RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 31, 2017

Teresa Fowler
Meridian Senior Living
Suite 220
PO Box 120143
Grand Rapids, MI 49528-0143

RE: License #:	AL410092341
Investigation #:	2017A0356024
	Alzheimer's Center of W MI #8

Dear Mrs. Fowler:

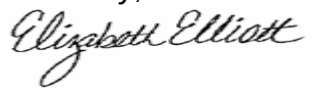
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410092341
Investigation #:	2017A0356024
Complaint Receipt Date:	03/06/2017
Investigation Initiation Date:	03/06/2017
Report Due Date:	05/05/2017
Licensee Name:	Meridian Senior Living
Licensee Address:	Suite 220 PO Box 120143 Grand Rapids, MI 49528-0143
Licensee Telephone #:	(616) 949-9500
Administrator:	Teresa Fowler
Licensee Designee:	Teresa Fowler
Name of Facility:	Alzheimer's Center of W Mi #8
Facility Address:	3948 Whispering Way, SE Grand Rapids, MI 49546-5804
Facility Telephone #:	(616) 949-9500
Original Issuance Date:	12/01/2000
License Status:	REGULAR
Effective Date:	08/07/2015
Expiration Date:	08/06/2017
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct Care Worker came to work under the influence of alcohol.	No
Resident needs are not being met in a timely manner by the direct care workers.	Yes
DCWs eat the residents' food and there is not enough left for the residents.	No
Soiled personal care items are put in the kitchen garbage.	No
Garbage cans are not covered with a lid.	Yes
Medications are not being disposed of in proper manner.	No
There is evidence of bed bug activity in the facility and resident rooms.	No
The facility is not properly staffed.	No
Staff are not properly trained.	No

III. METHODOLOGY

03/06/2017	Special Investigation Intake 2017A0356024
03/06/2017	Special Investigation Initiated - Telephone Complainant.
03/06/2017	APS Referral
03/14/2017	Contact-Telephone call made Complainant
03/20/2017	Contact-Document Received Centralized Intake referral to LARA
03/21/2017	Contact - Telephone call made Kevin Sousser, Kent DHHS APS.
03/26/2017	Inspection Completed On-site Sunday, late afternoon. Interview weekend staff.
03/26/2017	Contact - Face to Face

	DCW, LaTasha Stewart, Shift supervisor, Heather Calvin.
03/26/2017	Contact - Telephone call made Lucijana Tomic, administrator.
04/27/2017	Contact - Document Received
04/27/2017	Contact - Face to Face Heather Calvin, shift supervisor Lucijana Tomic, Administrator.
04/27/2017	Contact - Face to Face Resident Room inspection completed.
05/02/2017	Contact - Telephone call made DCW Tammy Bass.
05/02/2017	Contact - Telephone call made DCW Sierra McHerron
05/09/2017	Contact-Document Received
05/10/2017	Contact - Telephone call made DCW Sierra McHerron (Left voicemail message)
05/10/2017	Contact-Telephone call made Relative #1 & Relative #2 (unable to reach Relative #2, phone disconnected)
05/23/2017	Exit Conference Licensee Designee, Teri Fowler

ALLEGATION: Direct Care Worker came to work under the influence of alcohol.

INVESTIGATION: On 03/06/2017, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint alleging “employees of the facility are coming to work under the influence.” On 03/20/2017, another complaint was filed through the Centralized Intake Unit (CI) alleging that one of the staff members, Tammy (Unknown last name) had been drinking alcohol before she arrived to work on 03/04/2017 and on 03/05/2017. The complainant reported Tammy’s breath smelled of alcohol.

On 03/14/2017, I interviewed the complainant via telephone. The complainant stated Direct Care Worker (DCW) Tammy smelled of alcohol when she showed up late for

her shifts on 03/04/2017 and 03/05/2017. The complainant reported she did not contact a supervisor or administrator to report concerns but did bring it to the attention of DCW LaTasha Stewart.

On 03/21/2017, I interviewed Adult Protective Services Worker, Kevin Sousser, Kent County Department of Health and Human Services. Mr. Sousser stated he investigated the claim that staff Tammy Bass, arrived at work under the influence of alcohol. Mr. Sousser stated he was unable to substantiate this allegation.

On 03/26/2017, I conducted an unannounced inspection on a Sunday morning to interview weekend staff and to see how the facility was operating on a weekend. I interviewed DCW LaTasha Stewart. Ms. Stewart stated she, Ms. Bass and Sierra McHerron worked the weekend of 03/042017-03/05/2017. Ms. Stewart stated Ms. Bass did not appear to be under the influence of alcohol but she did notice that she smelled of what she thought to be alcohol. Ms. Stewart stated she did not question Ms. Bass about drinking but observed her closely. Ms. Stewart stated Ms. Bass was not exhibiting any signs other than smelling of what she thought was alcohol. Ms. Stewart stated Ms. Bass did not stumble, she was not slurring words, and she was not driving erratically as Ms. Stewart saw Ms. Bass arrive and park. Ms. Stewart stated she surmised there could have been a number of reasons why Ms. Bass smelled of alcohol other than having drank alcohol just prior to arriving at work. Ms. Stewart stated had she seen any of the above mentioned signs, she would have sent Ms. Bass home. Ms. Stewart stated Ms. Bass provided good care to the residents on the weekend of 03/04/2017-03/05/2017.

On 03/26/2017, I conducted an unannounced inspection and interviewed shift supervisor, Heather Calvin. Ms. Calvin stated on 03/05/2017, she was notified by Ms. Stewart that Ms. Polk thought Ms. Bass was drunk on the job over the weekend of 03/04/2017. Ms. Calvin stated on 03/06/2017, she spoke to Ms. Bass and obtained a written statement from her regarding the allegations by another DCW that she was drunk on the job over the 03/04/2017 weekend shifts. Ms. Calvin stated Ms. Bass told her (Ms. Calvin) that she was not drunk on the job and she would never come to work drunk because she would not want to jeopardize her job in that way. Ms. Calvin stated no one ever reported to her or anyone else in authority that they suspected a fellow DCW was drunk or smelled of alcohol while working at the facility. Ms. Calvin stated the first she heard of this concern was when Ms. Stewart told her about it on 03/05/2017 after the weekend shifts were done. Ms. Calvin stated she has no knowledge of or experience with Ms. Bass being under the influence or smelling of alcohol while on the job. However; Ms. Calvin stated she did counsel Ms. Bass regarding alcohol use in the work place. Ms. Calvin added there is no reported incidents having occurred over that weekend or since that would indicate Ms. Bass was using alcohol or under the influence of alcohol while at work.

On 03/26/2017, I interviewed Lucijana Tomic, facility Administrator via telephone. Ms. Tomic stated she was not made aware of any concerns regarding staff smelling of alcohol or possibly being under the influence of alcohol while working over the

weekend of 03/04/2017-03/05/2017. Ms. Tomic stated she has no prior reports or knowledge of staff including Ms. Bass working while under the influence of alcohol or any other substances.

On 05/02/2017, I interviewed Ms. Bass via telephone. Ms. Bass stated this allegation "is a lie" and that she has never gone to work under the influence of alcohol and over the weekend shift on 03/04/2017-03/05/2017, she had not been drinking alcohol prior to or during her shifts at this facility. Ms. Bass stated this allegation is not true.

On 05/02/2017, I interviewed Relative #1 via telephone. Relative #1 stated he is at the facility every other day to visit and stated he has not smelled alcohol or noticed any of the DCW's to be under the influence of alcohol while working at the facility.

On 05/23/2017, I conducted an Exit Conference with Licensee Designee, Teri Fowler via telephone. Ms. Fowler stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	The complainant reported Ms. Bass smelled of alcohol while working at the facility on 03/04-03/05/2017. Ms. Stewart reported that Ms. Bass smelled of what she thought was alcohol. Ms. Stewart stated Ms. Bass did not appear to be under the influence of alcohol while on the job. Ms. Stewart did not notify any supervision during the weekend of 03/04-03/05 until the weekend shift was over. Ms. Calvin stated after the weekend shift was complete, she was notified that Ms. Bass smelled of alcohol and/or was under the influence. Ms. Calvin stated Ms. Bass denied using alcohol before or during her shifts and Ms. Calvin counseled Ms. Bass regarding alcohol use in the work place. Ms. Calvin stated there are no reported incidents that occurred over that weekend or since that would indicate that Ms. Bass was using alcohol or under the influence of alcohol while at work. Ms. Bass denies using alcohol prior to or during working at the facility on the weekend of 03/04-03/05/2017.

	Ms. Tomic was not made aware of any concerns regarding staff smelling of alcohol and has no prior reports or knowledge of staff including Ms. Bass working while under the influence of alcohol or any other substances. Relative #1 who visits the facility every other day stated he has not smelled alcohol or noticed any of the DCW's to be under the influence of alcohol while working at the facility. APS Worker, Mr. Sousser stated he was unable to substantiate this allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident needs are not being met in a timely manner by the direct care workers.

INVESTIGATION: On 03/06/2017, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint alleging residents are not being checked on hourly as they are supposed to be and residents are left in soiled briefs for hours. Residents are missing meals because staff do not get them for meals, dried feces was left on a patient bed and clothing for hours. Residents' clothes are soiled and left unwashed in the laundry room. A new resident was left in the same clothes and soiled diapers from some time on Friday 03/03/2017 until Sunday 03/05/2017. The same new resident's clothes were not unpacked or put away until late on Sunday night when he had moved into the facility on Friday. In addition, another new resident slept on the couch in the main area of the facility all night long on his first night at the facility.

On 03/14/2017, I interviewed the complainant via telephone. The complainant stated the allegations made in the complaint are true, Resident A slept through meal time on Saturday, 03/04/2017 and none of the staff woke him up. The complainant stated when Relative #1 arrived to visit with his dad, Relative #1 brought him food and Resident A gulped the food down. The complainant stated Relative #1 said Resident A 'must not like the food here' but in reality, the complainant said, Resident A never got to eat lunch on Saturday 03/04/2017 and so he was very hungry. The complainant stated Resident B arrived on Friday night, 03/03/2017, as a new resident and he slept on the couch in the common area of the facility the entire night. The complainant stated none of the DCWs changed Resident B's briefs until later in the day on Sunday, 03/05/2017, which is completely unacceptable. The complainant stated hourly checks are not being made on the residents, she witnessed dried feces in a patient bedroom and residents' clothes are left soiled and unclean. The complainant Resident B's belongings were not put away in his room until 03/04/2017. Complainant stated Resident C needed a brief change and the DCW assigned to her, Sierra McHerron knew she needed to be changed but left the building and never changed Resident C. The complainant reported Relative #2 was

very upset that Resident C was left in urine soaked briefs and it took 35 minutes before staff assisted with changing Resident C.

On 03/26/2017, I conducted an unannounced inspection and interviewed DCW LaTasha Stewart. Ms. Stewart stated when she arrived to work on Saturday, 03/04/2017, there were 2 new residents, Residents A & B. Ms. Stewart stated she is unsure when Residents A & B actually arrived at the facility because she was not working the days prior to her Saturday shift. Resident A is in her “pod” and so she assisted him with toileting, cleaned him up and changed him on Saturday but did not find him sitting in urine soaked clothes or briefs upon arrival to work that day. Ms. Stewart stated Resident A did eat lunch that Saturday, he was in his room resting and did not want to get up so Ms. Stewart stated she brought him lunch on a tray in his room and he ate in his room. Ms. Stewart stated Resident A ate breakfast, went to his room and went to sleep, she took lunch to him in his room and he also ate dinner. Ms. Stewart confirmed that Relative #1 came in on Saturday and brought food so Resident A ate another time with Relative #1.

Ms. Stewart further stated when she arrived at the facility on 03/04/2017, Resident B was sitting on the couch in the common area of the facility. Ms. Stewart stated he was not sleeping, he did not smell of urine, he did not have urine in his briefs and he is capable of telling staff he is wet and Resident B did not say anything about being wet either. Ms. Stewart stated none of the staff on duty on 03/04/2017 worked on 03/03/2017 so how would anyone know that Resident B slept out in the common area on the couch? Ms. Stewart stated Resident B most likely woke up in his room and came out to the couch as she now knows he does on a daily basis. Ms. Stewart explained that when a resident is new to a dementia unit, it takes time to acclimate to the new surroundings and often residents will stay awake all night or walk around all night, therefore; if Resident B did come out in the night and sit or lay on the couch, staff may have allowed him to do that if that was what helped him. Ms. Stewart stated because Resident B was new to the facility, a shower day had not yet been established so Resident B received a shower on Saturday. Ms. Stewart stated depending on the date Resident B arrived at the facility he may have gone a day or two without a shower but for sure he was showered on 03/04. Ms. Stewart stated she did not see feces on the floor or the toilet in any resident room, there could have been but stated “that is what we are here for, to clean that up!” Ms. Stewart stated all DCW’s are capable of cleaning urine and feces up, which is all part of the job. Ms. Stewart stated the DCW’s conduct 2 hour checks of all residents and toilet residents on a 2 hour basis. Ms. Stewart stated the DCW’s are constantly doing resident laundry and there are baskets with dirty clothes in them all the time and Resident B’s room did not have boxes in it, his clothes were hung up. Ms. Stewart stated she is unsure if Resident A was unpacked and his room situated when she came to work on 03/04, she does not recall there being boxes or clothes not hung. Ms. Stewart stated she told Ms. McHerron that Resident C needed to be changed and that Relative #2 had come in and was upset because Resident C was wet and it appeared she had not been changed. Ms. Stewart stated Relative #2 was yelling at

Ms. McHerron about Resident C being wet. Ms. Stewart stated Resident C was cleaned and changed by Ms. McHerron after Relative #2 became upset.

On 03/26/2017, during the unannounced inspection at the facility, I observed residents that were out in the pods and their personal care appeared appropriate. I did not note any residents that had an odor or appeared disheveled as if they had not received personal care on this particular date.

On 04/27/2017, I interviewed Ms. Calvin and Ms. Tomic at the facility. Ms. Calvin and Ms. Tomic stated they received these complaints later in the day on 03/05/2017. The complaint was made regarding first shift staff so Ms. Calvin and Ms. Tomic looked into all of the allegations made of poor resident care and spoke to all the DCWs on first shift. They concluded based on staff statements that Ms. McHerron would be written up for unsatisfactory job performance and failure to respond promptly and effectively to the needs of the resident (in regards to Resident C being in a wet brief). However; Ms. Tomic explained they are not able to prove exactly what occurred regarding Resident C's care because the information received is hearsay and they did not have Relative #2's input. After discussion and approval on 03/09/2017 with Meridian Executive Director Marcia Curtiss each staff member on first shift on 03/04/2017 was required to take a training course on Resident Care, Peri-Care, Customer Service and How to Report Complaints and Incidents as a proactive and preventative measure stemming from this complaint. Ms. Calvin and Ms. Tomic stated in addition, each employee was written up for unsatisfactory job performance and failure to respond promptly and effectively to the needs of residents which is a violation of Meridian's General Standards of Conduct in the Workplace. Ms. Calvin and Ms. Tomic provided verification that each staff, Ms. Bass, Ms. Stewart, and Ms. McHerron, were re-trained in all above stated areas.

On 04/27/2017, during this inspection at the facility, I viewed residents that were out in the pods and their personal care appeared appropriate. I did not note any residents that had an odor or appeared disheveled as if they had not received personal care on this particular date.

On 04/27/2017, I received and reviewed resident assessment plans, hourly check logs, food acceptance logs and daily care logs. The hourly care logs for 03/04/2017, and 03/05/2017, document all residents being checked on and the location of where they were seen on an hourly basis signed by Ms. Bass and Ms. Stewart. The daily care logs reflect care given to each resident each day. I reviewed Resident A's food acceptance log and on the date in question, 03/04/2017, Resident A took in 100% of food for breakfast, 100% for lunch and 100+% for dinner, 100% for desserts and liquids were documented as 240cc's for each meal. I reviewed Resident B's daily care log and the document reflects that Resident B was showered, shampooed and shaved on 03/04/2017, during the first shift. The document reflects Resident B was showered, shampooed, shaved, oral care completed and clean linens on bed upon admittance to the facility on 03/03/2017, during 2nd shift. I reviewed Resident A's assessment plan dated 03/01/2017, documenting Resident A's need for assistance

with eating/feeding by staff setting up food, assisting and encouraging him to eat. Resident B's assessment plan dated 03/02/2017, documents staff standby with bathing, assistance washing back and feet and staff assist with all personal hygiene care. I received and reviewed the daily care log and hourly care log for Resident C and was able to view that 1st shift AM, 2nd shift PM and 3rd shift PM care is marked as completed on 03/04/2017-03/05/2017. I was also able to view that Resident C is documented as having eyes on check every hour. All residents are on an every 2 hour toileting schedule.

On 04/27/2017, I received a written statement from DCW Sierra McHerron dated 03/06/2017. Ms. McHerron stated DCW Ms. Polk told her Resident B had come into the facility on Friday 03/03/2017, and his clothes had not been changed until Sunday, 03/05/2017. Ms. McHerron stated Ms. Bass showered Resident B and changed his clothing on Saturday, 03/04/2017. Ms. McHerron stated she and Ms. Polk checked Resident B and made sure he was changed during their shift together. Ms. McHerron did not address the situation with Relative #2 complaining that Resident C was in soiled briefs for an extended period of time nor did she address any concerns regarding Resident A in her statement.

On 05/02/2017, I interviewed Ms. Bass via telephone. Ms. Bass stated Relative #1 was with Resident A when Resident A was admitted to the facility and he stayed with him the remainder of that day. Relative #1 came back the next day and brought Resident A food. Ms. Bass stated Resident A ate all meals on 03/04/2017 and 03/05/2017, he did not miss a meal. Ms. Bass stated Resident A at the time wore a pull up and was capable of toileting himself so he was not sitting in wet depends. Ms. Bass stated Resident B was admitted to the facility on Friday, 03/03/2017, and he received a shower on Saturday 03/04/2017, and a change of clothes so he was not sitting in dirty clothes and not showered all weekend. Ms. Bass stated Resident B has a room with a bed in it but this particular weekend was his first weekend at the facility and he kept coming out of his room and laying down on the couch in the common area. Once he became acclimated to his surroundings, he began to sleep in his own room and in his bed but that particular weekend, Resident B came out and laid on the couch but it wasn't because staff failed to put him to bed. Ms. Bass stated it was allowed because he was acclimating to his new surroundings. Ms. Bass stated she does not recall feces being on a resident's clothes, bed or floor for an extended period of time. Ms. Bass stated cleaning feces is part of the job so there could have been feces in a resident's room or on their clothes but it always is cleaned up. Ms. Bass does not recall Relative #2 being upset that Resident C was in wet briefs. Ms. Bass stated resident clothing is always being washed and there is always dirty laundry in the laundry room to do. Ms. Bass stated she does not recall that a resident's room was not unpacked and personal items not put away.

On 05/02/2017, I interviewed Relative #1 via telephone. Relative #1 stated he has no concerns or problems with staff or the care they provide Resident A. Relative #1 stated Resident A eats when he wants to eat and always has meals, his care is good, have never found him in urine soaked pants, the DCWs are always available

to help Resident A. Relative #1 stated he knows what is going on at the facility, he is at the facility every day or every other day and finds Resident A's care to be good.

As of 05/10/2017, I have not received a return telephone call from Ms. McHerron and I was unable to reach Relative #2 in order to get more information regarding the timeliness of Resident C's personal care.

On 05/23/2017, I conducted an Exit Conference with Licensee Designee, Teri Fowler via telephone. Ms. Fowler has no further information to add to this allegation and will review the substantiated issues in this report with Ms. Tomic.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	The complainant reported residents are not being checked on hourly, residents are left in soiled briefs for hours, residents are missing meals because staff do not get them for meals, dried feces was left on a patient bed and clothing for hours, residents clothes are soiled and left unwashed in the laundry room, a new resident was left in the same clothes and soiled diapers for days and another new resident slept on the couch in the main area of the facility all night. Ms. Stewart and Ms. Bass stated all residents' needs are tended to in a timely and appropriate manner. Relative #1 stated he is at the facility every day and finds Resident A's care to be good. Ms. Calvin and Ms. Tomic concluded after an internal investigation was conducted, that Ms. McHerron may not have changed Resident C in a timely manner. Each staff member on first shift on 03/04/2017 was required to take training courses on Resident Care, Peri-Care, Customer Service and How to Report Complaints and Incidents. Ms. Calvin and Ms. Tomic stated in addition, each employee was written up for unsatisfactory job performance and failure to respond promptly and effectively to the needs of residents.

	Ms. Calvin and Ms. Tomic provided verification that each staff, Ms. Bass, Ms. Stewart and Ms. McHerron (Ms. Polk was no longer employed at the facility) was re-trained in all above stated areas. Resident assessment plans, hourly check logs, food acceptance logs and daily care logs document care for Residents A & B were provided per the resident's assessed needs. Resident C is documented as having received care on every shift on 03/04-03/05/2017. Resident C is documented as having eyes on check every hour. Ms. McHerron provided a written statement documenting that Resident B's personal care needs were met in a timely manner on the weekend of 03/04-03/05. Ms. McHerron did not address the situation with Relative #2 complaining that Resident C was in soiled briefs for an extended period of time nor did she address any concerns regarding Resident A in her statement. Ms. Calvin and Ms. Tomic re-trained staff and staff were written up for unsatisfactory job performance and failure to respond promptly and effectively to the needs of residents. Based on Ms. Calvin and Ms. Tomic's internal investigation and conclusion regarding the probable lack of personal care provided to Resident C on first shift on 03/04/2017-03/05/2017, along with the information I gathered from interviews, I conclude that there is adequate information to substantiate a violation of this applicable rule in regards to the personal care for Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: DCWs eat the residents' food and there is not enough left for the residents.

INVESTIGATION: On 03/06/2017, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint alleging resident food is being eaten by staff and residents are not getting enough food.

On 03/14/2017, I interviewed the complainant via telephone. The complainant stated on 03/04/2017, residents had enough to eat but she witnessed staff, Ms. Bass eating residents' food. The complainant stated on 03/05/2017, residents wanted more food and there was not enough food due to staff eating it.

On 03/21/2017, I interviewed Adult Protective Services Worker, Kevin Sousser. Mr. Sousser stated he investigated and was unable to substantiate this allegation.

On 03/26/2017, I conducted an unannounced inspection and interviewed Ms. Stewart, DCW. Ms. Stewart stated Ms. Polk, DCW, gave an extra piece of meat that was going to be thrown away from Resident D's plate to Ms. Bass. Ms. Stewart stated Ms. Bass ate the piece of meat. Ms. Stewart stated Resident D had already eaten his food including a piece of meat and two sides but the kitchen had sent a double portion, two meals for Resident D on this particular day for some reason so it was extra food. Ms. Stewart stated she went to the kitchen and talked to kitchen staff regarding the double portion of food for Resident D. Ms. Stewart stated the kitchen is located in building 5 and the food is delivered for meals, there is a pantry located in this building with cereal, chips, bagels and muffins for example. Ms. Stewart stated the residents have never complained of not having enough food to eat and the building has a lot of snacks for in between meals. Ms. Stewart stated the kitchen will make up another plate of food for resident(s) that may still be hungry.

On 03/26/2017, I looked at the snack foods available in the facility for residents to eat between meals served. The snack pantry is as Ms. Stewart reported and contains a variety of snack foods.

On 03/26/2017, I conducted an unannounced inspection and interviewed shift supervisor, Heather Calvin. Ms. Calvin stated the residents are provided with enough food, three nutritious meals each day and snacks. Ms. Calvin reported if residents are still hungry after a meal, they can have another plate or they can have snacks out of the pantry located in the building.

On 03/26/2017, I interviewed Lucijana Tomic, facility Administrator via telephone. Ms. Tomic stated the residents are provided three nutritious meals every day including a variety of snacks whenever they want them given dietary restrictions and allowances. Ms. Tomic stated if there are left overs of food, sometimes staff will eat the left overs which is allowed as long as residents have their full meals. Ms. Tomic stated extra food is made for staff sometimes also. Ms. Tomic stated if residents are still hungry after a meal, the kitchen will provide them with another meal or they can have snack foods from the snack pantry in the facility. Ms. Tomic stated the regular meals offer a variety of foods and are typically enough for the residents in this facility.

On 04/27/2017, I conducted an inspection at the facility and saw a number of residents eating pretzels and string cheese as a snack. In addition, I stood at the counter in one of the Pods and talked to Residents E, F and G, while they were eating their snacks. This facility is an Alzheimer's Unit and the residents in this facility are memory impaired but at this time, all residents stated they have good meals and enough to eat.

On 05/02/2017, I interviewed Ms. Bass, DCW, via telephone. Ms. Bass stated she does not eat the facility food as it “does not agree” with her so she brings her own food every day. Ms. Bass denied she ate Resident D’s leftover meat on the weekend of 03/04/2017-03/05/2017. Ms. Bass stated the facility cooks in the kitchen make resident meals according to the menus. Ms. Bass stated residents get three meals per day with snacks and the DCWs are allowed to order more food from the kitchen for residents if they want more food. Ms. Bass stated residents are getting enough to eat.

On 05/02/2017, I interviewed Relative #1 via telephone. Relative #1 stated he has not observed staff eating resident’s food. Relative #1 stated his relative eats well and facility staff make sure he’s fed.

On 05/09/2017, I received and reviewed resident weight records from January 2017 to date, 05/01/2017. Residents weights appear to fluctuate slightly but the fluctuation is of weight gain for the most part rather than loss of weight. Resident D’s weight remained stable with an increase of weight of 4 lbs. In addition, I received and reviewed the menus for the facility for the month of March 2017. The meals prepared by the kitchen list a variety of nutritious foods prepared for each meal.

On 05/23/2017, I conducted an Exit Conference with Licensee Designee, Teri Fowler via telephone. Ms. Fowler stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	The complainant stated on 03/05/2017, residents wanted more food and there was not enough food due to staff eating it. Ms. Stewart stated Ms. Bass ate a left over piece of meat that was going to be thrown away. Ms. Stewart stated the residents have never complained of not having enough food to eat and the building has a lot of snacks for in between meals. Ms. Bass denied she ate Resident D’s leftover meat and stated residents are getting enough to eat. The snack pantry contains a variety of snack foods for residents to eat between meals served. Residents E, F and G, all stated they have good meals and

	enough to eat. Ms. Calvin and Ms. Tomic stated the residents are provided with three nutritious meals each day and snacks. Ms. Tomic acknowledged that staff will eat leftover food as long as the residents have their full meals. Ms. Calvin and Ms. Tomic state the kitchen will make up another plate of food if the resident wants more. Relative #1 stated he has not seen staff eating resident's food. Relative #1 stated his relative eats well and facility staff make sure he's fed. Resident's weights appear to fluctuate slightly but the fluctuation is of weight gain rather than loss of weight. Resident D's weight remained stable with a slight increase in weight.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Soiled personal care items are put in the kitchen garbage.

INVESTIGATION: On 03/06/2017, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint that reported staff dispose of dirty, soiled diapers in the kitchen area trashcan and other common areas with no covering.

On 03/14/2017, I interviewed the complainant via telephone. The complainant confirmed the allegation and stated she observed staff disposing of soiled briefs in the garbage cans in the common/snack area of the pods and the garbage cans did not have lids on them.

On 03/26/2017, I conducted an unannounced inspection at the facility. I located the garbage cans at the end of each counter in the snack area of Pod 1, 2 and 3, as well as the garbage in the laundry room of the facility. The garbage cans in the pods were clean with no soiled briefs in them at the time of my inspection however, the cans did not have lids on them. The large garbage can in the laundry room had a lid on it and was clean at the time of my inspection.

On 03/26/2017, I interviewed Ms. Stewart at the facility and she stated staff do put soiled briefs in the garbage containers in the pods and at the end of each shift the garbage is taken out of the pod and put into the dumpster. Ms. Stewart reported if the soiled brief smells or has feces in it, the brief is put into the garbage in the laundry room which is near the entrance door of the facility and then taken to the dumpster at the end of the shift.

On 04/27/2017, I conducted an inspection at the facility and noted the garbage cans in the pods were clean with no soiled briefs or smell emanating from them however; the cans in the pods did not have lids.

On 04/27/2017, I interviewed Ms. Tomic and Ms. Calvin at the facility. Ms. Tomic and Ms. Calvin stated the briefs are supposed to go in the garbage in the laundry room but acknowledges there are times when staff probably puts the briefs in the pod garbage. Ms. Tomic and Ms. Calvin stated all the garbage cans have lids however; the staff may have taken the lids off for quicker, easier access to the can. Ms. Tomic stated she will make sure all lids are on the cans at all times and remind staff that the lids must remain on the cans.

On 05/02/2017, I interviewed Ms. Bass via telephone. Ms. Bass reiterated the information provided to me during the interview with Ms. Stewart. Ms. Bass stated she is the med tech and typically does not change resident briefs but the garbage is taken out to the dumpster at the end of each shift and she does not have any experience with briefs in the pod garbage's smelling or creating an unsanitary environment.

On 05/02/2017, I interviewed Relative #1 via telephone. Relative #1 stated he is at the facility every other day and has no knowledge regarding resident briefs in the pod garbage's. In addition, Relative #1 stated he has not noticed an unsanitary environment created by resident briefs being in the pod garbage's.

On 05/23/2017, I conducted an Exit Conference with Licensee Designee, Teri Fowler via telephone. Ms. Fowler questioned whether or not the lids had been placed on the garbage containers in the pods and I informed Ms. Fowler that Ms. Tomic stated the lids have been purchased and would be on the containers immediately but the basis for the violation is that there were no lids on the two inspections conducted and staff readily acknowledged that they dispose of resident diapers in the containers that have no lid. Ms. Fowler has nothing further to add to the information, analysis and conclusion of the applicable rules.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Staff acknowledged putting residents' soiled briefs in the pod garbage cans but then removing the bags and disposing of them in the outside dumpster after each shift. After interviews with staff and a relative, the placing of the soiled briefs in the pod garbage cans has not reportedly created an unsanitary environment in their opinion and after two unannounced

	inspections of the facility, I did not find the facility to be in unsanitary condition due to staff placing resident briefs in pod garbage. After discussion with the Administrator and Licensee Designee, staff will place the soiled briefs in the garbage container located in the laundry area of the facility and not in pod garbage can in close proximity to where snacks are prepared and served.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.5401	**Environmental health.**
	(4) All garbage and rubbish that contains food wastes shall be kept in leak proof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.
ANALYSIS:	On two separate inspections of the facility, the garbage containers in each pod did not have lids on them. Staff acknowledged they place soiled briefs in the garbage. Ms. Tomic stated each can has a lid, and staff may have removed the lids for easier access while working but the lids will be on the cans and staff will be reminded to leave the coverings on the cans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Medications are not being disposed of in a proper manner.

INVESTIGATION: On 03/06/2017, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint alleging after a recent resident death at the facility, staff did not properly dispose of the resident medications.

On 03/14/2017, I interviewed the complainant via telephone. The complainant stated over the weekend of 03/04/2017-03/05/2017, she observed a deceased resident's medications in the cart. This resident's medication were not disposed of properly. The complainant stated the medications remained in the cart even though the resident died several days ago.

On 03/26/2017, I conducted an unannounced inspection and interviewed Ms. Stewart. Ms. Stewart acknowledged that Resident H's medications were still in the cart over the 03/04/2017-03/05/2017, weekend and that Resident H had died on 03/02/2017, so it was only a couple of days that the medications were in the locked

medication cart. Ms. Stewart stated the staff nurse, Latrice Smith is the only person that can dispose of resident medications and she had not been there to properly dispose of the medications yet. Ms. Stewart stated in the meantime, the medications were kept locked in the medication cart and included in the medication count. Ms. Stewart stated Ms. Smith disposed of the medications on 03/06/2017, four days after the resident death.

On 03/26/2017, I conducted an unannounced inspection at the facility and did not find Resident H's medications in the medication cart.

On 04/27/2017, I interviewed Ms. Tomic and Ms. Calvin at the facility. Ms. Tomic and Ms. Calvin stated the facility nurse, Ms. Smith, is the only person that can dispose of resident medications. Ms. Tomic and Ms. Calvin stated Ms. Smith contacts the pharmacy and gets instructions on properly disposing of resident medications and then removes the medications and disposes of them. Ms. Tomic and Ms. Calvin stated Resident H died on 03/02 and Ms. Smith had not disposed of the medications over the weekend of 03/04/2017-03/05/2017 but the medications were still included in the daily medication count and documented as being in the locked medication cart. Ms. Tomic stated Ms. Smith disposed of the deceased resident medications on Monday, 03/06/2017, four days after the resident's death.

On 05/02/2017, I interviewed Ms. Bass via telephone. Ms. Bass stated she is the med tech on staff for her shift. Ms. Bass reiterated the same information as Ms. Stewart, Ms. Calvin and Ms. Tomic regarding Resident H's death and the reason behind why the medications were left in the cart for four days. Ms. Bass stated this is not unusual for the medications to remain in the locked cart for a few days prior to disposal and that the medications continue to be included in the med count until they are disposed of.

On 05/23/2017, I conducted an Exit Conference with Licensee Designee, Teri Fowler via telephone. Ms. Fowler stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	The complainant reported after a recent resident death at the facility, staff did not properly dispose of the resident's medications. Ms. Stewart acknowledged that Resident H's medications were still in the cart after she died but that staff nurse, Ms. Smith had

	not been there to properly dispose of the medications yet. Ms. Tomic and Ms. Calvin confirmed the facility nurse, Ms. Smith, is the only person that can dispose of resident medications and Ms. Smith disposed of the medications four days after the resident's death. Ms. Bass concurred with this information. I conducted an unannounced inspection at the facility and did not find Resident H's medications in the medication cart.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is evidence of bed bug activity in the facility and resident rooms.

INVESTIGATION: On 03/06/2017, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint alleging evidence of bed bug activity in resident rooms.

On 03/14/2017, I interviewed the complainant via telephone. The complainant stated the facility had bed bugs in the past however, she did not observe any bedbugs.

On 03/26/2017, I conducted an unannounced inspection and interviewed Ms. Stewart and Ms. Calvin, both stated there are no bedbugs in resident rooms.

On 03/26/2017, I conducted an unannounced inspection and inspected all resident rooms finding no evidence of current or past bedbug activity. In addition, I noted all of the beds and box springs have bedbug coverings. The coverings on the beds are clean and also show no evidence of current or past bedbug activity.

On 03/26/2017, I interviewed Lucijana Tomic, via telephone. Ms. Tomic stated the resident rooms do not have bedbugs. Ms. Tomic reported in January 2017, the facility had Rose Pest Control conduct a K9 inspection of all of the buildings on this campus (8 in all) and there was no evidence of bed bugs at that time.

On 05/02/2017, I interviewed Ms. Bass via telephone. Ms. Bass stated she has no knowledge of bedbugs in resident's rooms at the facility.

On 05/23/2017, I conducted an Exit Conference with Licensee Designee, Teri Fowler via telephone. Ms. Fowler stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.5401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be

	maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	The complainant alleges past evidence of bed bug activity in resident rooms. Ms. Stewart, Ms. Bass and Ms. Calvin, both stated there are no bedbugs in resident rooms. Ms. Tomic stated the resident rooms do not have bedbugs and a K9 inspection of the facility conducted in January 2017 yielded no evidence of bedbugs in the building. I inspected all resident rooms finding no evidence of current or past bedbug activity.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility is not properly staffed.

INVESTIGATION: On 03/06/2017, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint alleging staff are working double shifts with no breaks, staff are taking long breaks away from the building and there is not enough staff coverage in the building.

On 03/14/2017, I interviewed the complainant via telephone. The complainant stated staff were take long breaks off site leaving minimal staff in the building's to take care of the residents.

On 03/21/2017, I interviewed Mr. Sousser, APS worker. Mr. Sousser stated he investigated and was unable to substantiate this allegation.

On 03/26/2017, I conducted an unannounced inspection and interviewed Ms. Stewart. Ms. Stewart stated the facility is staffed adequately with two DCWs and a med tech on first and second shifts for 17 residents and two DCWs on shift at night. Ms. Stewart stated there are times when staff call in and cannot make it in and times when staff stay an extra half shift or full shift but the ratio of residents to staff is sufficient. Ms. Stewart stated on the weekend of 03/04/2017-03/05/2017, there were enough staff on duty the entire weekend to meet the needs of the residents. Ms. Stewart denies that staff take long breaks off campus and leave the facility understaffed.

On 03/26/2017, I conducted an unannounced inspection and interviewed shift supervisor, Heather Calvin. Ms. Calvin stated there are three staff on duty on first and second shifts, two DCWs and one med tech. Also, one of the staff is the manager on duty every weekend and she (Ms. Calvin) manages staff and works 8-5

everyday so there is enough staff in the facility to meet the residents' needs. Ms. Calvin stated staff made no reports to her that there were issues with the amount of staff on duty in the facility on the weekend of 03/04/2017-03/05/2017.

On 03/26/2017, I interviewed Lucijana Tomic, facility Administrator via telephone. Ms. Tomic reiterated that there are three staff on duty during first and second shifts at the facility and two for third shift. Ms. Tomic stated staff get breaks and lunch as there are enough staff on duty to meet all resident needs and to give the required breaks staff get during their shifts. Ms. Tomic acknowledged staff will work more than a shift at a time if the DCW calls in sick or is unable to work their shift to ensure the staff to resident ratio is met.

On 04/27/2017, I received and reviewed the facility staff schedule for the month of March 2017. On the weekend of 03/04-03/05/2017, the schedule shows three DCWs (one in training) and a med tech on the schedule for first shift. On second shift there are two DCWs and a med tech and for third shift there are two DCWs documented on shift for night time care.

On 04/27/2017, I received and reviewed resident assessment plans. There are 17 residents in care in this facility and 3 of the 17 residents require a 2 person assist, the other 14 residents are ambulatory and able to follow DCW's instructions. I received and reviewed the facility fire drills covering a 1st, 2nd and 3rd shift drill for January, February and March 2017. In January 2017, a 2nd shift drill was conducted and residents were evacuated in 6 minutes 48 seconds, a 3rd shift drill was conducted in February 2017 and residents were evacuated in 6 minutes 45 seconds and a 1st shift drill was conducted in March 2017 and residents evacuated in 6 minutes 34 seconds. This facility is a sprinkled facility.

On 05/02/2017, I interviewed Ms. Bass via telephone. Ms. Bass stated she has no knowledge about staff taking hour long breaks offsite and it does not happen on her shift. Ms. Bass stated she gets two, 30 minute breaks for lunch if she works a double shift which would be 6:45AM to 8:00PM. Ms. Bass stated staff has to take a 30 minute break for every 6 hours worked. Ms. Bass stated she has worked a 13 hour shift before but does not know of any staff that have worked a 16 hour shift. Also, Ms. Bass stated there are enough staff on duty at the facility to take care of the residents. Ms. Bass stated during the day time hours there are three people on shift and at night there are two. Ms. Bass stated they are able to meet resident needs with the amount of staff on duty.

On 05/02/2017, I interviewed Relative #1 via telephone. Relative #1 stated there is always staff around to assist with caring for Resident A.

On 05/23/2017, I conducted an Exit Conference with Licensee Designee, Teri Fowler via telephone. Ms. Fowler stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	The complainant reported staff leave the building for long breaks so there is not enough staff coverage in the building. Ms. Stewart denies that staff take long breaks off campus and leave the facility understaffed. Ms. Bass stated there are enough DCW's on staff at any given time to adequately meet the needs of all residents. Ms. Calvin stated staff made no reports to her that there were issues with the amount of staff on duty in the facility on the weekend of 03/04-03/05/2017. Ms. Tomic reiterated that there are three staff on duty during first and second shifts at the facility and two for third shift. Ms. Tomic acknowledged staff will work more than a shift at a time if the DCW calls in sick or is unable to work their shift to ensure the staff to resident ratio is met. Relative #1 stated there is always staff around to assist with caring for Resident A. Mr. Sousser (APS) stated he was unable to substantiate this allegation. The resident assessment plans document 17 residents in the facility for the month of March 2017 with 3 of the 17 residents in need of a 2 person assist. 14 residents are ambulatory and capable of following staff directions. Fire drills document evacuation times of approximately 7 minutes to evacuate all residents. This facility is a sprinkled facility. Staff schedule for the month of March 2017 documents the ratio of 17 residents to the amount of direct care workers on duty at any given time was adequate according to the rule.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff are not properly trained.

INVESTIGATION: On 03/06/2017, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint alleging staff do not go through the proper training to care for residents and untrained staff are administering resident medications.

On 03/14/2017, I interviewed the complainant via telephone. The complainant stated new staff with no experience in care giving are expected to provide personal care to residents, including medication administration, prior to being properly trained in how to care for residents.

On 03/21/2017, I interviewed Mr. Sousser stated he investigated the claim that staff are not properly trained. Mr. Sousser stated he was unable to substantiate this allegation.

On 03/26/2017, I conducted an unannounced inspection and interviewed Ms. Stewart. Ms. Stewart stated staff are trained and then on the job instruction from other care givers is how a DCW gets going on the job. Ms. Stewart stated she went through Meridian's 2-day Training and then began shadowing workers. Ms. Stewart stated only certain people are Med Techs as that is different from being a direct care worker (DCW). Ms. Stewart stated the med techs go through the same Meridian training and then shadow a med tech and Meridian's corporate nurse, Wendy Ehnis is part of the training. Ms. Stewart stated the DCWs and med techs at the facility are trained.

On 04/26/2017, I interviewed Ms. Calvin and Ms. Tomic at the facility. Ms. Calvin and Ms. Tomic stated all DCWs and Med Techs go through "classroom" paperwork training prior to going out on the floor to shadow the other staff.

On 04/27/2017, I reviewed staff training records including the facility med techs training records. DCWs and Med Techs in this facility have documented training in all the required areas. In addition to the required training I reviewed training given to staff called AM/PM Care in Service and Meridian Senior Living First Impressions training.

On 05/02/2017, I interviewed Ms. Bass via telephone. Ms. Bass stated she has been working as a DCW and Med Tech for 3 years. Ms. Bass stated she is trained on direct care work and administering medications. Ms. Bass stated all Med Techs and DCWs go through training, both paper training and on the job training.

On 05/23/2017, I conducted an Exit Conference with Licensee Designee, Teri Fowler via telephone. Ms. Fowler stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) 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 competent before performing assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.
ANALYSIS:	The complainant alleged staff are not properly trained. Ms. Stewart stated she went through Meridian's 2-day Training and then began shadowing workers. Ms. Bass stated she is trained on direct care work and administering medications. Ms. Bass stated all Med Techs and DCWs go through training, both paper training and on the job training. Ms. Calvin and Ms. Tomic stated all DCWs go through "classroom" paperwork training prior to going out on the floor to shadow the other staff. I reviewed staff training records and according to facility records, all DCWs have documented training in all required areas. In addition to the required training I reviewed training given to staff called AM/PM Care in Service and Meridian Senior Living First Impressions training. Mr. Sousser stated he was unable to substantiate this allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member

	supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	The complainant reported untrained staff are administering resident medications. Mr. Sousser stated he was unable to substantiate this allegation. Ms. Stewart stated the med techs go through the same Meridian training and then shadow a med tech and Meridian's corporate nurse, Wendy Ehnis is part of the training. Ms. Stewart stated the med techs at the facility are trained. Ms. Calvin and Ms. Tomic stated all Med Techs go through "classroom" paperwork training prior to going out on the floor to shadow the other staff. I reviewed documented Med tech training and the training records reflect they are trained in all required areas. In addition to the required training I reviewed training given to staff called AM/PM Care in Service and Meridian Senior Living First Impressions training. Ms. Bass stated she is trained on direct care work and administering medications. Ms. Bass stated all Med Techs and DCWs go through training, both paper training and on the job training.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

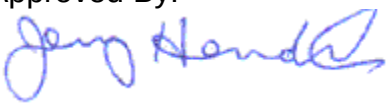
Upon receipt of an acceptable corrective action plan that includes how the corrective action measures will be monitored and maintained, I recommend the current status of the license remain unchanged.

Elizabeth Elliott

05/31/2017

Elizabeth Elliott Date
Licensing Consultant

Approved By:



05/31/2017

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Jerry Hendrick Date
Area Manager