GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2025

Ms. Svet
AV Beverly Hills Inc.
20799 W. Kennoway Circle
Beverly Hills, MI 48025

RE: License #: AS630302438
Investigation #: 2025A0605006
Ambrosia Villa Beverly Hills

Dear Ms. Svet:

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
3026 West Grand Blvd., 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 #:	AS630302438
Investigation #:	2025A0605006
Complaint Receipt Date:	02/06/2025
Investigation Initiation Date:	02/06/2025
Report Due Date:	04/07/2025
Licensee Name:	AV Beverly Hills Inc.
Licensee Address:	20799 W. Kennoway Circle Beverly Hills, MI 48025
Licensee Telephone #:	(248) 207-6511
Administrator/Licensee Designee:	Victoria Svet
Name of Facility:	Ambrosia Villa Beverly Hills
Facility Address:	20799 Kennoway Circle Beverly Hills, MI 48025
Facility Telephone #:	(248) 207-6511
Original Issuance Date:	09/16/2009
License Status:	REGULAR
Effective Date:	05/15/2024
Expiration Date:	05/14/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was in distress and in pain, but staff not administering her pain medication.	Yes

III. METHODOLOGY

02/06/2025	Special Investigation Intake 2025A0605006
02/06/2025	APS Referral Adult Protective Services (APS) referral made
02/06/2025	Special Investigation Initiated - Letter Made referral to APS
02/06/2025	Contact - Telephone call made Interviewed reporting source, Resident A's family and left message for Gentiva Hospice
02/10/2025	Inspection Completed On-site Conducted unannounced on-site investigation
02/10/2025	Contact - Telephone call received Interviewed Gentiva Hospice
02/10/2025	Contact - Document Received APS denied referral
02/11/2025	Contact - Telephone call received Discussed allegations with Gentiva Hospice nurse Chloe Williams
02/12/2025	Contact - Telephone call made Discussed allegations with DCS and Dr. Priti
03/13/2025	Contact - Document Sent Email to licensee designee Ms. Svet
03/25/2025	Exit Conference Left message for licensee designee Ms. Svet with my findings

ALLEGATION:

Resident A was in distress and in pain, but staff not administering her pain medication.

INVESTIGATION:

On 02/06/2025, intake #204230 was assigned for investigation regarding Resident A was in distress and in pain, but staff at this facility were not administering her pain medication.

On 02/06/2025, I made a referral to Adult Protective Services (APS). APS will not be investigating these allegations.

On 02/10/2025, I contacted the reporting person (RP) via telephone and discussed the allegations. On 02/01/2025, Resident A was observed to be in distress by her granddaughter. Resident A was waving her hands around and appeared to be in pain. The staff at the group home were asked to administer Morphine and Ativan which were prescribed to Resident A by Gentiva Hospice. However, staff refused, then contacted the owner, Ms. Svet. The granddaughter immediately contacted the hospice nurse who advised they were on their way to the group home. Ms. Svet arrived at the group home and berated both the granddaughter and the hospice nurse. The hospice nurse asked the family if they wanted to keep Resident A at the group home or to take Resident A home and hospice will provide services there. The family decided to move her to Resident A's daughter's home. Resident A passed away the next morning on 02/02/2025 at the family's home.

On 02/10/2025, I received a telephone call from Resident A's granddaughter regarding the allegations. Resident A moved into this group home on 12/05/2024 with Gentiva Hospice providing her with services. The first six-to-seven weeks, Resident A was ok; she was kept clean, well fed and sat in her chair most of the time. There are two direct care staff (DCS) at the group home. Jimmy is one of the DCS and then there is a female staff with Jimmy, name unknown. On 02/01/2025 at 11:30AM, the granddaughter arrived at the group home to visit with Resident A. She walked into Resident A's bedroom and found her oxygen to be off her nose and around her head. She was making noise, and her breathing was rapid, she was burning up, and it appeared she was in distress. The granddaughter called out to Jimmy and asked him if Resident A was getting her pain medication because she appeared to be in distress. Jimmy told her, "I'll find out." The granddaughter called Gentiva Hospice and spoke with Chloe Williams, the hospice nurse. Chloe advised the granddaughter she had planned to come out at 1:30PM to see Resident A but that the group home had all the comfort medications for Resident A. In the meantime, Ms. Svet was on Jimmy's phone and spoke with the granddaughter. Ms. Svet told the granddaughter, "you don't have the right to come in and say she's in destress. The granddaughter tried explaining to Ms. Svet that Resident A appeared in distress and needed medication. Ms. Svet said, "She's getting better." The granddaughter was explaining to Ms. Svet that she was not

getting better and while on the phone, Chloe, called. The granddaughter answered the call from Chloe and explained to her what was happening. During this time, Ms. Svet could be heard yelling on the phone at the granddaughter. Chloe told the granddaughter she was heading to the group home now and then Ms. Svet said she was on her way too. At this time, Resident A's daughter and grandson arrived at the home, Ms. Svet arrived and came into the bedroom saying, "look she has energy, she's awake." The granddaughter reiterated, "she's not well, she's in distress." Resident A's hands were gray in color, but Ms. Svet reported that grayness to be "dryness," because she was "dehydrated." The granddaughter stated that the last straw was when Ms. Svet took a straw and was giving water to Resident A who was not drinking and then Ms. Svet took spoonful of water and tried giving it to her. Resident A began choking. Then Ms. Svet gets thickened fluid and attempts to give that to Resident A who begins choking again. There was a sucking machine in Resident A's bedroom; however, Ms. Svet asked the granddaughter if she knew how to use the machine. The granddaughter stated, "Yes," but refused to use the machine on Resident A. Chloe arrived at the group home and immediately saw that Resident A was in distress. Chloe told Ms. Svet to have staff administer Morphine and Ativan. Jimmy administered both once and then again, an hour later since Resident A still appeared in distress. After the second time, Resident A began to calm down. Chloe modified the Morphine and Ativan from as needed to schedule. Ms. Svet said, "this is out of line. Giving morphine when she's ok." Chloe tried explaining to Ms. Svet that Resident A was in distress and that the medications should have been administered to her because she was transitioning. Ms. Svet was not acknowledging that Resident A was actively passing and seemed to focus on Resident A "being ok," and "getting better." This was concerning to both the family and Chloe; therefore, it was determined after Ms. Svet did not seem receptive to administering the comfort medication to Resident A that Resident A should move out of the group home. The family agreed with Chloe so Resident A moved into her daughter's home where the granddaughter who is also a hospice nurse administered the morphine and Ativan. Resident A passed away the next morning. The granddaughter expressed concerns about staff and Ms. Svet not recognizing distress and that Gentiva Hospice had informed staff that Resident A was transitioning, yet no medication was being administered when Resident A was in pain and discomfort.

On 02/10/2025, I conducted an unannounced on-site investigation at this group home. Present were licensee designee Ms. Svet, DCS Jim Jamili and DCS Ledencite Jumlos. Also present were Residents B, C, D, and E.

I interviewed Ms. Svet regarding the allegations. Resident A moved in on 12/04/2024 with Gentiva Hospice providing services. Prior to moving into this group home, Resident A's daughter was caring for Resident A, but then Resident A required additional care than the daughter could provide. Resident A was frail but could walk with a walker and standby assist. She had fallen at the daughter's home prior to admission so after she moved into this group home, she began doing well. Gentiva Hospice was visiting weekly. A comfort pack medication of Morphine and Ativan were prescribed by hospice on an as needed basis. The protocol was that when Resident A was in pain, staff must call hospice nurse for instructions before administering the comfort pack. On

01/13/2025, Resident A's daughter visited, then two days later called asking if Resident A was sick because the daughter was sick. A few days later, everyone in the home including Resident A was sick. Ms. Svet called Gentiva Hospice and Dr. Priti, the visiting physician saw the residents via Facetime and ordered antibiotics. Antibiotics was started immediately and then hospice nurse Vanessa came out along with Dr. Priti to check on the residents. Resident A got better, but her lungs were not clear, so oxygen was ordered and Vanessa advised to monitor Resident A. On 02/01/2025, Ms. Svet was called by DCS Jimmy who advised her that someone walked into the group home, did not say hello and walked into Resident A's bedroom. Jimmy followed the person and asked, "how can I help you?" The person identified themselves as Resident A's granddaughter. The granddaughter immediately asked for Morphine, so Ms. Svet told Jimmy "No, not until we get instructions from hospice or a doctor." Ms. Svet got on the phone with the granddaughter who expressed to Ms. Svet that Resident A "was in distress, and "needed Morphine." Ms. Svet and the granddaughter were going back and forth on the phone regarding Resident A, so Ms. Svet told Jimmy she was coming to the home. Ms. Svet arrived at the home and saw the granddaughter, Resident A's daughter and the hospice nurse, who identified herself as Chloe. This was the first time Ms. Svet met Chloe. Chloe, the granddaughter and Resident A's daughter spoke in the room privately after asking Ms. Svet to step out. Within minutes later, Chloe came out of the room and asked for Morphine. Jimmy administered the morphine and the Ativan around 12:22PM. An hour or less later, Chloe again came out and asked for another dose of morphine and Ativan which was also administered by Jimmy. Chloe informed Ms. Svet that according to hospice notes, Resident A was "transitioning," and that it was instructed for staff at this home to administer Morphine and Ativan when Resident A was in distress, which was not done until Chloe arrived at the home. The family decided to take Resident A home with them.

I requested the February 2025 medication log with Jimmy's initials, but there were not available for my review. I also requested any documentation and/or instructions given to staff by Gentiva Hospice pertaining to Resident A and they were not available for my review. Ms. Svet stated that she will email these documents to me.

On 02/10/2025, I interviewed DCS Jim Jamili (aka, Jimmy) regarding the allegations. Jimmy has been working for this corporation for four years. He works day shift and there are always two DCS working per shift. On 02/01/2025, Resident A's granddaughter walked into the home without identifying herself. He followed her and asked, "Who are you?" She said, "I'm the granddaughter." She then went into Resident A's bedroom and Jimmy followed her in there. He stated, "she immediately turned around and said, "Do you have Morphine?" Jimmy said, "I felt uncomfortable, so I called Ms. Svet. I told Ms. Svet there's a lady here who said she's Resident A's granddaughter and is asking for morphine." Jimmy handed the phone to the granddaughter who spoke with Ms. Svet. He's not sure what was said but was informed by Ms. Svet she was on her way to the home. Ms. Svet arrived at the home and so did the hospice nurse Chloe. Also arriving at the home was Resident A's daughter and grandson. Chloe told both Jimmy and Ms. Svet to leave Resident A's bedroom so she could speak to the family privately.

Afterwards, he was advised by Chloe to administer Morphine and Ativan, which he did. He stated that less than an hour passed, and he was told to administer Morphine and Ativan again, which he did. Jimmy told Chloe and the family that Resident A needed her "breathing treatment," but Chloe stated, "No." Jimmy described Resident A as "being alert," although he stated, "she was not feeling well." Resident A woke up this morning, Jimmy cleaned her and gave her soft food. She was nauseous so he called Gentiva Hospice and was informed to give her nausea medication which he did. He stated she was not in distress and nor uncomfortable. Jimmy stated, "She was fine." He has never observed Resident A in distress since moving into this home. He was never informed by Gentiva Hospice that Resident A was "transitioning," or "pre-actively dying."

On 02/10/2025, I interviewed DCS Ledencite Jumlos regarding the allegations. Ms. Jumlos has been working for this corporation for four years. On the morning of 02/01/2025, she gave Resident A Ensure, water and juice via spoon because she had difficulty swallowing. Resident A appeared fine and not in distress. She was with the other residents, so she does not know what happened when the granddaughter arrived at the home. She does not pass any medications and was never informed by Gentiva Hospice that Resident A was transitioning or pre-actively dying. She described distress as "not being calm." Resident A appeared calm to her.

On 02/10/2025, I observed Resident B lying on the couch sleeping. She was not interviewed. I observed Resident C sitting in her wheelchair and due to her dementia, she was unable to respond to questions. I observed Resident D sitting on the couch wrapped in a blanket and she too was not interviewed due to her diagnosis of dementia. I observed Resident E lying in her bed and she does not speak English; therefore, she too was not interviewed.

On 02/10/2025, I interviewed Bridget Freese, the Area Vice President of Operations at Gentiva Hospice. Resident A's start of care was on 05/10/2024, prior to her moving into this group home. On 12/04/2024, Resident A moved into this group home and was still receiving hospice services. On 01/28/2025, Ramona Berry, hospice nurse visited Resident A, and the following were her notes: Morphine concentrate was full, not given yet, patient is total care, eating less, incontinent." On 01/31/2025, Ikeisha White, the hospice nurse noted the following: "Patient is no longer eating solids, thicken liquids, sleeping more; patient pre-active, keep patient comfortable, call 911." This information was relayed to staff and to Resident A's daughter. On 02/01/2025, Chloe Williams, the hospice nurse noted the following: patient unresponsive, labored breathing, crackles in lungs, patient kept coughing and gagging, patient restless- trying to get out of bed. Ms. Svet attacked granddaughter and Chloe verbally saying, "Chloe is not a good nurse." Modified Morphine and Ativan from as needed to schedule.

On 02/10/2025, I contacted via telephone Ikeisha White with Gentiva Hospice. Ikeisha was one of the RN's that saw Resident A at this home. Her last visit was on 01/31/2025 and there were two DCS working there. She did not recognize any of the staff as Jimmy was off that day, which whom she usually discusses Resident A with. On this day, Resident A appeared to be declining. She was not eating nor making eye contact.

Ikeisha spoke with the staff with the initial “M.” Ikeisha told this staff that “Resident A was pre-actively dying and to keep Resident A comfortable by administering Morphine and Ativan.” Ikeisha also advised “M,” to “look for signs of distress, labored breathing, not eating and continued decline to call Gentiva Hospice.” Ikeisha stated “M,” did not speak much English, but stated she understood what Ikeisha was explaining to her. Ikeisha also stated that she was at this home a week prior and was told by staff that Resident A had been “sleeping more,” so Ikeisha told staff, “this is part of her pre-active stage of transitioning.” Ikeisha does not feel that staff have the proper knowledge of understanding the “transitioning process,” because staff never administered any of the comfort pack that was provided to this home for Resident A. Ikeisha explained to staff that staff must keep Resident A “comfortable,” always during these stages. Ikeisha did not leave any documentation for the home, nor did she see any staff document what she said; therefore, she does not know if this information was passed along to other staff or to Ms. Svet.

On 02/11/2025, I contacted Resident A’s daughter via telephone regarding the allegations. On 01/31/2025 the daughter received a call from Ikeisha White advising her that Resident A will be seen daily by Gentiva Hospice because she was “declining.” On 02/01/2025, Resident A’s granddaughter arrived at this home to see Resident A in distress. The granddaughter called Resident A’s daughter advising her, “grandma is in destress and they’re not giving her Morphine.” The granddaughter called Gentiva Hospice, and the nurse told the granddaughter she was coming to the home. The staff called Ms. Svet who took what was happening as “an insult,” because the granddaughter asked for Morphine. The daughter arrived at the home and then the nurse Chloe arrived too. Ms. Svet also arrived at the home. The granddaughter asked Ms. Svet, “were vitals taken?” Ms. Svet kept asking the daughter, “isn’t she better? Isn’t she better?” The daughter advised Ms. Svet that she was not “as responsive as before today.” On this day, the daughter observed Resident A “gasping for air and arms flaring.” Ms. Svet appeared “agitated,” and “upset.” It took a couple of doses of Morphine and Ativan to relieve Resident A’s distress. The family decided to take Resident A home because Chloe stated, “it was close to the end.” Resident A was taken to the daughter’s home and the granddaughter who is also a hospice nurse administered Morphine and the next day; Resident A passed. The daughter reported that she has not observed staff taking notes of what hospice instructs them to do. For example, the daughter recalls Gentiva Hospice on 12/24/2024 advising staff to have Resident A walk, but the daughter who visited every other day never observed staff walk Resident A so the daughter would have Resident A walk whenever she visited the home.

On 02/11/2024, I received a return call from Chloe Williams, Gentiva Hospice nurse. Chloe was the backup nurse who was assigned to see Resident A on 02/01/2025. Resident A was listed as “active,” so she required daily visits. Chloe would be seeing her on both 02/01/2025 and 02/02/2025. On 02/01/2025, Chloe received a telephone call from Resident A’s granddaughter asking when the hospice nurse is coming to the group home to see Resident A. Chloe told the granddaughter she will be at the home around 1:30PM. The granddaughter was crying on the phone saying that Ms. Svet

“verbally attacked her on the phone,” and that “Resident A was not actively dying.” The granddaughter told Chloe that Ms. Svet said, “The family is crazy, Resident A is not actively dying.” Chloe told the granddaughter that according to Gentiva Hospice notes, Resident A is “actively dying,” and that is why “hospice is seeing her daily.” Chloe told the granddaughter she was on the way to the home. Chloe arrived at the group home and in Resident A’s bedroom was, the granddaughter, the daughter, the grandson, and Ms. Svet. Chloe asked Ms. Svet to step out of the room so she can assess Resident A and speak to the family. The family was in distraught and when Chloe looked at Resident A, Chloe could tell that Resident A was “in distress.” Resident A was breathing “very fast, looked uncomfortable as she was trying to get out of bed.” Resident A’s heart rate was at 140 beats per minute and her oxygen was at 88 and then dropped to 84. As Chloe was listening to Resident A’s lungs, staff Jimmy came into the room trying to give Resident A water. Chloe immediately told staff to “stop, she’s aspirating.” Chloe then went to Ms. Svet and told Ms. Svet that “Resident A was actively dying.” Chloe stated that Ms. Svet “laughed,” and said, “No, she’s just dehydrated.” Chloe told Ms. Svet that Resident A needed Morphine and Ativan because she was “actively passing,” but again, Ms. Svet was hesitant in administering these comfort medications to Resident A. Chloe stepped outside and contacted Gentiva Hospice’s doctor and had the doctor change the as needed Morphine and Ativan to scheduled. Chloe gave the new orders to Ms. Svet who then told Jimmy to administer the Morphine and Ativan to Resident A. It took two doses of each medication to calm Resident A down. Then Ms. Svet came into Resident A’s bedroom and said, “I’m upset that you’re giving Morphine to a person who’s fine and you’re killing her.” Ms. Svet then told Chloe, “you don’t know what you’re doing or what you’re talking about. She’s not actively passing.” Chloe stated that on 01/28/2025, Resident A was deemed actively dying and that this information was provided to staff. It’s unclear if staff documented this information and it is unclear if Ms. Svet was also informed but that staff could just look at Resident A to see she was in fact in distress. It was decided by family to take Resident A home because there was concern that Ms. Svet would not allow staff to administer the comfort medication even if it was now scheduled. Resident A went to the daughter’s home and the granddaughter administered the comfort medications. Resident A passed away the next morning.

On 02/12/2025, I contacted Dr. Priti, the visiting physician for this group home. Dr. Priti only visited this group home on 01/30/2025 as it was new to her. She was establishing care as a new physician. When she was at the home, Resident A’s daughter was in the bedroom with Resident A and there was also a hospice nurse. Dr. Priti does not know what they talked about as she was not present. She recalls that Resident A was “quite emancipated; significant weight loss and failure to thrive. She did not appear in distress on this day and Resident A’s blood pressure was 127/73. The Gentiva Hospice nurse stated the chief complain was Resident A’s cough, so medication was ordered. Dr. Priti had no other information to provide.

On 02/12/2025, I sent an email to Ms. Svet. She emailed back stating that DCS Milagros Tan was filling in as staff on 01/31/2025. I included in the email the documents I had requested at the home visit on 02/10/2025; Resident A’s assessment plan,

Resident A’s progress notes from 01/28/2025-02/01/2025) and Resident A's February 2025 medication log.

On 02/12/2025, I contacted via telephone DCS Milagros Tan regarding the allegations. Miagros has been with this corporation for a while. She was filling in for Jimmy on 01/31/2025. She recalls two Gentiva Hospice nurses coming to the home and visiting with Resident A. The nurses went into the bedroom and closed the door behind them. Then both nurses came out, reviewed Resident A’s medication logs and told Milagros to discontinue the Vitamin D. She also recalls the hospice nurse advising her that Resident A’s foot is “modeling, gray in color,” and that if “staff observes respiratory distress to call hospice immediately.” Milagros also recalls that the nurse told her that “Resident A is pre-active in transitioning,” but Milagros stated she never wrote this information in the staff log, nor did she report this information to any other staff or to Ms. Svet. Milagros stated that during her shift, Resident A was “calm and not in distress.”

On 03/13/2025, I emailed licensee designee Ms. Svet requesting documents that were initially requested on 02/10/2025 and again on 02/12/2025 that I was still in receipt of. As of 03/25/2025, no documents were received.

On 03/25/2025, I left message for licensee designee Ms. Svet with my findings.

On 03/26/2025, I conducted exit conference with licensee designee, Victoria Svet with my findings. She texted February 2025 medication log; however, the Morphine and Ativan were both administered twice on 02/01/2025, but there was only one DCS initial for the Morphine and one DCS initial for the Ativan on 02/01/2025.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(11) A licensee shall contact a resident's physician for instructions as to the care of the resident if the resident requires the care of a physician while living in the home. A licensee shall record, in the resident's record, any instructions for the care of the resident.
ANALYSIS:	Based on my investigation and information gathered, Resident A was transitioning and should have been given her comfort medications; Morphine and Ativan on 02/01/2025 when she was observed to be in distress. Resident A was receiving hospice services through Gentiva. On 01/31/2025, it was noted by hospice nurse Ikeisha White that Resident A was “pre-actively transitioning.” Ikeisha reported this information to DCS Milagros Tan who worked on 01/31/2025 and Milagros confirmed that she

	was informed and instructed to contact Gentiva Hospice when Resident A was in distress and to administer comfort medications. However, Milagros never recorded these instructions and never informed any other DCS nor licensee designee Victoria Svet. On 02/01/2025, Resident A was observed by her granddaughter and by Chloe Williams, the hospice nurse to be in distress and licensee designee Ms. Svet was still hesitant about having the comfort medications administered to Resident A because she was never informed by Milagros Tan that Resident A was in fact actively passing. The family decided to discharge Resident A from the home on 02/01/2025 and Resident A passed away the next morning on 02/02/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	On 02/10/2025, during the on-site investigation, I reviewed the reason DCS Jim Jamili administered the as needed Morphine and Ativan twice on 02/01/2025 at 2PM and again at 3PM; but the medication log only had one DCS initial for both the Morphine and the Ativan. Staff did not initial the medication log when the Morphine and the Ativan were administered the second time at 3PM.
CONCLUSION:	**VIOLATION ESTABLISHED**

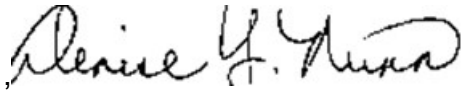
IV. RECOMMENDATION

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

03/25/2025

Frodet Dawisha Date
Licensing Consultant

Approved By:



04/17/2025

Denise Y. Nunn Date
Area Manager