GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2026

Deborah Waldo
Elder Empowerment Services Unlimited, LLC
38603 Eight Mile
Livonia, MI 48152

RE: License #: AS820408141
Investigation #: 2026A0993016
Lauren's Greenhouse Living

Dear Ms. Waldo:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (313) 456-0380.
Sincerely,

DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820408141
Investigation #:	2026A0993016
Complaint Receipt Date:	06/10/2026
Investigation Initiation Date:	06/11/2026
Report Due Date:	08/09/2026
Licensee Name:	Elder Empowerment Services Unlimited, LLC
Licensee Address:	38603 Eight Mile Livonia, MI 48152
Licensee Telephone #:	(313) 477-8728
Administrator:	Deborah Waldo
Licensee Designee:	Deborah Waldo
Name of Facility:	Lauren's Greenhouse Living
Facility Address:	20315 Hickory Lane Livonia, MI 48152
Facility Telephone #:	(734) 744-5769
Original Issuance Date:	12/01/2021
License Status:	REGULAR
Effective Date:	06/01/2026
Expiration Date:	05/31/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
• Resident D slept in a chair with no pants on. • Resident D did not have sheets on her bed. • Resident D was left in her own filth, and she was soiled down to her socks.	No
Resident C is bedridden, but staff forced her to be in a wheelchair.	Yes
• Staff have not administered Resident C's medications as prescribed. • The facility has a lot of medication errors.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

06/10/2026	Special Investigation Intake 2026A0993016
06/10/2026	APS Referral Received allegations from Adult Protective Services (APS)
06/11/2026	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation. I interviewed licensee designee Deborah Waldo and staff, Sarah Brown. I observed Resident C.
06/12/2026	Contact - Telephone call made Telephone call made to Comfort Care hospice nurse, Melissa Alsobrooks. Left a message.
06/12/2026	Contact - Telephone call made Telephone call made to Power of Attorney (POA) C1. Left a message.
06/12/2026	Contact - Telephone call made Telephone call made to POA C2. Left a message.
06/12/2026	Contact - Telephone call received Telephone call received from POA C1 and POA C2
06/15/2026	Contact - Telephone call made Comfort Care hospice nurse, Melissa Alsobrooks

06/16/2026	Contact - Telephone call made Telephone call made to Relative D1
06/16/2026	Contact - Telephone call made Telephone call made to staff, Clare McManus
06/16/2026	Contact - Telephone call made Telephone call made to staff, Dayona Dell
06/16/2026	Contact - Telephone call made Telephone call made to staff, Elizabeth Bada
06/16/2026	Contact - Telephone call made Telephone call made to staff, Nichole Davis
06/17/2026	Contact - Face to Face Observed Resident D in her current facility
06/17/2026	Contact - Document Received Received verification of staff medication administration training
06/23/2026	Contact - Telephone call made Telephone call made to Comfort Care hospice nurse, Melissa Alsobrooks. Left a message.
06/23/2026	Contact - Document Received Received a copy of Resident C's assessment plans
06/24/2026	Contact - Document Received Received email from Comfort Care hospice nurse, Melissa Alsobrooks
07/24/2026	Exit Conference Held with licensee designee Deborah Waldo

ALLEGATIONS:

- **Resident D slept in a chair with no pants on.**
- **Resident D did not have sheets on her bed.**
- **Resident D was left in her own filth, and she was soiled down to her socks.**

INVESTIGATION:

On 06/10/2026, I received allegations from Adult Protective Services (APS).

On 06/11/2026, I conducted an unannounced onsite investigation. I interviewed licensee designee Deborah Waldo and staff, Sarah Brown. I observed Resident C. I was unable to interview Resident C due to her limited cognitive abilities.

Ms. Waldo denied Resident D sleeps in a chair. Per Ms. Waldo, there was an incident where Resident D urinated through her sheets, and she was soiled down to her socks. Staff, Clare McManus took the pants off Resident D, cleaned her up and sat her in her chair. Ms. McManus also took the linen off Resident D's bed to clean it. Resident D fell asleep in the chair. Emergency medical services (EMS) transported Resident D to the hospital for an evaluation that day. Ms. Waldo did not state when this incident occurred. Ms. Waldo stated Resident D was discharged from the facility. She did not state the reason she was discharged.

Ms. Brown confirmed the allegations. On Ms. McManus' shift, Resident D slept in a chair with no pants on. She soiled herself as well as her sheets. Ms. Brown stated she was the manager on call that day, but she was not physically in the facility. Ms. McManus contacted her, and EMS transported Resident D to the hospital. Ms. Brown did not provide any other details regarding that incident.

At the time of the onsite investigation, Resident D no longer lived in the facility. I was unable to observe her bedroom and her bedroom furnishings.

On 06/16/2026, I conducted a telephone interview with Relative D1. She denied Resident D slept in a chair. She denied that Resident D was left soiled and did not have sheets on her bed. She denied knowledge of Resident D not being properly cared for. She stated she used to pop up at the facility unannounced and did not observe any concerns. In addition, she stated Resident D was verbal when she lived in the facility. If something was occurring that she did not like, she would have said something. Relative D1 confirmed EMS transported Resident D to the hospital. When she was ready to be discharged from the hospital, it was recommended that she had two people to assist with her care needs. As a result, Resident D was discharged from the facility and went to another licensed adult foster care facility that could meet her care needs.

On 06/16/2026, I conducted a telephone interview with staff, Clare McManus. Ms. McManus confirmed Resident D fell asleep in a chair with no pants on. Per Ms. McManus, Resident D kept urinating and soiled herself. She took her pants off to wash them. She also took the sheets off her bed to wash them. Ms. McManus cleaned Resident D as well. EMS transported Resident D to the hospital later that day for an evaluation. Ms. McManus could not recall the date of the incident.

On 06/16/2026, I conducted a telephone interview with staff, Dayona Dell. She stated she heard about an incident with Resident D, but she did not work the day of the incident. Ms. Dell did not state what she heard about the incident.

On 06/16/2026, I conducted a telephone interview with staff, Elizabeth Bada. She denied knowledge of Resident D sleeping in a chair with no pants on, being left soiled down to her socks and not having sheets on her bed.

On 06/16/2026, I conducted a telephone interview with staff, Nicole Davis. She confirmed Resident D was in a chair with no pants on. Resident D also did not have a pillow or blanket on her bed. EMS transported Resident D to the hospital that day for an evaluation. Ms. Davis did not report the date of the incident or provide any additional details about the incident.

On 06/17/2026, I observed Resident D in her current facility. I was unable to interview her due to her limited cognitive abilities.

On 07/22/2026, I conducted a follow-up call with Ms. Waldo. She confirmed Resident D had a bed while living in the facility. Ms. Waldo stressed that Resident D did not regularly sleep in the chair. On the day in question, Resident D soiled her sheets and was transferred to the chair to allow staff to wash her linen. Resident D fell asleep in the process. This was not a regular occurrence.

APPLICABLE RULE	
R 400.661	**Bedroom furnishings.**
	(1) Bedroom furnishings must include all of the following: (a) A bed that is not less than 36 inches wide and not less than 72 inches long with a foundation that is clean, in good condition, and provides adequate support.
ANALYSIS:	Resident D was transferred from her bed to a chair to allow staff to wash her sheets. Resident D fell asleep in the chair. Relative D1 denied that Resident D slept in a chair. Ms. Waldo stated Resident A had a bed when she lived in the facility. At the time of the inspection, Resident D no longer lived in the facility. I was unable to observe her bedroom and her bedroom furnishings. Evidence supports that Resident D's bedroom consisted of a bed when she lived in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following:

	(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.
ANALYSIS:	Resident D urinated on her sheets. Ms. McManus took her sheets off her bed to wash them. Relative D1 denied Resident D did not have sheets on her bed. She stated she used to pop up at the facility unannounced and did not observe any concerns. Evidence supports the licensee provided clean bedding in good condition to Resident D.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(2) A licensee shall ensure the resident receives or has access to all of the following: **(c) Assistance with resident hygiene as needed.**
ANALYSIS:	Resident D was soiled down to her socks. Ms. McManus cleaned Resident D. Relative D1 denied that Resident D was left soiled. She denied knowledge of Resident D not being properly cared for. She stated she used to pop up at the facility unannounced and did not observe any concerns. Evidence supports the licensee ensured the resident received assistance with resident hygiene as needed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C is bedridden, but staff forced her to be in a wheelchair.

INVESTIGATION:

On 06/11/2026, I conducted an unannounced onsite investigation. I interviewed licensee designee, Deborah Waldo, and staff, Sarah Brown.

Ms. Waldo denied Resident C is bedridden. She denied that staff are forcing Resident C to get in her wheelchair. She stated Resident C has Dementia, and staff are getting her out of bed as tolerated.

Ms. Brown stated Resident C is bedridden. Ms. Waldo is instructing staff to get Resident C out of bed daily and put her in her wheelchair.

On 06/12/2026, I conducted a telephone interview with POA C1 and POA C2. They denied knowledge of Resident C being bedridden, and her being forced to get in her wheelchair daily. POA C1 stated he saw a video of Resident C yesterday where she was sitting in her wheelchair and laughing. POA C2 stated she did not have any concerns regarding the care Resident C received in the facility.

On 06/15/2026, I conducted a telephone interview with Comfort Care hospice nurse, Melissa Alsobrooks. Ms. Alsobrooks stated several staff informed her that Ms. Waldo did not want Resident C to be in bed all day. Per Ms. Alsobrooks, Resident C was bedridden. However, she could be transferred to a wheelchair if there were two staff available to transfer her.

On 06/16/2026, I conducted a telephone interview with staff, Clare McManus. She stated Resident C is bedridden. When she worked, she usually did not put Resident C in her wheelchair. She denied knowledge of other staff forcing Resident C to be in her wheelchair.

On 06/16/2026, I conducted a telephone interview with staff, Dayona Dell. She stated Resident C is always in her bed. She was never in her wheelchair.

On 06/16/2026, I conducted a telephone interview with staff, Elizabeth Baba. She denied knowledge of staff forcing Resident C to be in her wheelchair.

On 06/16/2026, I conducted a telephone interview with staff, Nicole Davis. She stated Resident C is not bedridden. She denied forcing Resident C to be in her wheelchair.

On 06/23/2026, I reviewed a copy of Resident C's assessment plan, initially dated and signed by Ms. Waldo and POA C1 on 10/31/2025. Resident C did not use an assistive device. There was no documentation that she was bedridden. Ms. Waldo completed a resident assessment and plan update on 06/01/2026. Per the plan update, Resident C was receiving hospice services and utilizing a hospital bed as recommended by hospice. She was also encouraged to use assistive devices as tolerated. There was no documentation that Resident C was bedridden. The assessment plan did not specify that Resident C required two staff to transfer her to her wheelchair. Resident C's assessment plan did not document all her care needs.

APPLICABLE RULE	
R 400.671	**Resident care.**

	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. **A written assessment plan must include all of the following:** **(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.**
ANALYSIS:	Ms. Alsobrooks stated several staff informed her that Ms. Waldo did not want Resident C to be in bed all day. Per Ms. Alsobrooks, Resident C was bedridden. However, she could be transferred to a wheelchair if there were two staff available to transfer her. I reviewed a copy of Resident C's assessment plan, initially dated and signed by Ms. Waldo and POA C1 on 10/31/2025. Resident C did not use an assistive device. There was no documentation that she was bedridden. Ms. Waldo completed a resident assessment and plan update on 06/01/2026. Per the plan update, Resident C was receiving hospice services and utilizing a hospital bed as recommended by hospice. She was also encouraged to use assistive devices as tolerated. There was still documentation that Resident C was bedridden. The assessment plan did not specify that Resident C required two staff to transfer her to her wheelchair. Resident C's assessment plan did not document all her care needs. Evidence supports that Resident C's assessment plan did not include the amount of personal care, supervision, and protection required by the resident that is available at the facility. Not updating a resident assessment plan jeopardizes resident care, treatment and protection because the licensee is unable to determine the resident's needs and the ability to provide adequate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Staff have not administered Resident C's medications as prescribed.**
- **The facility has a lot of medication errors.**

INVESTIGATION:

On 06/11/2026, I conducted an unannounced onsite investigation. I interviewed licensee designee, Deborah Waldo and staff, Sarah Brown.

Ms. Waldo stated Resident C is administered medications as prescribed unless she refuses them. Per Ms. Waldo, Resident C refuses medications by closing her mouth when staff tries to give them to her. There have been times when staff have tried to give Resident C her medications three to four times, and Resident C refused to open her mouth each time. Ms. Waldo acknowledged that there have been medication administration errors in the past, but she is now at the facility each shift to reinforce training and make sure the medications are administered properly. Ms. Waldo stated all staff who administer medications have been trained to do so.

Ms. Brown did not wish to discuss the residents' medications. She instructed me to look at the residents' medications, and the medication administration records (MARs). In addition, she stated only her and staff, Nicole Davis have been trained to administer medications.

While at the facility, I reviewed Resident A's, Resident C's, Resident E's, and Resident F's June medications and June MARs. I observed the following:

Resident A:

- Per the MAR, staff administers Resident A Venlafaxine 7.5mg daily at 8am. Per the bottle, Resident A is prescribed Venlafaxine 15mg daily.
- Staff did not administer Venlafaxine 7.5mg, Atorvastatin 40mg, and Clopidogrel 75mg at 8am on 06/11/2026.

Resident C:
Except for Haldol 1mg, all of her medications are being held. She is prescribed Haldol 1mg 2 tabs every 4 hours even if she is asleep. Per the MAR, staff administered the medication to Resident C as prescribed at 8am, 12pm, 4pm, 8pm, 12am, and 4am from 06/01/2026 to 06/10/2026 except on the days she refused the medication. Resident C refused the medication at 4pm from 06/06/2026 to 06/08/2026, at 8pm on 06/06/2026, at 12am and 4am on 06/05/2026 and 06/06/2026. Staff administered the medication at 8am, 12pm, 4pm, 8pm, 12am, and 4am from 06/01/2026 to 06/10/2026.

Per the PRN log, staff administered Haldol 1mg in June at the following dates and times:

- 1 tab at 9am on 06/01/2026
- 2 tabs at 2pm on 06/01/2026
- 1 tab at 3pm on 06/01/2026
- 2 tabs at 9:40pm on 06/01/2026
- 2 tabs at 9:30am on 06/02/2026
- 2 tabs at 2:45pm on 06/04/2026
- No other administration dates and times were documented

Resident E:

- Staff initialed the MAR to show administration of Simvastin 20mg, Sertraline 100mg, Vitamin D3, Cranberry and Stool Softener at 8am on 06/11/2026. I observed Ms. Brown administer these medications to Resident E at 11am on 06/11/2026.

Resident F:

- Staff did not initial the MAR to show administration of Hydrocodone 7.5 325tab at 12am and 4am on 06/08/2026 and 06/09/2026.

On 06/12/2026, I conducted a telephone interview with POA C1. He confirmed it was discovered that staff were not administering medications to Resident C as prescribed, but hospice caught the error. Hospice also instructed staff to administer Resident C's medications to her as prescribed. POA C1 did not specify who from hospice caught the error or which staff were instructed to administer the medications properly.

On 06/15/2026, I conducted a telephone interview with Comfort Care hospice nurse, Melissa Alsobrooks. Ms. Alsobrooks stated Ms. Waldo instructed staff not to administer Resident C's medications to her and not to tell her. When she learned about that, Ms. Alsobrooks started making daily visits to the facility. She observed medications not being logged, medications not being properly administered as well as extra pills in the pack. She approached Ms. Waldo about what she observed, and Ms. Waldo could not provide an explanation.

On 06/16/2026, I conducted a telephone interview with staff, Clare McManus. She stated she used to administer medications, but she stopped a couple of months ago. Now, Ms. Waldo administers medications to the residents. Ms. McManus acknowledged there were medication administration errors in the past, but she did not have any details about the errors. Per Ms. McManus, all staff who administer medications have been trained to do so.

On 06/16/2026, I conducted a telephone interview with staff, Dayona Dell. She stated she has completed medication administration training, and she currently administers medications in the facility. She stated she administers medications as prescribed. Ms. Dell denied knowledge of any medication administration errors in the facility.

On 06/16/2026, I conducted a telephone interview with staff Elizabeth Bada. She stated she has completed medication administration training. She stated staff administer medications as prescribed. Ms. Bada denied knowledge of any medication administration errors in the facility.

On 06/16/2026, I conducted a telephone interview with staff, Nicole Davis. She stated she administered Resident C's medications to her at 12am and 4am. Ms. Davis denied knowledge of any medication administration errors.

On 06/17/2026, I received verification that Ms. Brown, Ms. Dell, Ms. Bada, Ms. McManus, staff, Brendstaff, Shayla Adams, staff, Chinarah Bow, staff, Latrece McGee as well as staff, Anderson Colburn completed medication administration training.

On 06/24/2026, I received two emails from Comfort Care hospice nurse, Melissa Alsobrooks. She stated the following in the emails:

- Based on the medication count and the physician orders, Haldo was withheld from Resident C from 12pm on 06/02/2026 until 12am on 06/03/2026. Resident C went 12 hours without the scheduled medication. Medication was withheld again starting at 7am on 06/03/2026 until the nurse arrived around 1pm.
- Pill count showed medications were withheld again starting at 12pm on 06/05/2026 through the nurse visit at 1pm. Resident C went 12 hours without the scheduled medication.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Per the MAR, staff administers Resident A Venlafaxine 7.5mg daily at 8am. Per the bottle, Resident A is prescribed Venlafaxine 15mg daily. In addition, staff did not administer Venlafaxine 7.5mg, Atorvastatin 40mg, and Clopidogrel 75mg to Resident A at 8am on 06/11/2026. Resident C is prescribed Haldol 1mg 2 tabs every 4 hours even if she is asleep. Per the PRN log, staff did not administer the medication to her as prescribed. Staff did not initial the MAR to show administration of Hydrocodone 7.5 325tab to Resident F at 12am and 4am on 06/08/2026 and 06/09/2026. Per Ms. Alsobrooks' email, Haldo was withheld from Resident C from 12pm on 06/02/2026 until 12am on 06/03/2026. Resident C went 12 hours without the scheduled medication. Medication was withheld again starting at 7am on 06/03/2026 until the nurse arrived around 1pm. In addition, pill count showed medications were withheld again starting at 12pm on 06/05/2026 through the nurse visit at 1pm. Resident C went 12 hours without the scheduled medication.

	Evidence supports medication was not given, taken or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. Renewal Licensing Study Report, 05/13/2026. CAP, 05/27/2026.**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Ms. Davis stated she administered Resident C's medications to her at 12am and 4am. During this investigation, I did not receive verification that Ms. Davis completed medication administration training. Evidence supports Ms. Davis was not trained in the proper handing and administration of medication. Lack of medication training when caring for residents can jeopardize the risk and safety of the residents and lead to a serious range of negative physical outcomes.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) Initials of the individual who administered the medication at the time given. **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	Per the MAR, staff administers Resident A Venlafaxine 7.5mg daily at 8am. Per the bottle, Resident A is prescribed Venlafaxine 15mg daily. In addition, staff did not administer Venlafaxine 7.5mg, Atorvastatin 40mg, and Clopidogrel 75mg to Resident A at 8am on 06/11/2026. Staff initialed the MAR to show administration of Simvastin 20mg, Sertraline 100mg, Vitamin D3, Cranberry and Stool Softener to Resident E at 8am on 06/11/2026. I observed Ms. Brown administer these medications to Resident E at 11am on 06/11/2026. Staff did not initial the MAR to show administration of Hydrocodone 7.5 325tab to Resident F at 12am and 4am on 06/08/2026 and 06/09/2026. Evidence supports that a licensee, administrator, or direct care staff did not complete the MAR when they supervised the taking of medication by a resident.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. SIR 2026A0901002, CAP, 12/15/2025.** **Renewal Licensing Study Report, 05/13/2026. CAP, 05/27/2026.**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/11/2026, I conducted an unannounced onsite investigation. I attempted to verify compliance with the corrective action plan submitted and approved on 05/27/2026. I observed the following:

- The smoke detector in the heat plant room was not functional.
- The door to the heat plant room was not positive latching.

On 07/22/2026, I conducted a follow-up telephone interview with Ms. Waldo. She stated she hired someone to repair the heat plant room door, but it is still not positively latching. I conducted the exit conference and informed her of the findings. Ms. Waldo acknowledged there have been several medication administration errors. She has been

actively working with staff to correct the errors. Ms. Waldo stated she agreed with the recommendation of a provisional license.

APPLICABLE RULE	
R 400.727	**Smoke detection equipment for family home and small group home with 6 or less residents after March 27, 1980.**
	1) At least 1 single battery-operated smoke alarm must be installed in the following locations: **(b) On each occupied floor, in the basement, and in areas of the facility that contain flame- or heat-producing equipment.**
ANALYSIS:	The smoke detector in the heat plant room was not functional.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. Renewal Licensing Study Report, 05/13/2026. CAP, 05/27/2026.**

APPLICABLE RULE	
R 400.731	**Flame-producing equipment; enclosures.**
	2) Heating plants and other flame-producing equipment located on the same level as the residents must be enclosed in a room that is constructed of material that has a 1-hour-fire-resistance rating and has a door made of 1-3/4-inch solid core wood. The door must be hung in a fully stopped wood or steel frame and must be equipped with an automatic self-closing device and positive-latching hardware.
ANALYSIS:	The door to the heat plant room was not positive latching.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. Renewal Licensing Study Report, 05/13/2026. CAP, 05/27/2026.**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend a six-month provisional license.

07/24/2026

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:

07/30/2026

Ardra Hunter — Date
Area Manager