GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 7, 2025

Kory Feetham
Ridgeline Lapeer, LLC
1442 Suncrest Dr.
Lapeer, MI 48446

RE: License #:	AL440417956
Investigation #:	2025A0872037
	The Ridge At Lapeer Memory Care

Dear Kory Feetham:

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL440417956
Investigation #:	2025A0872037
Complaint Receipt Date:	05/19/2025
Investigation Initiation Date:	05/22/2025
Report Due Date:	07/18/2025
Licensee Name:	Ridgeline Lapeer, LLC
Licensee Address:	1442 Suncrest Dr. Lapeer, MI 48446
Licensee Telephone #:	(810) 245-9302
Administrator:	Matthew Brawner
Acting Licensee Designee:	Kory Feetham
Name of Facility:	The Ridge At Lapeer Memory Care
Facility Address:	1446 Suncrest Dr. Lapeer, MI 48446
Facility Telephone #:	(810) 228-3520
Original Issuance Date:	11/22/2024
License Status:	TEMPORARY
Effective Date:	11/22/2024
Expiration Date:	05/21/2025
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 05/15/2025, Resident B sustained injuries from falling out of bed and the injuries are suspicious.	Yes
Third shift staff Sarenia Avendt and Courtney Blazo scream at the residents. Resident A wears hearing aids. 3 weeks ago, staff took Resident A's hearing aids because they wanted Resident A to go to bed.	No

III. METHODOLOGY

05/19/2025	Special Investigation Intake 2025A0872037
05/19/2025	APS Referral This complaint was referred by APS but was not assigned for investigation
05/22/2025	Special Investigation Initiated - On Site Unannounced
05/22/2025	Inspection Completed On-site Unannounced
06/03/2025	Contact - Document Sent I emailed the facility manager requesting information related to this complaint
06/03/2025	Contact - Document Sent I exchanged emails with APS Worker, Rose Koss
06/04/2025	Contact - Document Received Documentation received from FM Zandi
06/23/2025	Contact - Telephone call made I interviewed staff Ciera Lucas
06/23/2025	Contact - Telephone call made I interviewed staff Sarenia Avendt
06/26/2025	Contact - Telephone call made I interviewed staff Leprecious Moore

07/02/2025	Contact - Telephone call made I interviewed certified nurse practitioner, Angela Hanna
07/03/2025	Contact - Telephone call made I left messages for former staff, Carrie Yochum
07/03/2025	Contact - Telephone call made I interviewed staff Kourtney Bowman
07/03/2025	Contact - Telephone call made I interviewed staff Courtney Blazo
07/03/2025	Exit Conference I conducted an exit conference with the acting LD, Kory Feetham
07/03/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 05/15/2025, Resident B sustained injuries from falling out of bed and the injuries are suspicious.

INVESTIGATION: On 05/22/25, I conducted an unannounced onsite inspection of The Ridge at Lapeer Memory Care. I interviewed Residents A, B, and C, the resident care director (RCA), Allie Brode, and the 1st shift staff supervisor (SS), Heather Sagady.

RCA Brode confirmed that Resident B sustained injuries to her forehead on or around 05/15/25. According to RCA Brode, there was a storm and tornado watch the night of 05/15/25. RCA Brode said that she called the facility and notified staff that it was currently a watch and not a warning, and therefore staff did not need to move the residents to the tornado shelter. RCA Brode stated that she told staff that she would continue watching the weather and would notify them if the tornado watch was upgraded to a warning. RCA Brode told me that shortly after, the watch was upgraded to a warning, so she called the facility and told them to move the residents, but staff were already in the process of doing so. RCA Brode said that after the storm passed, staff moved the residents back to their rooms without incident.

According to RCA Brode, when she got to work the morning of 05/16/2025, staff Ciera Lucas told her that Resident B was in bed and did not want to be touched. Staff Lucas reported that she observed marks and bruises on Resident B's forehead and arms. Therefore, RCA Brode notified certified nurse practitioner (CNP) Angela Hanna who immediately examined Resident B. Since Resident B suffers from dementia, she was unable to explain how she received the injuries. CNP Hanna said that based on her physical examination, Resident B most likely fell which is how she received the injuries. CNP Hanna said that she did not suspect that the injuries were deliberately caused.

Because of Resident B's injuries, RCA Brode said that she and the facility manager (FM), Tony Zandi interviewed all staff who had been working 05/15/2025. Staff Leprecious Moore told RCA Brode and FM Zandi that she had been the one to transfer Resident B to the storm shelter during the tornado warning on 05/15/2025. Staff Moore told them that when she began trying to encourage Resident B to get up and move, Resident B was resistant. Therefore, Staff Moore left Resident B in bed and went to help assist some of the other residents. When Staff Moore went back to Resident B's room, she found Resident B on the floor, on her hands and knees. Staff Moore said that she assisted Resident B to her feet and helped Resident B to the storm shelter. RCA Brode said that according to Staff Moore, she did not observe any marks, bruises, or injuries when she got Resident B up off the floor. Staff Moore said that she checked on Resident B periodically throughout the night and did not observe any marks, bruises, or injuries.

According to RCA Brode, Resident B can ambulate with her walker independently. Resident B does sometimes become argumentative if staff asks her to do something she does not want to do, but she never flat out refuses to do anything. RCA Brode said that she interviewed Resident B and asked her how she received the injuries and Resident B said that she does not know. RCA Brode said that although Resident B suffers from dementia, she is still able to answer questions and hold conversations. RCA Brode asked Resident B if anyone deliberately harmed her, and she said no.

I met with Resident B in her bedroom where she was resting after lunch. Resident B was clean as was Resident B's room, and she was dressed appropriately. I noted that Resident B had a large yellowish-brown mark on her forehead, and she had dark bruises on the top of both forearms. I asked Resident B how she obtained the marks, and she said she did not know. I asked Resident B if someone hurt her, and she said no. I asked Resident B if she had had an accident, and she said no. I asked Resident B if anyone caused the marks to her, and she said no.

On 06/03/2025, I exchanged emails with Adult Protective Services (APS) Worker Rose Koss. APS Koss said that she is substantiating neglect regarding Resident B.

On 06/09/2025, I reviewed AFC documentation related to this complaint. Resident B is 92-years old. According to Resident B's Health Care Appraisal, she is diagnosed with dementia with agitation, Alzheimer's, anxiety, arthritis, gastroesophageal reflux disease, hypertension, cerebrovascular accident, and hypercholesteremia. According to Resident B's Assessment Plan, she uses a two-wheeled walker for ambulation, and she requires a 1-2 person staff redirect when she is having behaviors. Resident B can ambulate independently with her walker, but staff is to remind her to use it.

I reviewed an Incident/Accident Report (IR) dated 5/16/2025 completed by staff Ciera Lucas. According to the IR, Staff Lucas went to get Resident B up for the day and she complained that she did not want to get up. Staff noticed a large goose egg/bruise on her forehead and large bruises on both her wrists. Staff completed a skin assessment, notified the primary care physician who examined her, and staff notified Resident B's

family. The corrective measures taken were, “All staff were interviewed about the incident. Each staff will be educated again on resident behaviors and all protocols for emergency situations.”

I reviewed a progress note dated 05/16/2025 completed by CNP Hanna. Resident B was seen regarding a “fall with bilateral arm bruising.” CNP Hanna stated that staff reported that the previous night, staff were moving the residents to a safe area due to a storm and Resident B fell. CNP Hanna noted that Resident B was lying in bed, alert and confused. Resident B told CNP Hanna “leave me alone, I’m alright” and her only complaint was of back pain. CNP Hanna noted that Resident B had bruising to the left side of her forehead, bruising to right knee, and bruises to her bilateral forearms. CNP Hanna stated that Resident B is sometimes non-compliant with medications, and she suffers from anxiety in the evenings. Resident B has advanced dementia, she exhibits nonsensical conversation, but she does answer some questions appropriately. No tests, labs, medications, or other recommendations were ordered.

On 06/23/2025, I interviewed staff Ciera Lucas via telephone. Staff Lucas told me that when she got to work on 05/16/2025, she began doing rounds and noticed a bruise on the top of Resident B’s hand. She looked Resident B over and found bruises on both her wrists and a bruise/lump on Resident B’s forehead. Resident B was unable to say what happened. Staff Lucas said that she immediately notified RCA Brode and completed an IR. Staff Lucas said that she spoke to staff Sarenia Avendt who had worked the night shift on 05/15/2025. Staff Avendt reported to Staff Lucas that when she and staff Moore were getting the residents up and into the storm shelter area, Resident B had “thrown a fit” and threw herself on the ground on her buttocks. Staff Lucas said that Staff Avendt said that Resident B did not receive any injuries which is why an IR was not completed. Staff Lucas told me that she does not suspect that any of the staff deliberately caused the injuries to Resident B although the source of the injuries is still unknown.

On 06/23/2025, I interviewed staff Sarenia Avendt via telephone. Staff Avendt confirmed that she was working on 05/15/2025 along with staff Courtney Blazo and Leprecious Moore. Staff Avendt said that there were tornado drills that night, so she and the other staff were getting the residents out of their rooms into the laundry room. Staff Avendt said that Staff Moore was responsible for Resident B’s wing of the facility. According to Staff Avendt, she noticed that Resident B was sitting in a wheelchair and when she asked Staff Moore why, Staff Moore told her that Resident B had “put herself on the floor” so Staff Moore got her up and into the wheelchair. Staff Avendt said that she did not see any marks, bruises, or injuries on Resident B and Staff Moore did not report that Resident B received any injuries. Staff Avendt said that the next day, she found out that Resident B had bruises on her wrists and her forehead, and the cause of the injuries is unknown. Staff Avendt told me that she has never suspected any of the staff of deliberately injuring any of the residents and neither Resident B nor any of the other residents ever reported being mistreated by staff.

On 06/26/2025, I interviewed staff Leprecious Moore via telephone. Staff Moore confirmed that she worked from 6pm-6am on 05/15/2025. According to Staff Moore, there was a tornado warning so she and the other two staff, Courtney Blazo and Sarenia Avendt began moving residents to the tornado shelter. Staff Moore was able to get Resident B into the hallway but then Resident B refused to go any further. Staff Moore said that since Resident B can ambulate by herself, she left her in the hallway and continued moving the other residents. When she came back down the hallway, she observed Resident B on her knees in the hallway, holding onto the rail on the wall. Staff Moore told me that she called Staff Blazo for assistance and while Staff Moore lifted Resident B up off the floor, Staff Blazo held the wheelchair for her. Staff Moore said that she lifted Resident B under her arms and put her in the wheelchair. Staff Moore said that she did not see any marks, bruises, or injuries on Resident B because of this incident. I asked Staff Moore if she pulled Resident B up by her wrists and she said no. I asked Staff Moore if Resident B complained of any pain and she said that Resident B said “my head, my head” but there were no visible injuries and when Staff Moore asked Resident B if her head was hurting, she did not answer. According to Staff Moore, she and Staff Blazo last checked on Resident B at approximately 5am on 05/16/2025 and they did not observe any marks, bruises, or injuries on Resident B. I asked Staff Moore if she turned the light on when checking on Resident B and she said yes and again said that she did not see any marks, bruises, or injuries.

On 07/02/2025, I interviewed certified nurse practitioner (CNP), Angela Hanna via telephone. CNP Hanna confirmed that she examined Resident B on 05/16/2025 due to injuries. According to CNP Hanna, she was told that staff reported that Resident B had fallen the night before. CNP Hanna said that she observed Resident B with dark bruises on both wrists, a bruise on her right knee, and a bruise on the left side of her forehead. Resident B was unable to tell CNP Hanna what had happened but complained of back pain. CNP Hanna said that she examined Resident B’s back and did not see any marks, bruises, or injuries and since Resident B experiences chronic back pain, she did not order further treatment or tests.

CNP Hanna told me that Resident B is not on blood thinners, but she bruises very easily and also gets skin tears very easily. CNP Hanna said that if staff lifted Resident B up off the floor by her wrists, that would explain the bruises. CNP Hanna said that she feels the bruises are consistent with being pulled up by her wrists but said that she does not necessarily think that an unnecessary amount of pressure was used due to her tendency to bruise. CNP Hanna said that she does not suspect that staff deliberately harmed Resident B.

On 07/03/2025, I interviewed staff Courtney Blazo via telephone. Staff Blazo confirmed that she worked 3rd shift on 05/15/2025 along with Staff Moore and Staff Avendt. Staff Blazo said that due to the tornado sirens, she and the other staff were moving the residents to the laundry room. According to Staff Blazo, Staff Moore and she found Resident B on the floor in the hallway, so Staff Blazo held the wheelchair and Staff Moore lifted Resident B under the arms and into the wheelchair. Staff Blazo told me that she saw Resident B after the residents went back to their rooms and Resident B

seemed fine. Staff Blazo said that she last checked on Resident B at approximately 5am on 05/16/25 and she did not see any marks, bruises, or injuries on her.

APPLICABLE RULE	
R 400.15305	**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:	On the morning of 05/16/2025, 1st shift staff Ciera Lucas found Resident B with a bruise and bump on her forehead, and bruises on both wrists. Staff Lucas said that she does not know how the injuries occurred. 3rd shift staff Leprecious Moore, Sarenia Avendt, and Courtney Blazo confirmed that they worked with Resident B during the evening of 05/15/2025 and said that they do not know how Resident B sustained the injuries. Staff Moore told me that she found Resident B on the floor in the hallway so with Staff Blazo's assistance, she lifted Resident B up off the floor into a wheelchair. Staff Moore and Staff Blazo said that Staff Moore lifted Resident B under the armpits. Certified Nurse Practitioner (CNP) Angela Hanna said that she examined Resident B on 05/16/2025 and confirmed that she did have a bruise/bump on the left side of her forehead, bruises on both her wrists, and a bruise on her left knee. CNP Hanna said that Resident B was unable to tell her what had happened. CNP Hanna said that Resident B bruises easily and she has thin skin. CNP Hanna said that she feels the bruises are consistent with being pulled up by her wrists but said that she does not necessarily think that an unnecessary amount of pressure was used due to her tendency to bruise. Resident B told me that she does not know how the injuries occurred. Resident B was asked by several staff what happened, and she said she does not know. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Third shift staff Sarenia Avendt and Courtney Blazo scream at the residents. Resident A wears hearing aids. 3 weeks ago, staff took Resident A's hearing aids because they wanted Resident A to go to bed.

INVESTIGATION: On 05/22/2025, I conducted an unannounced onsite inspection of The Ridge at Lapeer Memory Care. I interviewed Residents A, B, and C, the resident care director (RCA), Allie Brode, and the 1st shift staff supervisor (SS), Heather Sagady.

I reviewed the allegations with RCA Brode and SS Sagady. RCA Brode said that she is aware of the allegations after speaking to APS Worker, Rose Koss. According to RCA Brode and SS Sagady, none of the allegations are true. RCA Brode said that she interviewed the residents and none of the residents stated that any of the staff yells at them or screams at them. RCA Brode said that she also interviewed the staff and none of them said that they have ever heard any of the staff yell or scream at the residents. RCA Brode and SS Sagady said that none of the residents' family members have ever reported concerns about the way that staff treats the residents.

I met with Resident A in her bedroom where she was taking a nap. Resident A was dressed appropriately and appeared clean as did her room. I discussed the allegations with Resident A, and she stated that none of the staff has ever yelled at her or mistreated her. Resident A told me that she has never heard any of the staff yell at any of the other residents and staff have never said anything to her that made her feel uncomfortable. Resident A said that she has "no complaints" about the way staff treats her.

I met with Resident B in her bedroom where she was resting after lunch. I asked Resident B if any of the staff ever yells at her or makes her feel uncomfortable and she said no. I asked Resident B if she has any concerns about the way staff treat her, and she said that she has no concerns. Resident B said that staff treats her well.

I met with Resident C in her bedroom where she was resting after lunch. Resident C was clean, as was her room, and she was dressed appropriately. I asked Resident C if any of the staff ever yells or screams at her and she said no. I asked Resident C if any of the staff ever says anything that makes her uncomfortable and she said no. I asked Resident C if she has ever heard staff yelling or screaming at any of the other residents and she said no.

RCA Brode confirmed that Resident A wears hearing aids. According to RCA Brode, Resident A is prone to losing her hearing aids, so the family requested that staff take her hearing aids out at night before Resident A goes to bed. For a couple of nights, staff would take Resident A's hearing aids while she was lying in bed, before she fell asleep. However, staff reported that Resident A became upset and aggravated when staff would take them out so management notified Resident A's family members that staff would no longer be removing them. RCA Brode said that at no time did staff take away Resident A's hearing aids as a punishment or to get her to go to bed.

I met with Resident A in her bedroom where she was taking a nap. I asked Resident A about her hearing aids. Resident A confirmed that she wears hearing aids but said that she does not remember losing them. Resident A also told me that she does not remember staff ever taking her hearing aids away from her.

On 06/09/2025, I reviewed AFC documentation related to this complaint. According to Resident A's Assessment Plan, Resident A is hard of hearing. Under "understands verbal communication" it states that staff will ensure both her hearing aids are in and working before communicating with her. According to Resident A's Health Care Appraisal, she is diagnosed with cerebrovascular disease, chronic obstructive pulmonary disease, hypertension, depression, anxiety, osteoarthritis, and she is hard of hearing.

On 06/23/2025, I interviewed staff Ciera Lucas via telephone. Staff Lucas said that she has worked at this facility almost 5 years and she typically works 1st shift. According to Staff Lucas, she has never heard any of the staff yell or scream at any of the residents and none of the residents have ever complained about being mistreated.

Staff Lucas confirmed that Resident A wears a hearing aid. According to Staff Lucas, Resident A lost her hearing aid in the past so family requested that her hearing aid be locked in the medication cart at night and staff should give it back to her when she wakes up. However, Resident A was agitated when she woke up during the night and did not have her hearing aid, so staff now leave it in her room. Staff Lucas told me that to her knowledge, staff never took Resident A's hearing aid away from her as a form of punishment.

On 06/23/2025, I interviewed staff Sarenia Avendt via telephone. Staff Avendt said that she has worked at this facility for 6 years and she used to work 3rd shift. According to Staff Avendt, she has never yelled or screamed at any of the residents, and she has never heard any other staff yell or scream at the residents.

Staff Avendt confirmed that Resident A wears a hearing aid. Staff Avendt stated that the hearing aid is very expensive and on one occasion, the hearing aid was lost so Resident A's family asked that staff take the hearing aid away from Resident A at night. According to Staff Avendt, Resident A became upset when staff took her hearing aid so staff now has Resident A put her hearing aid in a cup by her bed when she goes to sleep so she can put it back in the next day. Staff Avendt said that she never took Resident A's hearing aid away as a way to get her to go to sleep and she does not believe any other staff did so either.

On 06/26/25, I interviewed staff Leprecious Moore via telephone. Staff Moore said that she has worked at this facility since April 2024, she typically works 3rd shift, and she only works 4 days per month. According to Staff Moore, she has heard staff Sarenia Avendt yell at some of the residents at times. Staff Moore said that some of the residents tend to wander into other residents' rooms so Staff Avendt will yell at them

and tell them to get out. Staff Moore said that she has never heard any of the staff cuss at the residents or call them names.

Staff Moore confirmed that Resident A wears hearing aids. Staff Moore stated that she and other staff were told by management to take Resident A's hearing aids out at nighttime, but Resident A would become agitated. According to Staff Moore, on one occasion former staff Carrie Yochum yelled at Resident A and took her hearing aids out of her ears. Staff Moore said that she reported this incident to management and Staff Yochum no longer works at this facility.

On 07/03/2025, I interviewed staff Kourtney Bowman via telephone. Staff Bowman said that she has worked at this facility for approximately 2.5 years and she has worked with all staff. Staff Bowman said that she used to work closely with Staff Avendt and she never heard Staff Avendt or any of the other staff yell or scream at any of the residents. Staff Bowman said that she has never yelled or screamed at any of the residents and she and the other staff treat the residents with respect.

Staff Bowman confirmed that Resident A wears hearing aids. Staff Bowman also confirmed that for a short time, staff were told to put Resident A's hearing aids up before she goes to bed but since Resident A became agitated, staff now put her hearing aids in a cup in her room. Staff Bowman said that she does not believe that staff ever took Resident A's hearing aids away as a form of punishment.

On 07/03/2025, I interviewed staff Courtney Blazo via telephone. Staff Blazo said that she has worked at this facility for over a year. Staff Blazo told me that she has never heard any of the staff yell or scream at the residents. According to Staff Blazo, she and the rest of the staff treat the residents with respect and kindness.

Staff Blazo confirmed that Resident A wears hearing aids. She said that Resident A has a cup next to her bed and staff encourages her to put her hearing aids in the cup before she goes to sleep. Staff Blazo told me that for a short time, staff were instructed to put the hearing aids in the medication cart because the family was afraid that Resident A would lose them. However, Resident A became agitated, so staff stopped doing that and instead staff encourages her to use the cup. Staff Blazo said that she does not believe that staff ever took Resident A's hearing aids away as a form of punishment.

I have left messages for former staff, Carrie Yochum. As of 07/07/25, Staff Yochum has not returned my messages.

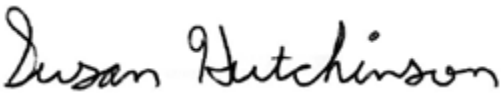
APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee,

	visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Residents A, B, and C said that none of the staff yells or screams at them. Resident A said that staff does not take her hearing aids away from her. Staff Sarenia Avendt and Courtney Blazo said that they do not yell or scream at the residents, and they treat the residents with respect. Staff Avendt and Staff Blazo said that they have never taken Resident A's hearing aids away from her as a form of punishment. Staff Leprecious Moore said that she heard Sarenia Avendt and former staff, Carrie Yochum yell at the residents. Staff Moore said that on one occasion former staff, Carrie Yochum yelled at Resident A and took her hearing aids out of her ears. The resident care director, Allie Brode, 1st shift staff supervisor, Heather Sagady, staff Ciera Lucas, staff Kourtney Bowman, and staff Courtney Blazo said that they do not yell or scream at the residents, and they have never heard any of the other staff yell or scream at the residents. All individuals stated that staff have never taken Resident A's hearing aids away as a form of punishment. As of 07/07/2025, former staff Carrie Yochum has not returned my messages. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 07/03/2025, I conducted an exit conference with the acting licensee designee (ALD), Kory Feetham. I told ALD Feetham that I have concluded my investigation and told him which rule violation I am substantiating. I asked ALD Feetham to complete and submit a corrective action plan upon receipt of my investigation report.

IV. RECOMMENDATION

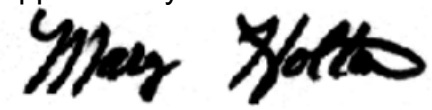
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



July 7, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:



July 7, 2025

Mary E. Holton Area Manager	Date