviewed DCW Emily Santos via phone and she reported that Resident A goes in the community twice a week and she has to request funds from management prior. DCW Santos reported that she does not have access to any funds for Resident A and it's locked up. DCW Santos reported that if she does not have any funds for Resident A she will just pay for it herself.

On 03/17/2025, I requested Resident A's Resident Funds Part II forms for January-March, 2025. After reviewing the forms, Resident A had current funds available during all three months.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(7) A resident shall have access to and use of personal funds that belong to him or her in reasonable amounts, including immediate access to not less than $20.00 of his or her personal funds. A resident shall receive up to his or her full amount of personal funds at a time designated by the resident, but not more than 5 days after the request for the funds. Exceptions to this requirement shall be subject to the provisions of the resident's assessment plan and the plan of services.

ANALYSIS:	Based on interviews with Guardian A1 and direct care workers, Resident A does not have immediate access to at least $20.00 of her personal funds, as they are locked up and require a request from management. Resident A had personal monies available but no access.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

03/24/2025

Amanda Blasius Date
Licensing Consultant

Approved By:

03/28/2025

Dawn N. Timm Date
Area Manager