GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 9, 2019

Nancy Harns
Williamston Compassionate Care, LLC
3800 Vanneter Rd
Williamston, MI 48895

RE: License #: AM330380484
Investigation #: 2019A0466042
Williamston Compassionate Care, LLC

Dear Ms. Harns:

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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330380484
Investigation #:	2019A0466042
Complaint Receipt Date:	08/15/2019
Investigation Initiation Date:	08/16/2019
Report Due Date:	10/14/2019
Licensee Name:	Williamston Compassionate Care, LLC
Licensee Address:	3800 Vanneter Rd Williamston, MI 48895
Licensee Telephone #:	(517) 204-2480
Administrator:	Nancy Harns
Licensee Designee:	Nancy Harns
Name of Facility:	Williamston Compassionate Care, LLC
Facility Address:	3800 Vanneter Rd Williamston, MI 48895
Facility Telephone #:	(517) 204-2480
Original Issuance Date:	03/25/2016
License Status:	REGULAR
Effective Date:	03/23/2018
Expiration Date:	03/22/2020
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
Resident A was administered morphine for pain from a fall and is not currently prescribed morphine.	Yes
The facility is a mess on 08/09/2019.	No
Resident A is being fed food that is hard for her to eat without teeth and is only being given fluids at mealtimes.	No
Facility was short staffed on 08/08/2019.	No
Additional Findings	Yes

III. METHODOLOGY

08/15/2019	Special Investigation Intake 2019A0466042
08/16/2019	Special Investigation Initiated - On Site
08/22/2019	Contact - Telephone call made assigned APS Worker Gene Mellen.
08/22/2019	Contact - Document Received Email from APS worker Gene Mellen.
09/18/2019	Contact - Document Sent Email to Licensee Designee Nancy Harns.
09/18/2019	Contact - Document Sent Email sent to APS worker Gene Mellen.
09/20/2019	Contact - Document Received Email from Nancy Harns.
09/20/2019	Contact - Telephone call made Relative A1, interviewed.
09/23/2019	Contact-telephone call made to DCW Shelly Stuber, message left.

09/24/2019	Contact- telephone call recevied from DCW Shelly Stuber, interviewed.
09/24/2019	Inspection completed on site.
10/03/2019	Contact-telephone call made to Nurse Beth at McLaren Visiting Nurse & Hospice Brian's House, message left.
10/03/2019	Contact-telephone call made to Elizabeth Hartell, Tri County Office on Aging, message left.
10/08/2019	Exit Conference with Licensee Designee/Administrator Nancy Harns.
10/08/2019	Contact-telephone to Elizabeth Hartell, Tri County Office on Aging interviewed.

ALLEGATION:
Resident A was administered morphine for pain from a fall and is not currently prescribed morphine.

INVESTIGATION:
On 08/15/2019, an anonymous Complainant reported that Resident A possibly fell last week and again yesterday. Complainant reported that the direct care workers (DCWs) at the facility gave Resident A morphine for the pain. Complainant reported today (08/15/2019), Resident A is fine and sleeping, the concern is that Resident A is eighty-nine years old and should not be given morphine.

On 08/16/2019, I conducted an unannounced investigation and I interviewed DCW Leah Henry who reported that she gave Resident A morphine because one of the hospice nurses told her to administer the medication to Resident A for pain that she had in her hip from a fall. DCW Henry reported that morphine was previously prescribed to Resident A but was not currently on Resident A's August 2019 Medication Administration Record (MAR). DCW Henry showed me Resident A's morphine that was stored in the refrigerator and was prescribed to Resident A on 07/11/2018, take "5MG every four hours or as needed for pain." The morphine did not have any refills and documented "discard by 07/11/2019." DCW Henry also showed me a note above the medication cart where the medication change was documented for Resident A that stated, "morphine every four hours." DCW Henry reported she did not realize that Resident A's morphine was expired when she administered it.

I interviewed DCW Anne Cole who reported that she did not know anything about Resident A being administered morphine and reported that she did not administer Resident A any morphine. DCW Cole was not aware of Resident A falling.

I reviewed Resident A's electronic August 2019 MAR which did not list morphine as a prescribed medication.

I observed Resident A in the facility at the time of the unannounced investigation, however she was asleep and unable to be interviewed.

I interviewed Resident B who reported that Resident A did have a recent fall but could not report the date the fall occurred.

On 08/21/2019, I interviewed Adult Protective Services (APS) Specialist Gene Mellen who reported that Resident A was no longer living at the facility and had been hospitalized. APS Specialist Mellen reported that he spoke with the hospital social worker who reported that Resident A's drug screen upon admission to the hospital was negative for opiates.

On 09/20/2019, I interviewed Relative A1 who reported that Resident A fell twice approximately one week apart with the first fall occurring around 08/10/2019 and the second around 8/15/2019. Relative A1 reported that DCW Shelly Struber told her that Resident A was given morphine for the pain from the fall but Relative A1 was not aware of the dosage, how often it was administered or who ordered the medication.

On 09/24/2019, I interviewed DCW Shelly Struber who reported that she was not aware of Resident A being prescribed morphine as she did not administer it to her. DCW Struber reported that morphine may have been in Resident A's hospice care kit but she was not sure. DCW Struber reported that lorazepam was prescribed for Resident A for pain.

I went to the facility for a second time on 09/24/2019 and I interviewed DCW Tanya Galmore. DCW Galmore reported that Resident A fell twice in a month, the first time she fell over her walker while putting her coffee cup on the counter and reported that Resident A sustained no injuries. DCW Galmore reported that Resident A fell again and after the second fall was in pain on her right hip and left shoulder. DCW Galmore reported that the hospice nurse came out to assess Resident A the same day of the fall and reported that Resident A had no bruising and appeared to be fine. DCW Galmore reported that Licensee Designee Nancy Harns came to the facility to check on Resident A and reported that Resident A's leg did not have any discoloration, nor did she have a fever or any bruising. DCW Galmore reported that an x-ray was done on the hip per the family's request and that was negative for any broken bones. DCW Galmore reported that Resident A's doctor prescribed Ativan for pain. DCW Galmore was not aware of Resident A being prescribed morphine for pain nor did she administer any morphine to Resident A.

I interviewed DCW Aleaha Penell who reported that she was aware that Resident A had fallen, however she not aware of Resident A being prescribed morphine nor did she administer any morphine to her.

I interviewed Licensee Designee/Administrator Nancy Harns who reported that Resident A did fall, was in pain but Resident A was prescribed Tylenol as needed not morphine. Licensee Designee Harns reported that she did not administer morphine to Resident A nor was she aware of any other DCW administering Resident A morphine. Licensee Designee Harns reported that the hospice nurse came to evaluate Resident A the same day Resident A fell, and the facility has been using the recommended repositioning techniques to keep Resident A comfortable from the fall as the hospice nurse did not identify any injuries. Licensee Designee Harns reported that Resident A recevied an x-ray which showed no broken bones, per the family's request. Licensee Designee Harns reported that she was made the hospice nurse aware that Resident A had an expired prescription bottle of morphine in the refrigerator on 08/16/2019 and reported that medication has since been disposed.

I reviewed the facilities communication log which documented on 08/15/2019 at 3:13pm that Resident A had x-ray today and everything came back negative.

Resident A was not able to be interviewed as she had been discharged from the facility.

On 10/08/02019, I interviewed Elisabeth Hartell from Tri County Office on Aging who is Resident A's case manager who reported that she was not aware if Resident A was prescribed or administered morphine as Resident A's medication management was done by hospice.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	On 08/16/2019, DCW Henry reported that she administered Resident A morphine after she fell. DCW Henry reported that morphine was previously prescribed to Resident A, however the morphine was not documented on Resident A's August 2019 MAR as it was not currently prescribed to Resident A. The prescription label on Resident A's bottle of morphine documented that it was prescribed on 07/11/2018 with instructions to take "5MG every four hours or as needed to pain." The morphine did not have any refills and further documented on the label to "discard by 07/11/2019." Consequently, Resident A was given expired morphine medication without a current prescription rather than being provided the pain medication she was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
The facility was a mess on 08/09/2019.

INVESTIGATION:
On 08/15/2019, anonymous Complainant reported that on 8/9/2019, the trash cans and recycling bins at the home were a mess as well as the entire facility. Complainant reported that on 8/11/2019, the home was immaculate. Complainant reported that the DCWs seemed to have cleaned the home once they realized people were visiting Resident A.

On 08/16/2019, I conducted an unannounced investigation and inspected the entire facility including all resident bedrooms, living areas, dining area, and bathrooms. I found that the facility was orderly, lacked any foul odor and the trash cans and recycling bins were by the garage and were not overflowing.

I interviewed Resident B who reported that the facility is kept clean, tidy, odor free and the trash cans and recycling bins are kept by the garage and emptied on a regular basis.

I observed Resident A in the facility at the time of the unannounced investigation, however she was asleep and unable to be interviewed. None of the other residents were willing/able to be interviewed.

I interviewed DCW Henry and DCW Cole who reported that the facility is kept clean and tidy and the trash cans and recycling bins are kept out of sight but are also emptied as needed. DCW Henry and DCW Cole reported that most of the cleaning of the facility is done by the midnight staff.

On 09/20/2019, Relative A1 reported that the facility was clean and that was done by the midnight staff. Relative A1 reported that Resident A wears briefs and her room did have a slight odor as did the bathroom. Relative A1 reported that it is difficult to keep a facility like that completely odorless due to the number of residents that wear incontinent briefs.

I conducted an unannounced investigation for a second time on 09/24/2019 and found the facility to be orderly, lacking foul odor and the trash cans and recycling bins were maintained.

On 09/24/2019, I interviewed DCW Struber, DCW Galmore, DCW Penell and Licensee Designee Harns who all reported that the facility is clean, orderly and trash cans and recycling bins are put away unless they are waiting for pick up on the curb. DCW Struber, DCW Galmore, DCW Penell and Licensee Designee Harns reported that most of the cleaning is done by the midnight staff.

On 10/08/02019, I interviewed Ms. Hartell who reported that when she was at the facility, it was clean, orderly and lacking any foul order. Ms. Hartell reported that the facility did have trash cans and recycling bins in the facility, however they were orderly and out of the way.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean and orderly appearance.
ANALYSIS:	Resident B, DCW Henry, DCW Cole, DCW Struber, DCW Galmore, DCW Penell, Licensee Designee Harns and Ms. Hartell all reported that the facility was well kept orderly, lacked any foul odor and the trash cans and recycling bins were maintained. I was at the facility on 08/16/2019 and again on 09/24/2019 and I observed the facility to be well kept and therefore there is not enough evidence to establish a violation**.**
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A is being fed food that is hard for her to eat without teeth and is only being given fluids at mealtimes.

INVESTIGATION:
On 08/15/2019, anonymous Complainant reported that Resident A has no teeth and only gets something to drink when the residents eat at mealtime. Complainant also

reported that other times Resident A is given to eat what the other residents are having for the meal/snack, which is concerning because she does not have teeth. Complainant reported that the residents eat things like burned tater tots and turkey dinners, which Complainant believes would be hard to eat with no teeth. Complainant reported that Resident A is able to eat soft foods and when given something to drink, she seems very thirsty.

On 08/16/2019, I conducted an unannounced investigation and I interviewed Resident B who reported that Resident A eats the same food everyone else does and she does not struggle to eat it. Resident B reported that fluids are provided throughout the day, not just at mealtimes. Resident B reported that the facility offers water, milk, coffee and a variety of juices.

I observed Resident A in the facility at the time of the unannounced investigation, however she was asleep and unable to be interviewed. None of the other residents were willing/able to be interviewed.

I interviewed DCW Henry who reported that Resident A was not often thirsty and that she ate and drank very little even when DCWs offered it to her. DCW Henry reported that although Resident A did not have any teeth that she did not have any problem eating the food that the facility served. DCW Henry reported that Resident A was not prescribed any special diet nor did her food have to be prepared in any special way. DCW Henry reported that fluids are provided throughout the day to all residents including Resident A, not just at mealtimes

I interviewed DCW Cole who reported that she did not have any knowledge that Resident A had difficulty eating. DCW Cole reported that residents are given fluids throughout the day, not just at mealtimes.

I observed that the facility did have a variety of beverages available for the residents to drink while I was at the facility. The refrigerator contained, water, milk and juice.

On 09/20/2019, I interviewed Relative A1 who reported that although Resident A did not have teeth, she was able to eat the food on the menu without any issue. Relative A1 reported that Resident A refused to eat with her dentures in and that she is able to chew food fine without them. Relative A1 reported that Resident A was provided with fluids and because she was not eating well, protein packs would be added to provide her nutrition. Relative A1 did not experience Resident A being thirsty when she visited her. Relative A1 reported that Resident A was not on a physician prescribed special diet or any fluid regime.

On 09/24/2019, I interviewed DCW Struber DCW Galmore, DCW Penell and Licensee Designee Harns who all reported that although Resident A did not have teeth, she did not have any trouble eating the food on the menu. DCW Struber, DCW Galmore and DCW Penell all reported that Resident A was picky eater and preferred yogurt with protein powder, cottage cheese and fruit. DCW Galmore

reported that Resident A always ate breakfast and ate a lot of soft foods. DCW Struber, DCW Galmore, DCW Penell and Licensee Designee Harns all reported that Resident A was provided with fluids throughout the day not just at mealtimes and Resident A was not on any physician prescribed special diet. DCW Struber DCW Galmore, DCW Penell and Licensee Designee Harns all reported that Resident A was not shy about requesting things she wanted to eat or drink.

I reviewed Resident A's record which contained a *Health Care Appraisal* dated 02/01/2019 which did not document any special dietary restrictions, food preparation instructions, or recommended caloric intake. I reviewed Resident *A's Assessment Plan for Adult Foster Care (AFC) Residents* dated 02/27/2019 that documented that Resident A requires assistance with eating/feeding, "needs food cut up if not soft- no teeth." Resident A's Assessment *Plan for AFC Residents* documented under special diets, "no teeth but no limitations."

I reviewed the facilities communication log which documented:

- On 08/14/2019, DCW Galmore reported at 5:58pm, tried to feed Resident A "mashed potatoes and chocolate cake and she spit both of those out, so I tried some yogurt with protein powder, and she ate that plus an extra yogurt and some berry applesauce."
- On 08/14/2019, DCW Galmore reported at 8:14pm, that Resident A" drank another cup of apple juice."
- On 08/15/2019, DCW Henry at 7:33am that she fed Resident A apple sauce.
- On 08/15/2019, DCW Struber reported at 4:02pm, fed "[Resident A] 3 puddings/bolthouse smoothie (drank ½ bottle).
- On 08/15/2019, DCW Struber reported at 8:10pm, "eating yogurt."
- On 08/15/2019, DCW Galmore reported at 9:24pm, "fed yogurt."

Resident A was not able to be interviewed as she had been discharged from the facility.

On 10/08/02019, I interviewed Ms. Hartell who reported that Resident A did not like to wear her dentures, she was able to eat without them, did not have any dietary restrictions and Resident A did not appear thirsty when she saw her. Ms. Hartell reported that residents are provided with fluids thought out the day and not just at mealtimes.

APPLICABLE RULE	
R 400.14313	**Resident Nutrition**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.

ANALYSIS:	DCW Henry, DCW Cole, Relative A1, DCW Struber, DCW Galmore, DCW Penell, Licensee Designee Harns and Ms. Hartell all reported that Resident A was not prescribed a physician ordered special diet and that she was able to eat foods from the menu without issue despite not having teeth or choosing to wear her dentures. Additionally, Resident A's *Health Care Appraisal* and her *Assessment Plan for AFC Residents* both documented that there was no physician ordered special diet and that even though she did not have any teeth, she did not have any limitations to what she could eat therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Facility was short staffed on 08/08/2019.

INVESTIGATION:

On 08/15/2019, anonymous Complainant reported that the home is short staffed. Complainant reported that there were two workers for twelve to fourteen residents on 8/8/2019. Complainant reported that it is unknown how many staff members there are supposed to be.

On 08/16/2019, I conducted an unannounced investigation and I interviewed Resident B who reported that the facility has 12 residents and that there are two to three DCWs per shift during the day and one DCW at night. Resident B reported that she does not remember a time where there was only one person on shift during the day including on 08/08/2019. Resident B reported that the facility has never had 14 residents. Resident B reported that there are enough DCWs to meet the needs of the residents and no resident requires assistance from two DCWs at the same time.

None of the other residents were willing/able to be interviewed.

I interviewed DCW Henry and DCW Cole who reported that the facility has 12 residents and two DCWs on duty. DCW Henry and DCW Cole reported that the two DCWs are enough to meet the needs of the residents at the facility. DCW Henry and DCW Cole reported that during the day there are two to three DCWs on shift and one at night. DCW Henry and DCW Cole reported that none of the residents required a two-person assist. DCW Henry and DCW Cole reported that the facility has never had 14 residents.

DCW Henry and DCW Cole could not provide me with a resident register, which is a list of all residents currently residing in the facility, for review. I did not observe more than 12 residents at the facility while I was there.

I reviewed the staff schedule dated 08/05/2019 through 08/18/2019 which documented that on 08/08/2019 three DCWs were scheduled from 7:30am until 8pm and from 8pm until 7:30 am, one DCW was scheduled. The staff schedule documented that two to three DCWs were scheduled during the day and one DCW was scheduled at night on a regular basis during that time period.

On 09/20/2019, Relative A1 reported that when she is at the facility during the day there are usually two DCWs and one DCW worker at night. Relative A1 reported that she has not observed more than 12 residents at the facility. Relative A1 reported that the facility does not have any room for additional residents.

On 09/24/2019, I interviewed DCW Struber, DCW Galmore, DCW Penell and Licensee Designee Nancy Harns who reported that minimally, two DCWs work 7:30am until 8pm and one DCW works from 8pm to 7:30 am daily, including on 08/08/2019.

On 10/08/02019, I interviewed Ms. Hartell who reported that when she has been at the facility there have been at least two DCWs and she believe that the needs of residents were being met. Ms. Hartell does not believe that she has observed more than 12 residents at the facility.

APPLICABLE RULE	
R 400.14206	**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 12 residents and children who are under the age of 12 years.
ANALYSIS:	Resident B, DCW Henry, DCW Cole, Relative A1, DCW Struber, DCW Galmore, DCW Penell, Licensee Designee Nancy Harns and Ms. Hartell all reported that two DCWs work 7:30am until 8pm and one DCW works from 8pm to 7:30 am daily. This was also the case on 08/08/2019. This was verified by reviewing the staff schedule therefore there is not enough evidence to support that the facility was understaffed on 08/08/2019. Further, there are no residents that require two DCWs to meet their personal care or supervision needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 08/16/2019, I conducted an unannounced investigation and I interviewed DCW Henry and DCW Cole who reported that the resident register was not available for review at the time of the unannounced investigation.

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	On 08/16/2019, the facility did not have a resident register available for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/16/2019, I conducted an unannounced investigation and I observed Resident A's prescription medication both morphine and NovoLog in the refrigerator not locked up. The facility did have a lock box in the refrigerator; however, it was full, so the overflow of other medications remained unlocked in the refrigerator.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Not all of the resident's prescription medication that required refrigeration were locked because the lock box was full, so the overflow medications were unlocked in the refrigerator.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/16/2019, I conducted an unannounced investigation and I interviewed DCW Henry who reported that she gave Resident A morphine because one of the hospice nurses told her to administer the medication to Resident A for pain from a fall. DCW Henry reported the previously prescribed morphine was not on Resident A's August 2019 MAR so she did not document administering morphine to Resident A.

APPLICABLE RULE	
R 400.14312	**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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	DCW Henry reported that she administered morphine to Resident A despite this medication not being listed on Resident A's August 2019 MAR without it being on the MAR and without documenting that this medication was administered therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 08/16/2019, I conducted an unannounced investigation and I observed Resident A's morphine medication label which read that there were no refills and documented to "discard by 07/11/2019" in the refrigerator. DCW Henry reported that she was not aware that medication had expired, and Resident A's morphine was not documented on Resident A's August 2019 MAR. Resident A's Novolog which was not listed on the MAR was also in the refrigerator and documented an original date of 04/19/2017.

APPLICABLE RULE	
R 400.14312	**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:	Resident A's morphine that expired on 07/11/2019 and Resident A's Novolog that was filled on 04/19/2017, both medications were still being stored in the refrigerator even though they were no longer prescribed to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/08/2019, I conducted an exit conference with Licensee Designee/Administrator Nancy Harns who was in agreement with the findings of the investigation.

IV. RECOMMENDATION

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

10/08/2019

_____

Julie Elkins Date
Licensing Consultant

Approved By:

10/09/2019

_____

Dawn N. Timm Date
Area Manager