GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 15, 2026

Patricia Thomas
Quest, Inc
36141 Schoolcraft Road
Livonia, MI 48150-1216

RE: License #: AS820418001
Investigation #: 2026A0992007
Parkgrove

Dear Patricia Thomas:

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 (313) 456-0439.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI  48202
(313) 300-9922

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS820418001 |
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| **Investigation #:** | 2026A0992007 |
| | |
| **Complaint Receipt Date:** | 11/20/2025 |
| | |
| **Investigation Initiation Date:** | 11/25/2025 |
| | |
| **Report Due Date:** | 01/19/2026 |
| | |
| **Licensee Name:** | Quest, Inc |
| | |
| **Licensee Address:** | 36141 Schoolcraft Road<br>Livonia, MI 48150-1216 |
| | |
| **Licensee Telephone #:** | (734) 838-3400 |
| | |
| **Administrator:** | Patricia Thomas |
| | |
| **Licensee Designee:** | Patricia Thomas |
| | |
| **Name of Facility:** | Parkgrove |
| | |
| **Facility Address:** | 34638 Parkgrove Dr.<br>Westland, MI 48185 |
| | |
| **Facility Telephone #:** | (313) 562-1715 |
| | |
| **Original Issuance Date:** | 04/17/2024 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/17/2024 |
| | |
| **Expiration Date:** | 10/16/2026 |
| | |
| **Capacity:** | 6 |
| | |

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|---|---|
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Residents A and B were found soaked in urine after being neglected by the afternoon staff. Staff from the afternoon and midnight shifts were arguing loudly in front of the residents while denying responsibility. There are concerns regarding the care provided to the residents. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 11/20/2025 | Special Investigation Intake<br>2026A0992007 |
| 11/25/2025 | Special Investigation Initiated - On Site<br>Home manager, Christina Williams, direct care staff, Treasure Goodwin, Residents A and B. |
| 11/26/2025 | Contact - Document Received<br>I received incident reports and Resident A's individual plan of service (IPOS). |
| 12/02/2025 | Contact - Telephone call made<br>Licensee designee, Patricia Thomas was not available. Message left. |
| 12/02/2025 | Contact - Telephone call made<br>Direct care staff, Milan Leonard. |
| 12/03/2025 | Contact - Document Received<br>I received in-service for the resident A Care Plan. and training for Treasure Goodwin, Ariel Hunter, Samiya Livingston & Milan Leonard. |
| 12/03/2025 | Contact - Telephone call received<br>Ms. Thomas |
| 12/03/2025 | Contact - Telephone call made<br>Direct care staff, Samiya Livingston |

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| 12/03/2025 | Contact - Telephone call made<br>Direct care staff, Aireal Hunter |
| 12/03/2025 | Contact - Telephone call made<br>Direct care staff, Tawanna Gorden |
| 12/03/2025 | Contact - Telephone call made<br>Direct care staff, Shavon Johnson |
| 1/06/2026 | Exit Conference<br>Ms. Thomas |
| 1/08/2026 | Contact - Telephone call made<br>Relative B's guardian, Relative B, was not available. Message left. |
| 1/08/2026 | Contact - Telephone call made<br>Office of Recipient Rights (ORR), Charles Carter |
| 1/08/2026 | APS Referral |
| 01/13/2026 | Contact - Telephone call made<br>Resident A's support coordinator with Community Living Services (CLS), Jacquelynne Johnson |

**ALLEGATION: Residents A and B were found soaked in urine after being neglected by the afternoon staff. Staff from the afternoon and midnight shifts were arguing loudly in front of the residents while denying responsibility. There are concerns regarding the care provided to the residents.**

**INVESTIGATION:** On 11/25/2025, I completed an unannounced onsite inspection and interviewed home manager, Christina Williams, direct care staff, Treasure Goodwin, Residents A and B regarding the allegation. Ms. Williams stated she was not on shift when the incident occurred but was made aware of what happened by management. Prior to addressing the allegation, Ms. Williams stated there are always three staff on shift. As for the allegation, she explained that the incident involved the afternoon shift on 11/16/2025 and the midnight shift. She stated the afternoon shift included Milan Leonard, Samiya Livingston and Ariel Hunter; and on midnight shift there was Tawanna Gorden, Shavon Johnson and Treasure Goodwin. She stated when the midnight shift arrived Resident A told Ms. Gorden that she had been yelling for staff to assist her with her urostomy bag for the last two hours, but no one responded. Ms. Williams stated, according to Ms. Gorden Resident A was soaked in urine and Resident B was wet as well. Ms. Williams explained that sometimes Resident A's port will come out and leak, which causes her to get wet. Ms. Willaims stated Ms. Gorden asked Ms. Leonard about Resident A being soaked

and an argument ensued. Ms. Williams stated an internal investigation was completed by management and all staff involved were interviewed; and they also provided written statements. She stated based on the investigation Ms. Leonard, Ms. Livingston and Ms. Hunter stated they checked on the residents as required and denied hearing Resident A yell out for help. Ms. Williams stated due to Ms. Gorden and Ms. Leonard arguing in the home, in front of the residents they were suspended. Ms. Williams stated during the investigation she also discovered that Ms. Leonard, which was the lead staff on the afternoon shift, left the home for a substantial amount of time, leaving Ms. Livingston and Ms. Hunter alone with the residents. Ms. Williams stated Ms. Livingston and Ms. Hunter are not completely trained and should not be left alone. I explained that if Ms. Livingston and Ms. Hunter are not completely trained, they cannot be included in the staff-to-resident ratio, which Ms. Williams stated she understands. She stated she was recently appointed as the home manager and was not aware all the staff were not thoroughly trained. I requested copies of the following: Resident A's individual plan of service (IPOS), and the training certificates/transcripts for Ms. Livingston, Ms. Hunter and Ms. Leonard, which she agreed to provide. Ms. Williams provided me with copies of the statements written by the staff and stated area manager, Linda Dunn will fax the other requested documents. Ms. Williams stated Resident A does not have a guardian and she provided me with the name and contact information for Resident B's guardian.

I interviewed Treasure Goodwin, regarding the allegation, which she confirmed. She stated she worked the midnight shift along with Ms. Gorden and Ms. Johnson. She stated Ms. Leonard and Ms. Hunter were getting ready to leave as their shift had ended; and Ms. Livingston had already walked out the door to her car. She stated Ms. Gorden and Ms. Johnson went and checked on the residents like they always do at the beginning of the shift. She stated Ms. Gorden asked Ms. Leonard and Ms. Hunter why Resident A was soaked and her urostomy bag was full. Ms. Goodwin stated, Ms. Gorden and Ms. Leonard started arguing, and Ms. Leonard left. She stated Ms. Gorden bathed Resident A and cleaned her up. As for Resident B, Ms. Goodwin stated she attended to her. She stated Resident B was wet but she was not soaked. She stated they normally change all the residents at the beginning of their shift, so as it pertains to Resident B it was not out the ordinary for her to be changed. As for Resident A, she required bathing. I asked Ms. Goodwin how often they check on the residents throughout the shift. She stated that Resident A is checked every hour; Resident B is checked every two hours; she stated Resident C is checked every two hours, as she is Resident B's roommate, so she checks on them at the same time, but it is not required for her or Resident D. She stated Resident D is capable of toileting herself.

I interviewed Resident A regarding the allegation, which she confirmed. Resident A stated that it was a couple hours before midnight and she was yelling out for help, but no one responded. She stated she was not sure who was on shift, but no one ever came to assist her. She stated sometimes her port comes loose which causes her to get wet which is what happened; Resident A stated she needed help with her

urostomy bag. Resident A stated when the midnight shift came to check on her, she let them know that she tried to get the staff to help her, but no one responded to her. Resident A stated this is the only time this has ever happened, and otherwise the staff are good at caring for her and making sure she is good.

I attempted to interview Resident B; she has limited communication skills and was unable to be interviewed.

On 11/26/2025, I received incident reports regarding the reported incident and Resident A's individual plan of service (IPOS). The incident report authored by Tawanna Gorden stated that upon arrival Resident A was calling out, Shavon Johnson checked on Resident A and noticed she was sitting in a bowel movement and urine. Ms. Gorden notified Milan Leonard, and she stated she checked on Resident A and changed her. Ms. Gorden notified Management.

According to Resident A's IPOS, her monitoring needs are as follows: "Sleeping hours- reposition every two hours or per doctor's order. Sleep hours are from 10p.m.- 6p.m. (woken up every 2 hours for repositioning)." According to Resident A's support coordinator with Community Living Services (CLS), Jacquelynne Johnson, there is an error in the IPOS, Resident A's sleep hours, are 10p.m.- 6a.m.

"Awake hours- support staff should know whereabouts. Support staff will visually check minimally every two hours or per doctor's orders. (Resident A) can ask for assistance as needed."

On 12/02/2025, I contacted direct care staff, Milan Leonard and interviewed her regarding the allegation. Ms. Leonard denied the allegation and stated the residents were checked on as required. She stated on the day in question, she worked along with Ms. Livingston and Ms. Hunter and at the beginning of the shift, each staff was assigned a resident to monitor and assist with care. She stated Ms. Livingston was responsible for Resident A, she couldn't recall who was assigned Resident B, C or D. She stated she floated and checked on all the residents throughout the shift. As far as monitoring requirements are concerned, Ms. Leonard stated Residents A, B and C are checked on every 30 minutes and Resident D every 15 minutes. Ms. Leonard stated she checked on the residents as required along with the other staff. She stated she was not aware Resident A was wet and Resident A never requested assistance to her knowledge. She stated Resident A has a urostomy bag and sometimes her port comes out, which may cause it to leak, but she denied Resident A was soaked or neglected. Ms. Leonard stated when the midnight staff arrived, Ms. Gorden asked her why Resident A was soaked and her urostomy bag was full. Ms. Leonard stated she was not aware Resident A was soaked. She stated she was not the only one responsible for caring for the residents but felt as though Ms. Gorden targeted her. Ms. Leonard stated she exchanged words with Ms. Gorden and an argument ensued. I asked Ms. Leonard if she left Ms. Livingston and Ms. Hunter on shift alone while she went running errands. Initially Ms. Leonard denied leaving the facility but then stated she did leave to get food for the residents. She could not

recall how long she had been gone but stated it was less than an hour. She stated Ms. Livingston and Ms. Hunter were responsible for the residents' care while she was gone. I asked Ms. Leonard if she was aware that Ms. Livingston and Ms. Hunter are not completely trained and cannot be left unsupervised; she stated she was made aware following this incident. Ms. Lenoard stated because of the incident she was suspended for neglect of duty. She stated this was an isolated incident and not indicative of her work ethics.

On 12/03/2025 I received IPOS in-service training log for Resident A's care plan and training/transcript for Treasure Goodwin, Ariel Hunter, Samiya Livingston and Milan Leonard. The IPOS in-service training log for Resident A's care plan was signed by Ms. Livingston, Ms. Hunter, Ms. Leonard, Ms. Gorden and Ms. Johnson acknowledging they were trained in 10/2025, Ms. Goodwin was trained in 12/2025.

As far as training Ms. Goodwin has completed all required training, she is not trained in medication administration. Ms. Hunter has not completed the following training: first aid/CPR, food safety, nutrition and special diets; she is not trained in medication administration. Ms. Livingston has not completed the following training: reporting requirements, food safety, nutrition and special diets. Ms. Livingston completed first aid/CPR on 12/02/2025 following the reported incident. Ms. Leonard has completed all required training.

On 12/03/2025, I contacted licensee designee, Patricia Thomas regarding the allegation. Ms. Thomas stated she was previously made aware of the allegation by area supervisor, Linda Dunn. I explained that I interviewed Resident A and she was adamant that she yelled out for staff for two hours to assist her and no one responded. Ms. Thomas stated Resident A is very forthcoming and if she said it, that is what happened. In addition to the allegation, I made Ms. Thomas aware that Ms. Williams discovered that Ms. Leonard left the facility leaving Ms. Livingston and Ms. Hunter alone with the residents and they are not completely trained. Ms. Thomas stated she was not aware of Ms. Leonard leaving the facility. I explained that Ms. Livingston and Ms. Hunter cannot be counted in the staffing ratio if they are not trained. Ms. Thomas stated she was also aware that there was a verbal altercation between Ms. Lenoard and Ms. Gorden, which is why they were suspended. I made Ms. Thomas aware that once the investigation is complete, I will follow up with her to discuss the findings. Ms. Thomas denied having any questions.

On 12/03/2025, I contacted direct care staff, Samiya Livingston and interviewed her regarding the allegation. Ms. Livingston stated at the start of her shift she checked on all the residents. She stated Ms. Hunter was assigned to Resident C, so she assisted her with showering her because she was not comfortable doing it alone. She stated after that she started dinner and changed Resident B. Ms. Livingston stated after dinner she checked on Resident A again and was fine. She stated she checked on Resident B and changed her. Ms. Livingston stated Ms. Leonard left around 5:30 p.m., and returned at 6:30 p.m., so it was just her and Ms. Hunter. She stated when Ms. Leonard returned, she had two children with her, and she wasn't

much help during the rest of the shift. She stated she remained in the office with the children. Ms. Livingston stated she checked on Resident A again at 10:30 p.m., and her shift ended at midnight. Ms. Livingston stated Ms. Hunter checked on the residents in between times. She denied having any knowledge of Resident A yelling for help. Ms. Livingston stated she did not witness an argument between Ms. Leonard and Ms. Gorden, she stated when her shift ended, she left. Ms. Livingston stated she is not completely trained, she stated she is scheduled to complete cardiopulmonary resuscitation (CPR) training today. Ms. Livingston stated she started on 4/2025 and was not aware she needed additional training.

On 12/03/2025, I contacted direct care staff, Ariel Hunter and interviewed her regarding the allegation. Ms. Hunter stated at the start of shift, she was assigned to Resident C, and she needed bathing. Ms. Hunter stated she bathed Resident C and assisted with the other residents. She stated after dinner she checked on Residents A and B at 9:00 p.m. and 10:00 p.m. She stated each time she checked on Resident A, she said she was fine. Ms. Hunter stated she was uncertain who checked on the residents in between those times. She stated Ms. Leonard left for 30-40 minutes and wasn't much help. Ms. Hunter stated when the midnight staff arrived, Ms. Gorden asked Ms. Leonard why Resident A was soaked and her urostomy bag was full; she stated they started arguing. Ms. Hunter stated she is not completely trained, she stated she needs to complete cardiopulmonary resuscitation (CPR), basic health needs, and medications. training today. She stated she started two to three months ago and was not aware she needed more training; she stated the office schedule the training.

On 12/03/2025, I contacted direct care staff, Tawanna Gorden and interviewed her regarding the allegation, which she confirmed. She stated she arrived on shift along with Ms. Goodwin and Ms. Johnson. She stated Ms. Johnson checked on the residents and stated Residents A and B were soaked. Ms. Gorden stated she went and checked Residents A and B, and sure enough they were soaked. She stated Resident A's urostomy bag was so full that it leaked. She stated Resident A was crying, stating that she had been yelling out for assistance for the past two hours and no one came to help her. Ms. Gorden stated Ms. Leonard was the lead on the afternoon shift, so she pulled her to the side and made her aware that Resident A was soaked with urine because no one assisted her. Ms. Gorden stated that the staff are there to care for the residents. She stated they applied for the job, the residents did not request them, so they need to do their job. Ms. Gorden stated there is no reason Resident A should have to sit in urine. She confirmed there was a verbal altercation between her and Ms. Leonard because Ms. Leonard kept following her around the house after she told her that she needed to do her job. Ms. Gorden stated she did swear at Ms. Leonard when arguing with her, which led to her being suspended.

On 12/03/2025, I contacted direct care staff, Shavon Johnson and interviewed her regarding the allegation. Ms. Johnson confirmed she worked the midnight shift on the day in question. She stated when she arrived, she checked on the residents and

Resident A appeared to be in distress. She went on to say that Resident A stated she had been yelling out for help for the past two hours and no one responded. Ms. Johnson stated the staff are required to check on Residents A, B and C every 30 minutes and Resident D every 15 minutes. She stated Resident A's urostomy bag was not on properly which is why she was wet. She stated if they had checked on her as required, they would have noticed. Ms. Johnson stated as far as care is concerned, the staff are assigned to a resident to monitor and assist with care, but the overall operation is a joint responsibility as far as monitoring, medication, hygiene and house duties.

On 1/06/2026, I conducted an exit conference with Ms. Thomas. I explained that based on the investigative findings, there is evidence to support the allegation that direct care staff on duty did not provide the services specified in Resident A's assessment plan and based on the verbal altercation between Ms. Gorden and Ms. Leonard, it is uncertain that either staff could meet the resident's emotional needs. Due to the violations identified in the report, a written corrective action plan is required. Ms. Thomas denied having any questions and agreed to review the report and submit the corrective action plan.

On 1/08/2026, I contacted Office of Recipient Rights (ORR), Charles Carter regarding the allegation. He confirmed he investigated the allegation and substantiated. He stated the staff was suspended and corrective measure were implemented.

| **APPLICABLE RULE** | |
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| **R 400.633** | **Staffing requirements.** |
| | **(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following:**<br>**(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.**<br>**(b) 12 residents for small group and family homes.** |

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| **ANALYSIS:** | During this investigation, I interviewed licensee designee, Patricia Thomas; home manager, Christina Williams; direct care staff, Treasure Goodwin, Milan Leonard, Samiya Livinsgton, Airel Hunter, Tawanna Gorden and Shavon Johnson, and Resident A regarding the allegation.<br><br>I reviewed Resident A's IPOS which outlines her monitoring needs as follows: "sleeping hours- reposition every two hours or per doctor's order. Sleep hours are from 10p.m.- 6a.m. (woken up every 2 hours for repositioning)." "Awake hours- support staff should know whereabouts. Support staff will visually check minimally every two hours or per doctor's orders. (Resident A) can ask for assistance as needed."<br><br>Resident A stated she yelled out for assistance and no one responded.<br><br>Based on the findings there is sufficient evidence that the direct care staff on duty did not provide the services specified in Resident A's assessment plan. The allegation is substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.629** | **Direct care staff; qualifications and training.** |
| | **(4) Direct care staff shall possess all of the following qualifications before working independently:**<br>**(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.** |

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| **ANALYSIS:** | During this investigation, I interviewed licensee designee, Patricia Thomas; home manager, Christina Williams; direct care staff, Treasure Goodwin, Milan Leonard, Samiya Livinsgton, Airel Hunter, Tawanna Gorden and Shavon Johnson, and Resident A regarding the allegation.<br><br>Ms. Goodwin, Ms. Gorden, and Ms. Hunter confirmed that there was a verbal altercation in the home in the presence of the residents. Ms. Gorden stated she did swear during the argument with Ms. Leonard. Ms. Leonard and Ms. Gorden received a written reprimand.<br><br>Based on the findings, direct care staff Tawanna Gorden and Milan Leonard behavior was not sufficient to meet the needs of the residents. The allegation is substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** On 11/25/2025, home manager, Christina Williams, stated Ms. Leonard, which was the lead staff on the afternoon shift, left the home for a substantial amount of time, leaving Ms. Livingston and Ms. Hunter alone with the residents. Ms. Williams stated Ms. Livingston and Ms. Hunter are not completely trained and should not be left alone. I explained that if Ms. Livingston and Ms. Hunter are not completely trained, they cannot be included in the staff-to-resident ratio, which Ms. Williams stated she understands. Ms. Williams provided me with a copy of statements written by Ms. Hunter and Ms. Livingston, both stating Ms. Leonard left the home for a substantial amount of time leaving them to manage the shift alone.

On 12/02/2025, direct care staff, Milan Leonard initially denied leaving the facility, but then stated she did leave to get food for the residents. She could not recall how long she had been gone but stated it was less than an hour. She stated Ms. Livingston and Ms. Hunter monitored the residents. I asked Ms. Leonard if she was aware that Ms. Livingston and Ms. Hunter are not completely trained and cannot be left unsupervised; she stated she was made aware following this incident.
On 12/03/2025, direct care staff, Samiya Livingston stated Ms. Leonard left around 5:30 p.m., and returned at 6:30 p.m., so it was just her and Ms. Hunter. She stated when Ms. Leonard returned, she had two children with her, and she wasn't much help during the rest of the shift. She stated she remained in the office with the children. Ms. Livingston stated she checked on Resident A again at 10:30 p.m., and her shift ended at midnight. Ms. Livingston stated she is not completely trained, she stated she is scheduled to complete cardiopulmonary resuscitation (CPR) training

today. Ms. Livingston stated she started on 4/2025 and was not aware she needed additional training.

On 12/03/2025, direct care staff, Ariel Hunter stated Ms. Leonard left for 30-40 minutes, leaving her and Ms. Livingston responsible for the residents. Ms. Hunter stated she is not completely trained, she stated she needs to complete cardiopulmonary resuscitation (CPR), basic health needs, and medications.  training today. She stated she started two to three months ago and was not aware she needed more training; she stated the office schedule the training.

On 1/06/2026, I conducted an exit conference with Ms. Thomas. I made her aware during the investigation it was discovered that Ms. Leonard left the facility for a significant amount of time, leaving Ms. Livingston and Ms. Hunter unsupervised and they are not completely trained. I explained that Ms. Livingston and Ms. Hunter cannot be included in the staff to resident ration until they have been completely trained. Based on the violation, a written corrective action plan is required, which Ms. Thomas agreed. She denied having any questions.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.629** | **Direct care staff; qualifications and training.** |
| | **(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently:**<br>**(a) Reporting requirements.**<br>**(b) First aid.**<br>**(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.**<br>**(d) Personal care, supervision, and protection.**<br>**(e) Resident rights.**<br>**(f) Safety and fire prevention.**<br>**(g) Prevention and containment of communicable diseases including recognizing signs of illness.**<br>**(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.**<br>**(i) Nutrition and special diets.** |
| **ANALYSIS:** | Direct care staff, Airel Hunter and Samiya Livingston were performing assigned tasks independently and are not completely trained. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

1/13/2026

Denasha Walker Date
Licensing Consultant

Approved By:

1/15/2026

Ardra Hunter Date
Area Manager