GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 25, 2020

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

RE: License #: AS440392507
Investigation #: 2020A0501032
Beacon Home At Lapeer

Dear Mr. Kalinowski:

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

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

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

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 (810) 787-7031.

Sincerely,

Crecendra Brown

Crecendra Brown, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 931-0965

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS440392507
Investigation #:	2020A0501032
Complaint Receipt Date:	04/23/2020
Investigation Initiation Date:	04/23/2020
Report Due Date:	06/22/2020
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Matthew Owens
Licensee Designee:	Kevin Kalinowski
Name of Facility:	Beacon Home at Lapeer
Facility Address:	2368 Greenwood Rd., Lapeer, MI 48446
Facility Telephone #:	(810) 667-6167
Original Issuance Date:	05/08/2018
License Status:	REGULAR
Effective Date:	11/08/2018
Expiration Date:	11/07/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The police were called to the home on April 21, 2020 because Resident A and a staff member were physically assaulted by Resident E.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/23/2020	Special Investigation Intake 2020A0501032
04/23/2020	Special Investigation Initiated - Letter
04/23/2020	APS Referral APS Referral denied.
04/24/2020	Contact - Telephone call made Lapeer Township Police Bill Stokes.
04/24/2020	Contact – Document Received Lapeer Township Police Report.
04/24/2020	Contact - Document Sent Sent email to Licensee Designee Kevin Kalinowski and Administrator Matthew Owens requesting documents.
04/29/2020	Contact - Telephone call made Staff Taylor Bowles.
04/29/2020	Contact - Telephone call made Staff Jana Goss.
05/12/2020	Contact - Telephone call made Guardian E.
05/12/2020	Contact - Telephone call made Guardian A.
05/12/2020	Contact - Telephone call made Guardian F.
05/12/2020	Contact - Telephone call made Staff Brenda Morningstar.

05/12/2020	Contact - Telephone call made Staff Carolyn Beardsley.
05/12/2020	Contact - Telephone call made Staff Denise Fifield.
05/12/2020	Exit Conference Licensee Designee Kevin Kalinowski.
05/14/2020	Contact - Telephone call made Macomb County CMH Recipient Rights Amber Sultes.
06/19/2020	Exit Conference Licensee Designee Kevin Kalinowski

ALLEGATION: The police were called to the home on April 21, 2020 because Resident A and a staff member were physically assaulted by Resident E.

INVESTIGATION: On April 24, 2020, I conducted a phone interview with Lapeer Township Police Bill Stokes. Officer Stokes stated that he would send me a copy of the police report. Officer Stokes stated that he has been called to the AFC home several times for physical assaults. Officer Stokes stated that he has seen Adult Protective Services at the home a few times. Officer Stokes stated that since the home opened up May 8, 2018, his police department has been called to the home 75 times. Officer Stokes stated that most of the police calls to the home are assaultive complaints with violence between the residents. Officer Stokes stated that an arrest warrant has been submitted for Resident E to the prosecutor's office. Officer Stokes stated that on April 21, 2020 Resident A assaulted two other residents and a staff member. Officer Stokes stated that there was only one staff member on duty in the home with four residents. Officer Stokes stated that the home is understaffed, and the one staff appeared to be overwhelmed. Officer Stokes stated that before he left the home another staff member drove up in the driveway. Officer Stokes stated that one of the residents that was attacked called the police. Officer Stokes stated that all the residents were verbal, but hard to understand. Officer Stokes stated that Staff Taylor Bowles wrote out a statement and gave it to him.

On April 24, 2020, I received the Lapeer Township Police Report on the incident at Beacon Home at Lapeer. On April 21, 2020 at 12:35pm Officer Stokes was dispatched to Beacon Lapeer. Resident F stated that Resident E was trying to pick fights with everyone in the home that day. Resident F stated that Resident E poked him in the eyes with his thumbs and then started choking him. Resident F stated that he was afraid of Resident E. Resident E admitted that he assaulted Resident A and Resident F, but he denied starting the altercations. Resident A's interview was not included due to him being difficult to understand as he is diagnosed with

intellectual developmental disorder. A copy of the report with a warrant for Resident E's arrest was sent to the Lapeer County Prosecuting Attorney's office for review. A voluntary written statement was provided by Staff Taylor Bowles and summarizes the following events: Resident E was bothering Resident A while staff Bowles was helping Resident A clean his room. Resident E kept calling Resident A names and trying to fight Resident A. Resident A went outside to smoke and Resident E followed him. Resident E was banging on the back-porch door and punched Resident A. Resident A came back into the house and Resident E ran into his room. Resident E kept calling Resident A names. Resident E walked into the laundry room and grabbed a water jug. Resident E threw the water jug at Resident A. Resident A picked up a chair and threw it at Resident E. Staff Bowles got the other residents into their rooms until Resident E calmed down.

On April 24, 2020, I sent an email to Licensee Designee Kevin Kalinowski and Administrator Matthew Owens requesting documents for the investigation.

I reviewed the staff schedule for February 24 – April 30, 2020. From 8:00am – 8:30pm, there were 31 days when only one staff person was listed on the schedule and 5 days had no staff listed on the schedule. From 830pm – 8am, there were 56 days with only one staff person listed on the schedule and 10 days had no staff listed on the schedule.

I reviewed Resident A's assessment plan and individual plan of service. The assessment plan was dated January 8, 2020. Resident A was assessed as being able to control his aggressive behavior and is to receive "line-of-sight" supervision in the community. Resident A's individual plan of service was dated February 13, 2020. Documentation revels that Resident A struggles with anxiety, physical aggression, property destruction, and verbal aggression. Resident A has been stealing in the community and displays has aggression towards staff that can put them and other residents at risk.

I reviewed Resident E's assessment plan and individual plan of service. The assessment plan was dated January 6, 2020. Resident E was assessed as being able to control his aggressive behavior. Resident E's individual plan of service was dated December 9, 2019. Resident E's plan of service reported nothing regarding his behavior, past or present.

I reviewed Resident F's assessment plan and individual plan of service. The assessment plan was dated April 17, 2020. Resident F does not move independently in the community, has limited comprehension, is verbally aggressive, physically aggressive to people and property, and does not get along with others. The individual plan of services was dated February 13, 2020. Resident F has had recent physical aggression towards staff and the police had to be called. Resident F has pending criminal charges. Resident F is known to take advantage of others and is verbally explosive. Resident F had to leave his last two jobs due to behavioral aggressiveness.

I reviewed Resident G's assessment plan and personal care plan. The assessment plan was dated January 27, 2020. Resident G has to be supervised in the community, lacks life skills, and sometimes controls his aggressive behavior. When Resident G is upset, he has self-injurious behaviors, he needs prompting with eating, bathing, grooming, dressing, and mobility. Resident G uses a weighted vest and noise cancelling headphones to assist with his "triggers". Resident G sometimes has an elevated heart rate. The personal care plan was dated February 10, 2020. Resident G has difficulty with controlling aggressive behavior, has a history of property destruction, history of physical aggression, history of elopement, history of suicidal and homicidal thoughts. Resident G's plan states that he requires extensive monitoring by staff due to his autism diagnosis, which requires consistent monitoring of staff on every shift.

On April 29, 2020 and April 30, 2020, I attempted to contact staff Taylor Bowles at the phone number provided to me. I left voice messages for Ms. Bowles to return my phone call.

On May 1, 2020, I called Beacon Home at Lapeer and conducted a phone interview with staff Taylor Bowles. Ms. Bowles stated that Resident E had been bothering all of the residents on April 21, 2020. Ms. Bowles stated that Resident E was going into all of the other residents' rooms. Ms. Bowles stated that Resident A told Resident E to get out of his room. Ms. Bowles stated that Resident E refused to leave Resident A's room. Ms. Bowles stated that Resident E went outside to smoke a cigarette. Ms. Bowles stated that she was alone with all of the residents and no other staff was working. Ms. Bowles stated that Resident E started banging on all of the windows on the back patio and then went outside where Resident A was smoking. Ms. Bowles stated that Resident E punched Resident A and then Resident E ran back into the house. Ms. Bowles stated that when Resident A came back into the house Resident E threw a water jug at him. Ms. Bowles stated that Resident A picked up a chair and threw it at Resident E. Ms. Bowles stated that she got the other residents to go into their rooms for safety while Resident E calmed down. Ms. Bowles stated that later on that same day, Resident E started attacking Resident F. Ms. Bowles stated that Resident E was calling Resident F "bitch" and Resident E was hitting Resident F. Ms. Bowles stated that Resident E pushed his thumbs into Resident F's eyes. Ms. Bowles stated that Resident E started physically attacking Resident F and Resident E choked Resident F until he turned purple. Ms. Bowles stated that she was told staff cannot touch Resident E because he was placed in the home by Macomb County Community Mental Health, but she had to get Resident E off of Resident F because Resident E would not stop choking Resident F. Ms. Bowles stated that once she was able to get Resident E off of Resident F, Resident E started hitting her. Ms. Bowles stated that Resident F called 911 and said he did not feel safe. Ms. Bowles stated that she was the only staff working, but she called Assistant Manager Jana Goss to come out to the home before the police left. Ms. Bowles stated that she was the only staff at the home from 8am to 8pm. Ms. Bowles stated that this was the 6th time she was attacked by a resident in the home. Ms.

Bowles stated that she had to go to the hospital and has injuries to her back. Ms. Bowles stated that the residents like to be violent and they like to throw things. Ms. Bowles stated that there needs to be at least two staff on every shift. Ms. Bowles stated that one staff is working alone with the residents on 12 ½ hour shifts. Ms. Bowles stated that only one staff works on the night shift alone from 8pm to 8am. Resident E was yelling, screaming, throwing things and using profanity in the background the entire time I was on the phone with Ms. Bowles. Ms. Bowles stated that her shift started at 8am and another staff is not scheduled to come in until 8pm.

On April 29, 2020, I conducted a phone interview with Staff Jana Goss. Ms. Goss stated that she was the assistant manager. Ms. Goss stated that she arrived at the home on April 21, 2020 before the police left. Ms. Goss stated that she received a phone call to come to the home because the police were on their way there. Ms. Goss stated that a lot of the residents in the home are violent towards each other. Ms. Goss stated that she is also the assistant manager at two other Beacon Homes. Ms. Goss stated that she is currently at the Clarkston location today. Ms. Goss stated that she has asked about putting more staff on each shift because it is needed, but it is the company's policy to only have one staff per shift when there are only four residents in the home. Ms. Goss stated that all of the residents in the home are violent. Ms. Goss stated that Resident A is usually more violent than Resident E. Ms. Goss stated that Resident A has had the police called on him several times and Resident E has put most of the holes in the walls at the home. Ms. Goss stated that Resident F is new to the home and he sometimes triggers Resident E's behaviors.

On May 12, 2020, I conducted a phone interview with Guardian E. Guardian E stated that she did not know anything about the incident on April 21, 2020 at the AFC home. Guardian E stated that she thought the home had at least two staff on duty at all times and they need to have at least two staff on every shift. Guardian E stated that Resident E was moved to Beacon Lapeer because of all the issues he was having at his previous adult foster care home. Guardian E stated that she had heard that Resident E was already having issues with another resident at the home. Guardian E stated that Resident E needs one-on-one staffing to deal with his behaviors and his behaviors are an ongoing problem.

On May 12, 2020, I conducted a phone interview with Guardian A. Guardian A stated that he was not aware of the incident on April 21, 2020 at the AFC home. Guardian A stated that Resident A has a history of violence in the home. Guardian A stated that he thought the home had two staff or more working every shift because of the residents they have. Guardian A stated that he is in the process of looking for another placement for Resident A. Guardian A stated that Resident A is usually the aggressor in the fights he is involved in at the AFC home.

On May 12, 2020, I conducted a phone interview with Guardian F. Guardian F stated that she did not know anything about the incident on April 21, 2020 at the AFC home. Guardian F stated that she did not know the home was only staffing one

person on shifts. Guardian F stated that she is concerned about the staffing level because there are at least two other residents in the home that have a lot of behaviors and can be pretty violent. Guardian F stated that Resident F recently moved to the home and he has a pretty intensive care plan. Guardian F stated that the home needs to have more than one staff on duty at all times for the safety and needs of all the residents.

On May 12, 2020, I conducted a phone interview with Staff Brenda Morningstar. Staff Brenda Morningstar stated that she was not at the home when the police came on April 21, 2020. Ms. Morningstar stated that the residents in the home do get into fights sometimes. Ms. Morningstar stated that Resident E gets upset when no one understands him. Ms. Morningstar stated that she usually works by herself in the evening from 8:00pm to 8:30am. Ms. Morningstar stated that there is always only one staff on duty in the evening and she was not sure about the day shift. Ms. Morningstar stated that she has to do a lot of prompting and encouraging with the residents in the evening so they can go to bed at night and are in a better mood in the morning.

On May 12, 2020, I conducted a phone interview with Staff Carolyn Beardsley. Ms. Beardsley stated that there has been fights with the residents in the home in the past. Ms. Beardsley stated that she works during the night alone at the home. Ms. Beardsley stated that there has always only been only one staff person on shift at night at the home even when there are more than four residents in the home. Ms. Beardsley stated that the day shift usually gets two staff on duty when there are more than four residents in the home.

On May 12, 2020, I conducted a phone interview with Staff Denise Fifield. Staff Denise Fifield stated that she was not at the home on April 21, 2020. Ms. Fifield stated that she has worked alone frequently at the home. Ms. Fifield stated that there have been some fights at the home with residents, but the fights are usually resolved some way. Ms. Fifield stated that she usually works 8:00am to 8:30pm alone and no residents receive one-on-one supervision.

In the Renewal Licensing Study Report dated October 16, 2018, it was noted that Resident D required assistance from two staff for fire drills and the facility was only scheduling one staff on third shift. The corrective action plan dated October 30, 2018 for the Renewal Inspection report stated that when there is evidence that a resident needs additional staffing, it will be addressed, and adjustments will be made.

In Special Investigation 2019A0501026 dated May 30, 2019, on March 26, 2019, staff Larry Kelly asked Resident A to tell Resident B it was time for bed. Resident B physically attacked Resident A and Resident A had to be sent to the hospital. Resident B physically attacked Resident A and Resident C during third shift when only one staff member was scheduled to work. Resident A and Resident C both had to go to the hospital after the attacks. The corrective action plan dated June 17,

2019 for Special Investigation 2019A0501026 stated that all staff will be trained on and understand the resident care plans. The home manager was demoted, and Resident B was moved to another Beacon home. Staff were supposed to receive specific training on individual plans of service, behavior plans and line-of-sight supervision.

On May 12, 2020, I attempted to contact Licensee Designee Kevin Kalinowski. I left him a message to call me back for an exit conference. On May 13, 2020, Licensee Designee Kevin Kalinowski called me back with Beacon Employee Melissa Williams. I informed Mr. Kalinowski that a six-month provisional license was recommended for the repeat violations. Mr. Kalinowski and Ms. Williams stated that they were not in agreement with the six-month provisional license. Mr. Kalinowski and Ms. Williams stated that they would look into some things and get back with me.

On May 14, 2020, I received a call from Macomb County CMH Recipient Rights Amber Sultes. Ms. Sultes stated that she did not receive a call, report, or documentation on the April 21, 2020 incident at the AFC home. Ms. Sultes stated that she should have received a report from the home on the incident. Ms. Sultes stated that Resident E, Resident G and Resident H were placed in the home by Macomb County CMH. Ms. Sultes stated that any incidents involving Resident E, Resident G, and Resident H are to be reported to Macomb County CMH Recipient Rights. Ms. Sultes stated that she thought the home had at least two staff on duty in the home at all times. Ms. Sultes stated that Resident H was moved out of the home on April 2, 2020, so the home was only staffing one person on shift when there was five residents in the home, which is definitely a problem since they take residents with high behaviors.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A has a history of physical aggression, property destruction, and verbal aggression. Resident A has aggression towards staff that can put them and other residents at risk. Resident F has limited comprehension, is verbally aggressive, physically aggressive to people and property, and does not get along with others. Resident F has had recent physical aggression towards staff and the police had to be called. Resident F is known to take advantage of others and is verbally explosive.

	Resident G lacks life skills and "sometimes" controls his aggressive behavior. When Resident G is upset, he has self-injurious behaviors, needs prompting with eating, bathing, grooming, dressing, and mobility. Resident G has difficulty with controlling aggressive behavior, has a history of property destruction, physical aggression, elopement, suicidal and homicidal thoughts. Resident G's plan states that he requires extensive monitoring by staff due to his autism diagnosis, which requires consistent monitoring of staff on every shift. Officer Bill Stokes and Staff Taylor Bowles stated that on April 21, 2020, Resident E physically attacked Resident A, Resident F and Staff Taylor Bowles. Officer Stokes stated that he has been called to the AFC home several times for physical assaults. Officer Stokes stated that since the home was opened on May 8, 2018, his police department has been called to the home 75 times. Officer Stokes stated that most of the police calls to the home are assaultive complaints with violence between the residents. Officer Bill Stokes, staff Taylor Bowles, Assistant Manager Jana Goss, Guardian A, Guardian E, Guardian F, and Macomb County CMH Recipient Rights Amber Sultes all expressed their opinion that the home needs to have at least two staff on duty at all times to properly meet the needs of the residents. I reviewed the staff schedule for February 24 through April 30, 2020. From 8:00am – 8:30pm and noted there were 31 days when only one staff person was listed on the schedule and 5 days had no staff listed on the schedule. From 8:30pm – 8:00am, there were 56 days when only one staff person was listed on the schedule and 10 days had no staff listed on the schedule. The licensee is not providing sufficient staff on duty at all times in the home for the supervision, personal care and protection of the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal Licensing Study Report dated October 16, 2018.** **Special Investigation 2019A0501026 dated May 30, 2019.**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Officer Bill Stokes and Staff Taylor Bowles stated that on April 21, 2020, Resident E physically attacked Resident A, Resident F and Staff Taylor Bowles. Officer Stokes stated that since the home opened on November 8, 2018, his department has been called to the home 75 times. Officer Stokes stated that most of the police calls to the home are assaultive complaints with violence between the residents. Ms. Bowles stated that Resident E had been bothering all of the residents on April 21, 2020. Ms. Bowles stated that Resident E punched Resident A and then Resident E ran back into the house. Ms. Bowles stated that when Resident A came back into the house Resident E threw a water jug at him. Ms. Bowles stated that Resident A picked up a chair and threw it at Resident E. Ms. Bowles stated that later on that same day, Resident E started attacking Resident F. Ms. Bowles stated that Resident E was calling Resident F “bitch” and Resident E was hitting Resident F. Ms. Bowles stated that Resident E pushed his thumbs into Resident F’s eyes. Ms. Bowles stated that Resident E started physically attacking Resident F and Resident E choked Resident F until he turned purple. Ms. Bowles stated that she had to get Resident E off of Resident F because Resident E would not stop choking Resident F. Ms. Bowles stated that once she was able to get Resident E off of Resident F, Resident E started hitting her. Ms. Bowles stated that Resident F called 911 and said he did not feel safe. Beacon Home at Lapeer has had several violent incidents in the home between residents, including the incident on April 21, 2020. Due to these incidents and lack of sufficient staff in the home, residents’ personal needs, including protection and safety, is not being attended to at all times in the home.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2019A0501026 dated May 30, 2019.**

ADDITIONAL FINDINGS:

On April 24, 2020, I sent an email to Licensee Designee Kevin Kalinowski and Administrator Matthew Owens requesting documents for the investigation.

I reviewed the staff schedule for February 24 through April 30, 2020. From 8:00am to 8:30pm, there were 31 days when only one staff person was listed on the schedule and 5 days had no staff listed on the schedule. From 8:30pm to 8:00am, there were 56 days with only one staff person listed on the schedule and 10 days had no staff listed on the schedule.

On February 24th, 25th, 26th and 27th, there were no staff on the schedule from 8:30pm to 8:00am. On March 2, 2020, there were no staff on the schedule from 10:30pm to 8:00am. On March 3rd, 4th, 5th, and 12th, there were no staff on the schedule from 8:30pm to 8:00am. On April 2nd and April 9th, there were no staff on the schedule from 8:30pm to 8:00am. On April 5th, 11th, 12th, 18th and 19th, there were no staff on the schedule from 8:00am to 8:30pm.

On June 18, 2020, I attempted to conduct a phone exit conference with Licensee Designee Kevin Kalinowski. Mr. Kalinowski's phone went to voicemail and I left a voice message for him to call me back. On June 19, 2020, I called Mr. Kalinowski back and conducted a phone exit conference. Mr. Kalinowski attempted to include Beacon Employee Melissa Williams on the phone call, but she did not answer. I informed Mr. Kalinowski of the additional findings of the investigation and the recommendation of the six-month provisional license. Mr. Kalinowski stated that he would look into the schedule for the staff and he did not agree to the six-month provisional license. Mr. Kalinowski stated that he would be requesting a compliance conference to discuss the investigation.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	I reviewed the staff schedule for February 24 through April 30, 2020. From 8:00am to 8:30pm, there were 31 days when only one staff person was listed on the schedule and 5 days had no staff listed on the schedule. From 8:30pm to 8:00am, there

	were 56 days with only one staff person listed on the schedule and 10 days had no staff listed on the schedule. On February 24th, 25th, 26th and 27th, there were no staff on the schedule from 8:30pm to 8:00am. On March 2, 2020, there were no staff on the schedule from 10:30pm to 8:00am. On March 3rd, 4th, 5th, and 12th, there were no staff on the schedule from 8:30pm to 8:00am. On April 2nd and April 9th, there were no staff on the schedule from 8:30pm to 8:00am. On April 5th, 11th, 12th, 18th and 19th, there was no staff on the schedule for 8am to 830pm. A daily schedule of work assignments and schedule changes has not been maintained by the licensee. The staff schedule during February 24, 2020 through April 30, 2020 had several days with no staff listed to work for various shifts.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable and approved corrective action plan, a six-month provisional license is recommended.

Crecendra Brown June 25, 2020

Crecendra Brown Date
Licensing Consultant

Approved By:

June 25, 2020

Jerry Hendrick Date
Area Manager