



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 16, 2026

Kennedy Shannon
Serenity House Residential Care Services LLC
21838 Van K Drive
Grosse Pointe Woods, MI 48236

RE: License #: AS500419032
Investigation #: 2026A0990011
Serenity House- Columbus

Dear Ms. Shannon:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "L. Reed".

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
 BUREAU OF COMMUNITY AND HEALTH SYSTEMS
 SPECIAL INVESTIGATION REPORT
 THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS500419032
Investigation #:	2026A0990011
Complaint Receipt Date:	01/06/2026
Investigation Initiation Date:	01/09/2026
Report Due Date:	03/07/2026
Licensee Name:	Serenity House Residential Care Services LLC
Licensee Address:	21838 Van K Drive Grosse Pointe Woods, MI 48236
Licensee Telephone #:	(313) 587-0861
Administrator:	Kennedy Shannon
Licensee Designee:	Kennedy Shannon
Name of Facility:	Serenity House- Columbus
Facility Address:	23204 Columbus Warren, MI 48089
Facility Telephone #:	(313) 587-0861
Original Issuance Date:	02/10/2025
License Status:	REGULAR
Effective Date:	08/10/2025
Expiration Date:	08/09/2027
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED

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II. ALLEGATION(S)

	Violation Established?
Resident A was allegedly assaulted by a staff member at the home, resulting in serious injuries, and Resident A now fears returning despite the staff member being relocated.	Yes

III. METHODOLOGY

01/06/2026	Special Investigation Intake 2026A0990011
01/06/2026	APS Referral Assigned at intake.
01/09/2026	Special Investigation Initiated - Face to Face I conducted an unannounced onsite. I interviewed Kelsie Williams, home manager, and Resident A. Resident B refused to be interviewed.
01/09/2026	Contact- Document Received I received an email from Kennedy Shannon, licensee designee.
01/09/2026	Contact - Document Sent I requested documents from Ms. Shannon. Ms. Shannon sent requested documents.
01/15/2026	Contact - Document Received I received an email from Debra Johns, Adult Protective Services (APS) Worker.
02/26/2026	Contact - Document Received I reviewed the resident records.
02/26/2026	Contact - Document Sent I emailed Julia Magaluk, case manager.

02/26/2026	Contact - Document Sent I emailed Guardian A. No response to date.
02/26/2026	Contact - Telephone call made I texted direct care staff Trinity Jamil and Kristina Wiggins-Shannon to contact me for a phone interview. Both replied on 02/27/2026.
02/26/2026	Contact - Telephone call received I received a phone call from Ms. Shannon in response to my email today asking for additional information.
02/26/2026	Contact - Document Sent I emailed Debra Johns, APS Worker.
02/27/2026	Contact - Telephone call made I conducted a phone interview with Trinity Jamil.
02/27/2026	Contact - Telephone call made I conducted a phone interview with Kristina Wiggins-Shannon.
03/03/2026	Contact - Telephone call made I conducted a phone interview with Sarah Rupkus, Office of Recipient Rights (ORR) investigator.
03/03/2026	Exit Conference I conducted an exit conference with Ms. Shannon.
03/05/2026	Contact – Document received I received an email from the case manager Julia Magaluk.
03/06/2026	Exit Conference I conducted an exit conference with Ms. Shannon.

ALLEGATION:

Resident A was allegedly assaulted by a staff member at the home, resulting in serious injuries, and Resident A now fears returning despite the staff member being relocated.

INVESTIGATION:

On 01/09/2026, I conducted an unannounced onsite. I interviewed Kelsie Williams, home manager. Ms. Williams said that the altercation occurred between Resident A and direct care staff Trinity Jamil, who is now working in a different home as result of the altercation. Ms. Williams said that the altercation was precipitated by an event in which Resident A snuck out of the home on 12/16/2025 during Ms. Jamil's shift (afternoons). Resident A was observed on the ring camera leaving out the side door on 12/16/2025 and entering a vehicle parked outside. Ms. Williams said that Resident A had sex with the male in the vehicle that she had met on the internet.

Two days later, on 12/18/2025, Resident A was told that she could not attend the Christmas party because she had left home without permission. Resident A was transported to Prospect Group Home where there were other residents/staff present that were not attending the Christmas party. After the Christmas party, Ms. Jamil picked up Resident A from Prospect home. Resident B was present in the vehicle. Ms. Williams said that Ms. Jamil and Resident A both told her that they were talking about the incident in which Resident A snuck out of the home on the ride home from Prospect. Ms. Williams said that Ms. Jamil expressed to Resident A that she placed herself and others in danger by meeting with a strange male in front of the home. Ms. Williams said that the conversation triggered Resident A.

Ms. Williams said that on the day of the altercation, she received a phone call from home manger Kristina Wiggins-Shannon informing her that Ms. Jamil and Resident A were arguing. Ms. Williams said that she called Resident A and she was very upset. Ms. Williams said that Ms. Jamil was told to remove herself from the home once Ms. Wiggins-Shannon arrived at the home. Ms. Williams said that the physical altercation was captured on the Ring camera. Ms. Williams said that Resident A weighs about 300 pounds and Ms. Jamil is about 5'3" and maybe 120 pounds. Ms. Williams said that in the video Resident A is observed running up and physically attacking Ms. Jamil. Ms. Williams said that because of the fight, Resident A had two black eyes and a broken nose. The police transported Resident A to the hospital. Ms. Jamil refused to press criminal charges. Resident A was hospitalized for two weeks at Harbor Oaks Psychiatric Hospital. There are currently three residents in the home. At the time of the altercation, the only witness present was Resident B.

On 01/09/2026, I interviewed Resident A. Resident A said that she was seen on the ring camera sneaking out of the home to see "a boy". Resident A said that Ms. Jamil was "irritated" with her because she snuck out of the home on her shift. Resident A said that

right before the altercation, she was sitting on the couch, and Ms. Jamil was “knit picking” and Ms. Jamil called her liar. Resident A said the home manager Ms. Wiggins-Shannon was trying to calm her down. Resident A admitted to running outside to fight Ms. Jamil. She said that Ms. Jamil was fighting her back. Resident A said that she had a broken nose and a black eye. Resident A said that after the fight she ran to her bedroom and locked the door. The police came to the home and took her to the hospital. Resident A said she was told that Ms. Jamil did not press criminal charges against her. Resident A said hospitalized at Harbor Oaks Psychiatric Hospital for seven days after leaving the emergency room (ER). Resident A said that prior to the altercation, she had not had any issues with Ms. Jamil. She feels safe that the home now that Ms. Jamil is no longer working there. Resident A was interviewed by APS, and she has a public guardian.

On 01/09/2026, I attempted to interview Resident B. Resident B said that she did not want to talk about the physical altercation anymore. She said that she has already talked to many people about it and does not want to speak about it. The interview was concluded.

On 01/09/2026, I received an email from Kennedy Shannon, licensee designee. Ms. Shannon said that an Incident Report (IR) was filed with Community Mental Health (CMH) and the Office of Recipient Rights (attached). At the time of the incident, a report was not submitted to LARA because responding to law enforcement did not document any injuries to any party, and to their understanding the police report similarly does not note any injuries. To date, we have not received any medical documentation substantiating the injuries allegedly sustained by Resident A. As reflected in the attached video (Ring doorbell footage), the employee involved was in the process of exiting the home while Resident A was speaking with the Area Supervisor.

The employee, Trinity Jamil, went outside to de-escalate and diffuse the situation. As the video clearly shows, Resident A then ran up to Ms. Jamil and physically attacked her. Ms. Jamil responded only as necessary to protect herself and did not use excessive force. When law enforcement arrived, officers indicated they were prepared to take Resident A to jail for assault. However, Ms. Jamil requested time to consider whether she wished to press charges. As a result, law enforcement transported Resident A to the hospital under a mental health petition. From the emergency room, Resident A was admitted for inpatient treatment at Harbor Oaks. Upon her return, the only documentation provided was her Harbor Oaks discharge paperwork, which did not reference or document any physical injuries. We have shared the attached Incident Report and video footage with the Office of Recipient Rights, Adult Protective Services, and now LARA. We are fully cooperating and remain committed to transparency and compliance. If there is any additional information or documentation needed at this time, please let me know. For reference, the employees involved are Trinity Jamil, Direct Care Worker (individual attacked) and Kristina Wiggins Shannon, Area Supervisor:

I reviewed the video which was about 15 seconds long. The video showed Ms. Jamil walking out the front door. The video jumps to a person yelling (later known to be

Kristina Wiggins-Shannon) yelling “No Resident A do not hit her; I’m going to call the police”. At about seven seconds I observed Ms. Jamil kicking off her shoes in and taking off her coat, throwing it on the ground. Ms. Jamil put her arms and fist in a fighting position as Resident A charged at her. Resident A threw the first punch. Both ladies were swinging and punching each other. Ms. Wiggins-Shannon is observed intervening and breaking up the fight.

On 01/15/2026, I received an email from Debra Johns, Adult Protective Services (APS) Worker. Ms. Johns will be closing her investigation this week and it will be substantiated against the alleged perp for physical abuse as she admitted to defending herself against Resident A by hitting her. Resident A’s guardian was notified of the incident. Trinity Jamil was cooperative with APS investigation. Ms. Johns said, “this was a tough one as I know staff must have been frightened”. Ms. Johns spoke to Resident A’s MORC worker, and she reported Resident A has a long mental health history and was removed from her previous home due to behavioral concerns. Ms. Johns attached the law enforcement report, incident report and video footage of the incident.

On 02/26/2026, I reviewed Resident A’s resident record and Ms. Jamil’s employee file. Ms. Jamil was hired on 07/08/2025 for full-time direct care staff. Ms. Jamil had a completed job application, two reference checks and a Workforce Background check. Ms. Jamil was trained specifically on Resident A’s IPOS and Crisis & Safeguard plan on 12/01/2025. Ms. Jamil is fully trained. Ms. Jamil is trained in the employee specialized certification requirements. Ms. Jamil is trained in Crisis Planning and Behavior & Crisis Intervention.

I reviewed Resident A’s Individual Plan of Service (IPOS) and Crisis Plan. Resident A admission date to the home is 05/01/2025. Resident A’s diagnosis is as follows: Autism, mild intellectual disabilities PTSD, severe mood disorder with psychotic features, ADHD, combined type, disruptive mood disorder, agitation and fetal alcohols syndrome. Caregivers are encouraging to provide praise and encouragement with Resident A. Resident A is described as warm, likable young woman who makes consistent effort to maintain positive relationships with her housemates and staff. Resident A is willing to engage and connect with others. Situations to avoid limiting that may trigger a crisis are as follows: strong commands or controlling statements, telling her what is expected of her rather than discussing options and outcomes. Caregiver activities to de-escalate a crisis are as follows: Provide a quiet place, suggest listening to music or practicing coping strategy; remove work or demands that she perceives as too difficult; remain with her but avoid asking too many questions; use low pleasing, gentle voice, kind words and praise for calm behavior. When Resident A is in crisis, staff should follow the activities to de-escalate a crisis situation and if these strategies does not work and Resident A continues to escalate and becomes a danger to herself or others, then staff should call 911 to have her taken to hospital for evaluation.

Resident A has a history of using her phone in attempts to give strange men her address and sneaking visitors in the home or sneaking out of the home. Resident A requires 24/7 personal care and supervision to monitor her health and safety including vulnerability/exploitation from others, understanding healthy relationships and behaviors, including oppositional behavior outbursts, verbal and physical aggression towards others. Interventions to address behaviors are as follows; No use of personal cell phone, limited and supervised Wi-Fi access to the home, locked medication and food. The IPOS documents that all restrictions are implemented solely to protect Resident A's health and safety and are not intended to be punitive.

I reviewed the Warren Police Department report dated 12/18/2025. The report summaries that Resident A attacked Ms. Jamil because she told her that she was not allowed to leave the group home. Ms. Jamil informed the officers that she told Resident A that she was not allowed to leave the group home. Ms. Jamil did not want to press charges but came to the station on 12/19/2025 stating that she wanted to press charges.

In review of the incident report, the physical altercation occurred on 12/18/2025 at 8:20 PM. Resident A started making threats towards staff. She expressed feelings of aggression and said she might end up in jail that night. Trinity Jamil, the employee on duty, called area supervisor Kristina Shannon for assistance due to Resident A's threats. Kristina Wiggins-Shannon arrived at the house and spoke with Resident A, who was on the phone with home manager Kelsi Williams. Staff were trying to calm Resident A down because she was upset about possibly losing her phone privileges after sneaking out to meet a boy. While Kristina was talking to Resident A, she continued to direct threats towards Ms. Jamil. Ms. Jamil stepped outside to help de-escalate the situation. At that moment, Resident A charged out of the house and attacked Trinity Jamil. Ms. Jamil hearing Resident A charge behind her turned around to take off her coat so she could defend herself. Resident A charged Ms. Jamil and began punching her in her head and body. Ms. Jamil defended herself during the incident, which was recorded on the doorbell camera. Police were called and Resident A was taken to ER for mental health evaluation.

On 02/26/2026, I received a phone call from Ms. Shannon in response to my email today asking for additional information. Ms. Shannon said that Office of Recipient (ORR) investigative report is incomplete. ORR has been trying to obtain the emergency room discharge paperwork to no avail. Ms. Shannon said that they never received the ER paperwork because Resident A went from the hospital to Harbor Oaks Psychiatric Hospital. Ms. Shannon said that she was the one that made the decision to exclude Resident A from attending the Christmas party. She said that Resident A was agitated because she upset that she would be losing her phone privileges Ms. Shannon described that Resident A had a history of being sexually assaulted in prior placement due to her inviting strange men to the home. Resident A talks to random men she meets on the internet. Resident A may have contracted a STD due to making unsafe decisions with strange men. Ms. Jamil is fully trained but Resident A is defiant. Ms. Jamil is her youngest employee and at times, Resident A feels as though she does not have to

respect Ms. Jamil because she is few years older than she is. Ms. Shannon does not feel that the staff were over discussing Resident A's decisions to sneak out of the home. She was the person that reviewed the ring camera. Ms. Jamil was on shift but did not know that Resident A had sneaked out. Resident A was only outside for about ten minutes. Resident A was observed having sex with a man she possibly met on the internet in the car. Ms. Shannon said that Resident A was upset about her cell phone and that the man she had just had sex with in the car, blocked her number after the affair. Ms. Wiggins-Shannon came to the home to prevent Resident A being fixed on Ms. Jamil. Prior to the altercation Resident A and Ms. Jamil were close. That was the first time that Resident A became aggressive in the home. Resident A also assumed that Ms. Jamil was responsible for getting her phone privileges suspended because she was on shift the night she sneaked out of the home.

On 02/26/2026, I emailed Debra Johns, APS Worker. Ms. Johns forwarded an email from Sarah Rupkus, ORR regarding the hospital discharge paperwork that read: I have not. I've inquired about it on 2/2 and 2/11. The case manager has been extremely helpful and is trying very hard to get it. However, according to her, the Henry Ford records Dept is unresponsive. The Home Manager is also going to try once more to get it.

On 02/27/2026, I conducted a phone interview with Trinity Jamil. Ms. Jamil said that on 12/18/2025 when she arrived back at work that Resident A sneaked out of the home there was a Christmas party. The home manger told her that Resident A had to go to the other group home for 2-3 hours because she was not allowed to attend the Christmas party because of her behavior. When Ms. Jamil picked up Resident A from the other home, she asked her why she sneaked out. Ms. Jamil said it was an open conversation, and she was not chastising Resident A. Resident A became defensive about the conversation, and she no longer responded to her. When they arrived back home Resident A was still triggered and was using profanity. Ms. Jamil said she called Ms. Wiggin-Shannon to inform her of what was occurring. Ms. Wiggin-Shannon called Resident A to calm her down to no avail.

Ms. Wiggins-Shannon came to the home shortly thereafter to speak to Resident A who continued to make threats towards her. Ms. Wiggin-Shannon instructed Ms. Jamil to leave the home. Ms. Jamil said she did not have car at the time, so she said she was going to go outside to sit inside the vehicle until her ride came. Ms. Jamil said that as she was walking outside, Resident A came charging at her. Ms. Jamil said she could hear Ms. Wiggins-Shannon telling Resident A "Don't hit her". Her reaction to Resident A was self-defense as Resident A is significantly larger than she is. Ms. Jamil said that she never used harsh words to upset Resident A. Ms. Jamil said that they had recently got a new resident, and she believes that Resident A was trying to show off to the new resident and show dominance. She denied calling Resident A liar. She also denied asking her why she snuck out on her shift. Ms. Jamil said that she was trained in Resident A's IPOS and Crisis Plan. Ms. Jamil said that she remained calm although Resident A could be heard yelling "I'm going to smack that bitch" and called her a chicken.

On 02/27/2027, I conducted a phone interview with Kristina Wiggins-Shannon. Ms. Wiggins-Shannon, on the day of the fight, received a phone call from Ms. Jamil informing her that Resident A was upset and yelling. Ms. Wiggins-Shannon said that she was in the area, so she decided to make her way there to intervene. It took her 10 minutes to get there. When she arrived, Ms. Jamil was sitting in the office and Resident A was in her bedroom. When she went to the bedroom to talk to her, Resident A was on the phone with Ms. Williams. She stood there listening to the conversation and Resident A said "I'm going to smack that bitch, and I don't care about going to jail. Resident A ended the phone call with Ms. Williams she proceeded to de-escalate. She also called Ms. Kennedy to inform her what was happening. Ms. Wiggins-Shannon said that she went to the office and instructed Ms. Jamil to leave the home. Then she heard Resident A yell "I'm about to jail tonight". Ms. Wiggins-Shannon said that she told Resident A if she hit anyone that she would have to call the police. Ms. Jamil proceeded to leave the home and then Resident A charged out the front door after Ms. Jamil. Ms. Wiggins-Shannon said she intervened in the fight and called the police. Ms. Wiggins-Shannon said that Resident A said that she was upset because Ms. Jamil told her during the transport that she was doing well up until the incident and that she had just got her phone back. Ms. Wiggins-Shannon said that she blamed Ms. Jamil for her phone privileges being removed from her. When the police arrived, Resident A was in her bedroom she did not observe any marks or bruises on Resident A. The police escorted Resident A the ER.

On 03/03/2026, I conducted an exit conference with Ms. Shannon. We discussed the investigation. We discussed that the crisis plan did not have an intervention in place for physical attacks but there are interventions noted to follow in the event of a crisis. The crisis plans also mentioned that she has a history of physical aggression and explicitly outlines her triggers in which they were not followed. Ms. Shannon was strongly opposed to the tentative rule violations. Ms. Shannon was informed that I would speak to Area Manager for guidance. Ms. Shannon said that her staff have the right to protect themselves and she plans to file legal paperwork against the state because the licensing rules place her staff at risk.

On 03/03/2026, I conducted a phone interview with Sarah Rupkus, Office of Recipient Rights (ORR) investigator. Ms. Rupkus has not been able to obtain the hospital discharge paperwork. The guardian is not responding to her calls. The case manager has attempted to obtain them as well. Ms. Rupkus said that she will be substantiating her investigation because staff are never engaged in physical blows with residents regardless of this not documented in the plan.

On 03/05/2025, I received an email from Julie Magaluk, case manager. Ms. Magaluk said that he assigned behaviorist for Resident A has been out of the office for a few months and there is a substitute behaviorist assigned (Lacey Sith) at the time of the incident. Now, as of this month, her behaviorist is Mia Sarafini Murphy. Ms. Magluk said that Ms. Jamil did not press charges nor was Resident A formally charged. Kennedy

Shannon called and asked for Resident A's crisis plan to be updated on what to do if she attacks staff, I have informed the behaviorist (Mia) that edits need to take place in her plan.

On 03/06/2026, I conducted an exit conference with Ms. Shannon. I informed her of the tentative findings prior to supervisory approval. I informed Ms. Kennedy that I consulted an area manager who agreed with the findings and had viewed the video. Ms. Kennedy was informed that while an employee has the right to defend oneself from injury this does not include doing so by harm to the residents. The video shows a continuation by the employee even after the home manager is attempting to intervene. I informed Ms. Kennedy that there is no evidence of deescalation on the part of the employee in the video. Ms. Kennedy was informed that a corrective action plan would be required. Ms. Kennedy following up with an email to me and the area manager requesting an administrative hearing.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (a) Use any form of punishment.
ANALYSIS:	Based on the investigation there is sufficient evidence to support that Trinity Jamil used physical punches as a form of punishment as Resident A charged her on 12/18/2025. Resident A made threats and attacked Ms. Jamil. Ms. Jamil was observed on the video taking off her coat and shoes in a fighting stance before Resident A threw a punch. Both were observed punching each other before Ms. Wiggins-Shannon intervened. Resident A alleges injuries, however, there is documentation to support this claim. Ms. Jamil, although she was leaving the home, and there was opportunity for her to flee or shield herself and not engage with Resident A, who has significant mental and developmental disabilities and was in crisis.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and

	<p>rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.</p>
<p>ANALYSIS:</p>	<p>Based on the investigation there is sufficient evidence to support Ms. Kennedy Shannon and direct care staff Trinity Jamil interventions to address Resident A's documented behavioral issues were not followed properly according to her IPOS and Crisis Plan. Resident A was restricted from attending the company Christmas Party on 12/18/2025 which precipitated a physical altercation between Resident A and Ms. Jamil that occurred two days later.</p> <p>Ms. Kennedy said that she made the decision not to allow Resident A to attend the Christmas party on 12/18/2025 because Resident A was agitated because her personal cell phone privileges were going to be removed due to her sneaking out of the home on 12/16/2025. Refraining Resident A from events is not an intervention outlined in her IPOS. The IPOS reads that Resident A's personal cell phone is limited and Wi-Fi access is limited to the home when she is making unsafe decisions. Resident A's IPOS documents that all restrictions are implemented solely to protect Resident A's health and safety and are not intended to be punitive.</p> <p>Furthermore, Ms. Jamil admitted to discussing with Resident A during a transport trip asking her why she left the home. Resident A said Ms. Jamil was knit picking and called her liar. Ms. Williams also reported that Ms. Wiggin-Shannon told her that Resident A and Ms. Jamil were arguing.</p> <p>Per the police report, Ms. Jamil reported that Resident A was upset because she told her that she wasn't not allowed to leave the group home. There was no point in discussing the matter with Resident A as the incident occurred two days prior.</p> <p>Resident A's IPOS clearly states that Resident A is triggered by strong commands or controlling statements. Ms. Jamil telling Resident A what is expected of her rather than discussing options and outcomes causes a crisis situation which resulted in possible injuries to Resident A and seven days hospitalization.</p>

CONCLUSION:	VIOLATION ESTABLISHED
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IV. RECOMMENDATION

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

L. Reed

03/06/2026

LaShonda Reed
Licensing Consultant

Date

Approved By:

Jay Calwerts

For

03/16/2026

Denise Y. Nunn
Area Manager

Date