



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 8, 2026

Nichole VanNiman
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS330392259
Investigation #: 2026A0007035
Beacon Home at Leslie

Dear Nichole VanNiman:

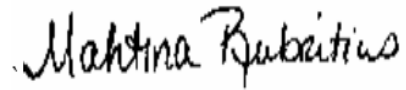
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

Sincerely,

A handwritten signature in black ink that reads "Mahtina Rubritius". The script is cursive and fluid, with the first name "Mahtina" being more prominent than the last name "Rubritius".

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

THIS REPORT CONTAINS QUOTED DEROGATORY LANGUAGE AND QUOTED PROFANITY.

I. IDENTIFYING INFORMATION

License #:	AS330392259
Investigation #:	2026A0007035
Complaint Receipt Date:	07/13/2026
Investigation Initiation Date:	07/15/2026
Report Due Date:	09/11/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Leslie
Facility Address:	4066 Oak Road Leslie, MI 49251
Facility Telephone #:	(517) 878-6200
Original Issuance Date:	05/21/2018
License Status:	REGULAR
Effective Date:	11/21/2024
Expiration Date:	11/20/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
There is a resident (Resident A) in the facility who keeps attacking herself and others. The resident has wrapped things around her neck and tried to cut herself.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/13/2026	Special Investigation Intake - 2026A0007035
07/15/2026	Special Investigation Initiated - On Site - Unannounced Face to face contact with Beth Pierce, Administrative Staff, Danyel Baldwin, DCW, Emily Sturgill, DCW, Resident A, Resident B, Resident C, Resident D, Resident E, and representatives from CEI-CMH and Environmental Health.
07/16/2026	Contact - Telephone call received from Individual #1. Discussion.
07/16/2026	Contact - Telephone call made - Interview with Resident B.
08/10/2026	Contact - Document Sent- Email to LaShanda Walker, ORR.
08/10/2026	Contact - Telephone call received from LaShanda Walker, ORR. Discussion.
08/25/2026	Contact - Telephone call made to Resident B. Follow-up Interview.
08/28/2026	Contact - Telephone call made to Brooke Landis, Program Director, East Region. Discussion and Documents requested.
08/31/2026	Contact - Document Received BTP (Behavioral Consulting Services #1).
08/31/2026	Contact - Telephone call made to Chantel Soto, DCW. Interview.
08/31/2026	APS Referral made.
08/31/2026	Contact - Telephone call made to Danyel Baldwin, DCW. Message left. Return phone call requested.

08/31/2026	Contact - Telephone call received from Danyel Baldwin, DCW. Follow-up.
08/31/2026	Contact - Document Received- Staff Schedule & BTP (CEI-CMH)
08/31/2026	Contact - Telephone call made to Resident B. Follow-up Interview.
09/03/2026	Contact - Telephone call made to Brooke Landis, Program Director. Discussion.
09/03/2026	Contact - Document Sent - Email to Nichole VanNiman, Licensee Designee, regarding conducting the exit conference.
09/04/2026	Exit Conference conducted with Nichole VanNiman, Licensee Designee.

ALLEGATION: There is a resident (Resident A) in the facility who keeps attacking herself and others. The resident has wrapped things around her neck and tried to cut herself.

INVESTIGATION:

On July 15, 2026, I conducted an unannounced on-site investigation and made face to face contact with Beth Pierce, Administrative Staff, Danyel Baldwin, direct care worker (DCW), Emily Sturgill, DCW, Resident A, Resident B, Resident C, Resident D, Resident E, and representatives from CEI-CMH and Environmental Health. When I arrived, it was noted that Cheyenne Wilcox from Environmental Health was there conducting an inspection and Beth Pierce was meeting with CEI-CMH case management. Resident A was walking around the facility.

I interviewed Danyel Baldwin, DCW, who informed me that Resident A was trying to hurt herself and her behaviors are addressed in her *Behavioral Treatment Plan* (BTP). Danyel Baldwin recalled that last week (July 8, 2026) Resident A was squeezing her neck with her own hands until her lips turned blue. Resident A also pinched her right eyelid with her glasses and informed staff, while laughing, that they couldn't take her glasses away from her or she would call Recipient Rights. Everything had been removed from her room, and her glasses were all she had left. Danyel Baldwin informed me there were two incident reports written regarding these behaviors. She informed me that there was an incident in which Resident A went after Resident C, stating she was going to kill her. Danyel Baldwin was trying to safeguard Resident C by blocking the door and in the process her finger was injured. Danyel Baldwin informed me that according to Resident A's team she does not receive 1:1 staff supervision.

On July 16, 2026, I interviewed Resident B via telephone. I inquired about how she got along with Resident A. She informed me that Resident A demands attention from the staff and if they ask her to hold on, she'll start choking herself or will attack other residents. Resident B recalled there was an incident about two weeks prior, in which Resident A came after her, and she had to contact law enforcement. Resident B stated that Resident A said to her that she hoped she died. Resident B also recalled that Resident A hurt Danyel Baldwin's finger (DCW), during an incident. Resident B stated that Resident A was doing good now. Resident A told her (Resident B) that she wasn't on her right medications, but she was doing good now. Resident B also informed me that Resident A tried to cut herself with a butter knife and a hanger, so staff had to lock everything up.

As a part of this investigation, I reviewed three incident reports, and the following information was noted:

On July 7, 2026, at 12:50p.m., it was documented that there was an incident involving Resident A. Resident B was listed as another person involved or a witness. Kyja Bently, who has the role of home manager, documented that staff were in the office talking with the nurse. Resident A came out of her room with a scarf around her neck. The housemate reported to staff that Resident A was choking herself. Staff approached Resident A and asked for the scarf, and she gave it to them. The action taken by staff included staff asking for the scarf, and Resident A gave the scarf to staff. It was also noted that staff completed a room sweep, as documented in *Behavior Treatment Plan* for Resident A.

I reviewed the second incident report, regarding Resident A. Resident C, Resident D, and Resident F were listed as other persons involved or witnesses to the incident. Danyel Baldwin documented that on July 8, 2026, at 7:15 a.m., "Resident A] was agitated when staff arrived, and asked staff if they could speak with her after shift change. Staff replied "yes, after shift change" as staff was wrapping up [Resident A] came out and said it's important we speak NOW, staff said "come on out [Resident A], we're almost finished if u want to stand by the van, then we can talk. [Resident A] said "NO" and slammed the door. Another resident came out right after and said that [Resident A] was using a butter knife to cut herself. Staff came in and night shift went to her room to take out all dangers while the day shift staff focused on [Resident A]. [Resident A] handed the knife to the CTM then went to her room. Staff cleared out anything she could self-harm with then night shift left and [Resident A] had settled. Staff was in the med room preparing morning meds and 2nd staff had left with another resident for their appt when [Resident A] came out of her room and approached a housemate saying "look what I did to my eye and I did it with my glasses bc [because] they aren't allowed to take those from me." The housemate responded, "I don't care" and went to her room. [Resident A] started screaming "you fucking bitch I'll kill you" then started pounding in the door, when there was no response to the pounding [Resident A] started kicking the door standing backwards to get more force. Staff guided [Resident A] away as we headed into

the living room [Resident A] saw a different housemate on the phone and started screaming at the housemate "you have 10 min to get off the phone I want to use it" staff told [Resident A] that's not a respectful way to speak to our housemates and [Resident A] stated she doesn't care, and she's going to call her mom even though she knows her mom won't answer this early just so the housemate has to get off the phone. [Resident A] got up and headed down the hall and started pounding on the housemate's door saying "I want my call give me the damn phone" staff intervened and told [Resident A] it hasn't been 10 min, and you have to respect her time while she is on the phone. [Resident A] walked away from that housemate's door and went back to the other one and started banging on it screaming "I'm going to kill you [Resident C]!" staff said [Resident A] you have to stop why don't we come out here and finish taking meds. [Resident A] acted like she was going to walk away with staff but after exiting the hallway [Resident A] turned around and ran full force into the housemate's door. There was a loud crack and the door bulged. [Resident A] then went out the door and left the property, she got almost out of sight before she turned and came back stating she was going to wait for a car to hit her. [Resident A] then came back inside and went right to the 1st housemate's door and started banging on it again after not getting a response she went back into the living room and started trying to pull pictures off the wall and she saw staff walk by with another residents food and she charged staff and had them pinned to the wall with her forearm and her other first [fist] drawn back saying "I'm going to punch you! do you want me to punch you?" That is when a separate housemate grabbed [Resident A's] hand and pulled her off staff, [Resident A] stumbled back a little then turned and ran out the door, by this time staff had started calling 911. [Resident A] again left the property, got halfway down to Kinneville Rd and laid down in the middle of the street. [Resident A] laid there and refused to get up traffic was stopped on both sides of the street. After about 15 min [Resident A] got up and walked back to the house, sat in the swing and the police arrived. Somewhere in all of that staff's right hand pointer finger was injured." Danyel Baldwin documented that she followed Resident A's BTP to the best of her capabilities.

I reviewed a third incident report involving Resident A.

Resident B was listed as another person involved or a witness. It was noted that on July 9, 2026, at 3:45 a.m., Chantel Soto, DCW, observed Resident A coming out of her bedroom. Resident A started saying words and threatening to harm herself and others. Staff documented that they were not able to calm Resident A down, so they contacted emergency services.

As a part of this investigation, I reviewed the *Behavior Treatment Plan* (BTP) for Resident A. It was documented that Resident A "Is a 40-year-old female diagnosed with Bipolar I, ADHD, Borderline personality disorder, intellectual developmental disorder (mild), and Autism Spectrum Disorder. She is additionally diagnosed with Diabetes mellitus due to underlying condition without complications, other seizures, and other specified hypothyroidism. She was referred to [Behavior Consulting Services #1] for threats of self-harm, self-harm, suicidal ideation, verbal aggression,

physical aggression, elopement, and property destruction.” The BTP addressed these target behaviors.

The following Reactive Strategies were also documented in the plan:

“In response to verbal aggression, aggression, and/or property destruction at any time:

1. Remove and/or secure any item that has been threatened to be used for aggression. This includes sharp objects or objects that could easily be broken into sharp objects.
2. Encourage other consumers to distance themselves from [Resident A] in accordance with their rights.
3. Do not engage with [Resident A] or attempt to de-escalate.
4. Step back and monitor for safety.
 - a. If [Resident A] uses her FCT phrase (i.e., “Can I talk to you?”) honor this immediately.
 - b. If [Resident A] appropriately asks in the immediate absence of target behavior for an available item, honor that request and discontinue this strategy.
 - c. If [Resident A] asks for an item in conjunction with problem behavior, tell her one time that she needs to show safe behavior before you can help her with that.
 - d. If at any point [Resident A] requests an item that is not available, let her know it is not available and she can make a different choice.
5. If [Resident A] does not have target behavior for 2 minutes, discontinue this strategy.

In response to self-harm, threats of self-harm, suicidal ideation or attempts at any time:

1. Take steps necessary to ensure safety and remove any objects that have been threatened to be used in self-injury or a suicide attempt or that may be utilized to act upon the ideation or self-harm. This includes sharp objects, objects that could easily be broken into sharp objects, and potentially toxic items. This may include removing these items from the environment for up to 24 hours if they are still deemed a safety concern.
2. Only if necessary, engage with her in a neutral sympathetic and compassionate tone; do not offer additional items, objects, activities, or program modifications that would not be typically available.
3. Provide the level of monitoring necessary for safety.

4. If at any point she uses common FCT phrases (“Can I talk to you?”) engage with her immediately.
5. Remind [Resident A] of the DRO/DRA program.
6. Once staff are certain [Resident A] is de-escalated and safe, normal level of monitoring and typical interactions with her can resume. Do not discuss the incident with [Resident A].
7. Prevent [Resident A] from accessing unsupervised areas, including the community in which implements of self-harm may be present (e.g., her bedroom) for 24 hours. [Resident A] can access these areas following a room search to ensure the absence of implements of self-harm (see restrictive strategies).

In response to elopement at any time:

1. If [Resident A] attempts to leave the property without staff supervision, staff will follow as staffing ratios allow and verbally redirect her to either sign out for a walk (if available) or return to the designated area.
2. If [Resident A] has engaged in other target behaviors in the last hour and/or is on emergency supervision (i.e., does not have access to ICA), staff will attempt to follow [Resident A] and implement agency policies regarding Resident Absent without Leave (BSLS Policy #CTS-026).
3. If at any time staff cannot find [Resident A] in the home and she is not on an independent walk, they will search the home and implement agency policy regarding Resident Absent without Leave...

Restriction of Personal Property (self-harm).

Due to [Resident A's] recent history of self-harm, suicidal attempts, and specific threats of suicidal behaviors, she should not have possession of the following items at any time:

1. Sharps, including razors (unless for shaving purposes and should be supervised at all times), glass objects such as figurines, picture frames not secured to the wall, light bulbs not affixed to the ceiling and/or installed by Beacon staff.
 - b. All knives should be locked and out of [Resident A's] immediate reach. [Resident A] can use a butter knife or other safety knife to cut food, however once she is done, she should return it to staff. She should not be given a knife in an agitated state.
 - c. Lighters, matches or any objects/materials that could start a fire.

d. If [Resident A] is in possession of these items or making threats of self-harm staff may complete a room search per MDHHS rules.”

On August 25, 2026, I spoke with Resident B. She stated that Resident A has called her names including the “N word” and “[Color] trash.” Resident A has held a fork to her [Resident A] neck. According to Resident B, Resident A has also banged on her bedroom door. Staff were aware and also contacted Brooke Landis regarding the matter.

On August 28, 2026, I spoke with Brooke Landis, Program Director, we discussed the pending investigation, and she stated there was also a recent incident. I requested additional information be submitted.

On August 31, 2026, I interviewed Chantel Soto, DCW, as I had some follow-up questions regarding the incident that occurred on July 9, 2026, (and documented on the incident report). She stated that she and Resident B were at the table playing cards when Resident A came out of her room yelling and cursing. Chantel Soto attempted to redirect her, but she kept yelling and cursing. Resident B went outside on the porch. Chantel Soto contacted emergency services. She informed me that once the police and emergency services arrived, they ended up strapping Resident A down and taking her to the hospital. Chantel Soto informed me that the sharp knives were locked up but the butter knives were not.

On August 31, 2026, I spoke to Danyel Baldwin, (previous) DCW. I inquired if Resident A physically harmed herself when she attempted to cut herself with the butter knife during the incident on July 8, 2026, and she informed me that she did not. She informed me that butter knives are generally not locked up, but anything sharper is safeguarded. Danyel Baldwin stated that Resident A got the butter knife out of the drawer. She also informed me that they had just finished breakfast when the incident occurred. She informed me that she left and no longer works for the facility.

On August 31, 2026, I spoke with Brooke Landis, Program Director. I informed her that I reviewed the BTP for Resident A. I inquired if the butter knives were to be locked up and she stated that generally, they were not, unless they had a resident that is suicidal. If that is the case, they will contact clinical, and they will have the butter knives locked up for the time being. I reviewed the information as documented in Resident A’s plan and she agreed that based on her plan, the butter knives should be locked up. She stated that she would contact the home manager to ensure they were locked up, if they were not already. We also discussed another incident which occurred on August 25, 2026, in which Resident A had a cable cord wrapped around her neck and a resident went to tell staff. She was not sure how Resident A got the cable cord. Brooke Landis informed me that Resident A was taken to the hospital and evaluated. She assisted and coordinated with CEI-CMH. Brooke Landis informed me that she was not sure if there were any changes to the supervision levels for Resident A; however, clinical had safety planned for when she returned to the facility.

I reviewed the incident and the following was noted:

On August 25, 2026, at 11:35 a.m. Journie Parker documented that “[Resident A] became upset after an argument with another resident. [Resident A] began making threats of injecting her insulin into her heart during medication pass. [Resident A] took a butter knife from the kitchen and stated she was going to put the butter knife in the outlet. Staff were able to get the butter knife from [Resident A]. [Resident A] went to her room and staff checked on her frequently. [Resident A]'s roommate came out and notified the staff that she had a charger cord wrapped around her neck. Staff prompted [Resident A] to give staff the cord. Three other staff came into the room and were able to get the cord from around her neck. [Resident A]'s face and lips were blue and her neck had markings. Staff called emergency services and requested paramedics. Clinical was contacted and instructed a room sweep to be conducted to ensure the health and safety of [Resident A]. After being evaluated by EMS, she was then transported to McLaren Hospital.” The actions taken by staff included removing the cord from [Resident A's] neck. Staff monitored until EMS and police arrived. Staff called clinical and were told to do a room sweep.”

As a part of this investigation, I also reviewed the CEI-CMH Behavioral Treatment Plan.

It was noted that Resident A reported the following (in relevant part) regarding her hopes and dreams:

“[Resident A] would like to have "no hospitalizations in six months." She says she wants to volunteer. [Resident A] said she has to go six months without behaviors in order to work at the behavior hospital. "I want to work on going for longer walks." "I want to get a cell phone." [Resident A] stated that she needs to work on "not saying "N" word and "R" word...." [Resident A]'s team would like to see [Resident A's] mental health return to baseline.”

It was also noted that “On 3/20/26, the Behavior Treatment Review Committee continued to recommend that supervision in the home be increased to 15-minute checks when (when) increased supervision is needed, due to statements or attempts of self-harm or suicidal ideation. [Resident A] has access to personal items and no restrictions on movement when she appears stable and is avoiding self-harm threats and/or actions. When she does threaten self-harm, safety measures are outlined in the BTP to assist [Resident A] in avoiding self-harm. The behavior specialist continues to track targeted behaviors to determine if restrictive or reactive methods can be reduced or eliminated. [Resident A] benefits from monitoring during times when she threatens and/or engages in self-harm. During these times, staff will follow the BTP to determine any actions needed to ensure [Resident A]'s safety. The plan identifies what restrictive strategies should be implemented during these times of increased potential for harm. In addition, if [Resident A] attempts to elope when she is on emergency supervision, the BTP outlines how staff should respond. The plan also identifies

some objects that [Resident A] should not have access to unless under supervision.”

On August 31, 2026, I spoke with Resident B. She stated that Resident A had wrapped a cord around her neck last week and that she went to the hospital for two days. Resident A returned to the facility, and she was in a good mood. According to Resident B, Resident A had questioned if she was getting her medications like she was supposed to; she was unsure. Resident B stated that Resident A's roommate, Resident E, notified staff that Resident A had the cord around her neck. I inquired if the butter knives were locked up and Resident B informed me that they were not, and they were kept with the spoons and forks. However, she stated the sharps were locked up. She also voiced concerns that were addressed by staff.

On September 3, 2026, I spoke with Brooke Landis, Program Director. We spoke regarding the staffing patterns. She stated there were two direct care staff assigned on 1st shift and one on 2nd shift (12-hour shifts). She also informed me that none of the residents were assigned to have 1:1 staff supervision. I inquired about the butter knives being locked up and she informed me that when she first called and spoke with Kaja Bentley, Home Manager, she said the butter knives were not locked up but that she would lock them up that day. Brooke Landis informed me that she went to the facility yesterday (9/2/2026) and observed the butter knives to be locked up. They were being kept in the drawer with the other sharps. I also informed her that there were incidents that involved Resident A using a butter knife, in an attempt to self-harm, and Brooke Landis informed me that she observed that as well. It was noted that the butter knives are now safeguarded.

On September 4, 2026, I conducted the exit conference with Nichole VanNiman, Licensee Designee. We discussed the investigation, the findings, and my recommendations. Nichole VanNiman informed me that after the first incident involving the cord, they've had multiple meetings and working with the clinician. She stated she has known Resident A for many years, she's been on several medications, had several hospitalizations and intervention services. They have been coordinating and working with CMH. They have monitored the situation, evaluating if checks should be completed every ten or fifteen minutes. She questioned what happens the minute after the resident is checked on, as they can't have eyes everywhere. She stated that it was not a 1:1 staffing ratio in that setting. I expressed my concerns to her regarding this situation. Additionally, it was concerning that the residents were having to notify staff of Resident A's behaviors. Nichole VanNiman informed me that Resident A was not at baseline. She also informed me that she would follow up with the team to address these concerns and findings; and would submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based upon my investigation, which consisted of an unannounced on-site investigation, interviews with a resident, direct care staff and administration, and review of relevant documents, it's concluded that there is a preponderance of the evidence to support the allegations that the residents in the home were not kept safe; as there have been incidents in which Resident A has gone after other residents, while making statements that she would harm them. In addition, on three occasions, staff have been notified by other residents in the home that Resident A was attempting to self-harm.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

A review of the BTP, in relevant part, documented that "All knives should be locked and out of [Resident A's] immediate reach. [Resident A] can use a butter knife or other safety knife to cut food, however once she is done, she should return it to staff. She should not be given a knife in an agitated state."

On August 31, 2026, during the interview, Chantel Soto informed me that the sharp knives are locked up but the butter knives were not.

On this same date, Danyel Baldwin stated that the butter knives are generally not locked up, but anything sharper is safeguarded. Danyel Baldwin stated that Resident A got the butter knife out of the drawer.

On August 31, 2026, during the interview with Brooke Landis, I reviewed the information as documented in Resident A's plan; and she agreed that based on her plan, the butter knives should be locked up. She stated that she would contact the home manager to ensure they were locked up, if they were not already.

During the interview with Resident B, I inquired if the butter knives were locked up and Resident B informed me that they were not, and they were kept with the spoons and forks. However, she stated the sharps were locked up.

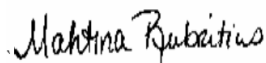
On September 3, 2026, during the interview with Brook Landis, I inquired about the butter knives being locked up and she informed me that when she first called and spoke with Kaja Bentley, Home Manager, she said the butter knives were not locked

up but that she would lock them up that day. Brooke Landis informed me that went to the facility yesterday (9/2/2026) and observed the butter knives to be locked up.

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 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.
ANALYSIS:	Based upon my investigation, which consisted of an unannounced on-site investigation, interviews with direct care staff, a resident, administrative staff and review of relevant documentation, it's concluded that there is a preponderance of the evidence to support the allegations that the interventions specified in Resident A's <i>Behavioral Treatment Plan</i> , which included locking up and safeguarding the butter knives, were not carried out as outlined in the written plan.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of very detailed and acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



09/04/2026

Mahtina Rubritius
Licensing Consultant

Date

Approved By:



09/08/2026

Dawn N. Timm
Area Manager

Date