GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 17, 2021

Michael Houck
Adapt St. Joe, Inc.
907 N. Clay
Sturgis, MI 49091

RE: License #: AS750238862
Investigation #: 2022A0578003
MERCURY CLF

Dear Mr. Houck:

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,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS750238862
Investigation #:	2022A0578003
Complaint Receipt Date:	10/20/2021
Investigation Initiation Date:	10/20/2021
Report Due Date:	12/19/2021
Licensee Name:	Adapt St. Joe, Inc.
Licensee Address:	907 N. Clay Sturgis, MI 49091
Licensee Telephone #:	(269) 651-7900
Administrator:	Michael Houck
Licensee Designee:	Michael Houck
Name of Facility:	MERCURY CLF
Facility Address:	1616 West Chicago Road Sturgis, MI 49091
Facility Telephone #:	(269) 659-9131
Original Issuance Date:	12/06/2001
License Status:	REGULAR
Effective Date:	08/14/2020
Expiration Date:	08/13/2022
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff found Resident A in her wheelchair with the seat belt around her neck, choking and turning blue. Resident A became unconscious and had to be resuscitated by EMS.	Yes

III. METHODOLOGY

10/20/2021	Special Investigation Intake. 2022A0578003
10/20/2021	Special Investigation Initiated-Telephone.
10/21/2021	Contact-Telephone. -Interview with licensee designee Michael Houck.
10/22/2021	Special Investigation Completed On-site. -Interview with staff member Amanda Warner.
10/22/2021	Contact-Documentation Reviewed. -*Health Care Assessment* for Resident A, dated 11/17/20.
10/22/2021	Contact-Documentation Reviewed. -*Behavior Treatment Plan* for Resident A, dated 02/13/2020.
10/22/2021	Contact-Documentation Reviewed. -*Assessment for AFC Residents* for Resident A, dated 01/17/2021.
10/22/2021	Contact-Documentation Reviewed. -Physician's Order, Hoyer Lift use, 10/17/2021.
10/22/2021	Contact-Documentation Reviewed. -Physician's Order, Wheelchair Safety Belt, 10/20/2021.
10/22/2021	Contact-Documentation Reviewed. -Written statement by direct care staff Jason Milliman, dated 10/19/2021.
10/22/2021	Contact-Documentation Reviewed. -Written statement by direct care staff Heather Schrock, dated 10/19/2021.
10/22/2021	Contact-Documentation Reviewed.

	-Written statement by direct care staff Tasha Williams, dated 10/19/2021.
10/22/2021	Contact-Documentation Reviewed. -Written statement by licensee designee Michael Houck, dated 10/21/2021.
10/22/2021	Contact-Documentation Reviewed. -*Incident / Accident Report*, dated 10/19/2021.
10/22/2021	Contact-Documentation Reviewed. -*Medical Case Notes* for Resident A, dated 10/19/2021.
12/06/2021	Special Investigation Completed On-site. -Interview with staff member Amanda Warner.
12/06/2021	Contact-Telephone. -Interview with direct care staff Heather Schrock, unsuccessful.
12/06/2021	Contact-Telephone. -Interview with direct care staff Tasha Williams.
12/07/2021	Contact-Telephone. -Interview with direct care staff Heather Schrock, unsuccessful.
12/07/2021	Exit Conference -With the licensee designee, Mr. Michael Houck.
12/08/2021	APS Referral Completed.

ALLEGATION:

Staff found Resident A in her wheelchair with the seat belt around her neck, choking and turning blue. Resident A became unconscious and had to be resuscitated by EMS.

INVESTIGATION:

On 10/20/2021, I interviewed licensee designee, Mr. Michael Houck, regarding the allegation. Mr. Houck reported Resident A was in her wheelchair and had inadvertently slid down in this wheelchair and choked herself with the seatbelt equipped on her wheelchair. Mr. Houck reported direct care staff found Resident A with her face discolored and blue when staff removed the seatbelt from Resident A's neck, but Resident A was unresponsive. Mr. Houck reported direct care staff contacted 911 and initiated CPR until EMS arrived and successfully resuscitated

Resident A. Mr. Houck reported Resident A was taken to Sturgis Hospital for treatment and discharged back to the facility. Mr. Houck clarified that he was still obtaining information and that incident reports would be forthcoming shortly.

On 10/21/2021, I received an additional telephone call from licensee designee Mr. Michael Houck, informing me the direct care staff present and working at this facility on the day of the allegations may have misrepresented some of the facts of the event, as another direct care staff from an adjacent facility had observed both direct care staff outside of the facility visiting with two unknown men in a private vehicle prior to Resident A choking on her seatbelt. I noted the adjacent facility Mr. Houck was referencing was directly north of this facility, approximately 30yds with a shared driveway to this facility. I noted Mr. Houck as the licensee designee for this adjacent facility as well. Mr. Houck also reported that one of the involved direct care staff made a comment to another about purchasing marijuana prior to the occurrence detailed in the allegation. Mr. Houck reported concern both direct care staff members may have been outside purchasing marijuana while Resident A was choking on her seatbelt inside the facility unattended and unsupervised. Mr. Houck reported both direct care staff members have been suspended pending the investigation by the department as well as the Office of Recipient Rights. Mr. Houck added written statements would be obtained from direct care staff involved.

Equipped with personal protective equipment, on 10/22/2021, I completed an unannounced investigation on-site at this facility and interviewed direct care staff member Amanda Warner regarding the allegations. Ms. Warner reported serving as the home manager for this facility. Ms. Warner acknowledged the allegations and clarified that written statements regarding the allegations were obtained from the two direct care staff members, Ms. Heather Schrock, and Ms. Tasha Williams, that were working the day of the allegations as well as two additional direct care staff that were witness to the events. Ms. Warner reported Resident A had experienced a physical decline and weight loss which was suspected due to age. Ms. Warner reported Resident A had a history of being combative and attempting to bite prior to her decline. Ms. Warner reported direct care staff had also observed Resident A sliding down in her wheelchair while being transported in the van and added that Carelink Medical had come to the facility to adjust Resident A's wheelchair to prevent Resident A from sliding down in her wheelchair. Ms. Warner reported Resident A's wheelchair is often used when Resident A is in the community, in the van or feeding and that Resident A's seatbelt prevents Resident A from falling forward while moving or sliding down and out of the wheelchair. Ms. Warner clarified that Resident A is often lying on the couch in a reclined position so there is no concern for Resident A falling in this position. Ms. Warner reported Resident A was being closely followed by her physician, Dr. Bruce Hyde, and that Resident A's Ativan medication would be adjusted and that Resident A's Restoril was discontinued to increase Resident A's cognitive awareness.

While at the facility, I observed Resident A in a reclined position on a couch and observed Resident A's wheelchair and noted the width of this wheelchair exceeded

suitable dimensions for Resident A's current body size. I also noted the seatbelt permanently attached to this wheelchair consisted of a webbed belt with locking clip and push button release that was similar to a vehicle seat belt. I noted the length of the webbing of this seat belt was not adjustable by hand and was of a fixed and extended length. I observed Resident A to be of smaller stature and frame with no visible marks or bruising. Ms. Warner stated Resident A had a red mark on her neck shortly after the incident, but it had since gone away. I observed Resident A being examined by visiting RN Shannon Mitchel from Dr. Bruce Hyde's office. Ms. Warner stated Resident A was not capable of being interviewed due to language delay and cognitive disabilities. Ms. Warner denied that Resident A had the ability to unfasten the seatbelt attached to her wheelchair. Ms. Warner clarified that two months ago Resident A would have been able do so but not in her current state. I provided Ms. Warner with consultation regarding the use of an assistive device that could not be removed independently by the resident and informed Ms. Warner that in her current state, the seat belt attached to Resident A's wheelchair was not an appropriate assistive device and could not be used. Ms. Warner reported that a prescription for an assistive device that could be operated and removed by Resident A would be obtained that same day while RN Mitchel was present in the facility. Ms. Wagner acknowledged these concerns and stated a prescription to use a Hoyer lift with Resident A instead of her wheelchair due to these concerns had already been obtained from Resident A's physician Dr. Bruce Hyde. Ms. Warner further stated all direct care staff had been instructed on how to use the Hoyer lift to transfer Resident A. When asked if she knew why Resident A was in her wheelchair when the allegations occurred, Ms. Wagner reported that initially this was concerning to her as well and she confronted the direct care staff working the night of the allegations and they informed her that Resident A was placed in the chair so that she would not move or get hurt while they were outside. Ms. Wagner identified these direct care staff as Ms. Tasha Williams and Ms. Heather Schrock.

On 10/22/2021, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 01/17/2021. The *Assessment Plan for AFC Residents* for Resident A identifies Resident A's assistive devices as a wheelchair, van lift, shower chair, half bed rail and floor mat. The *Assessment Plan for AFC Residents* for Resident A did not identify the use of a Hoyer lift. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A uses a wheelchair for mobility and is a "stand and pivot" with staff assistance.

While at the facility, I reviewed the *Health Care Assessment* for Resident A, dated 11/17/20. The *Health Care Assessment* for Resident A documented that Resident A is diagnosed with a Seizure Disorder and Mental Retardation with an inability to stand and support her own weight. The *Health Care Assessment* for Resident A documented that Resident A's general appearance includes "scooting" her wheelchair with her feet on the floor and appears "weak" with "repetitive realizations." The *Health Care Assessment* for Resident A documented Resident A's mental and physical status and limitations as unable to bear weight on her left knee

with decreased cognition and poor communication. The *Health Care Assessment* for Resident A identified Resident A's use of a wheelchair with the use of a seat belt.

While at the facility, I reviewed the *Behavior Treatment Plan* for Resident A, dated 02/13/2020. The *Behavior Treatment Plan* for Resident A identified that Resident A incurred an irreparable knee injury in 2015 and is unable to bear weight on this knee and requires the use of a wheelchair. The *Behavior Treatment Plan* for Resident A identified that Resident A required the use of a seatbelt on this wheelchair to prevent Resident A from attempting to transfer herself on her own or get out of her wheelchair without assistance. The *Behavior Treatment Plan* for Resident A identified that Resident A will often undo the seatbelt of her wheelchair to try to standup without proper support or assistance. The *Behavior Treatment Plan* for Resident A identified Resident A as displaying combative behavior such as hitting, pinching, kicking, and biting when staff are attempting to provide physical assistance with personal care.

While at the facility, I reviewed the *Patient Visit Information* for Resident A from Sturgis Hospital ER, dated 10/19/2021. The *Patient Visit Information* for Resident A documented that Resident A was seen for "Aspiration in the airway" and a Urinary Tract Infection. The *Patient Visit Information* for Resident A identified that Resident A was provided Keflex for the Urinary Tract Infection and Flagyl as an additional measure for the aspiration to prevent aspiration pneumonia and to follow up with Resident A's regular physician.

On 10/22/2021, I reviewed a physician's order for Resident A, dated 10/18/2021 by Bruce Hyde, MD. Dr. Hyde ordered that Resident A has permission to be transferred by Hoyer lift in the home as needed.

On 12/06/2021, I reviewed a physician's order for Resident A, dated 10/20/2021 by Bruce Hyde, MD. Dr. Hyde ordered that Resident A needed to be fitted for a wheelchair safety belt.

On 10/22/2021, I contacted licensee designee Mr. Michael Houck and provided him with consultation regarding the seat belt attached to Resident A's wheelchair and informed him this belt was not an appropriate assistive device and could not be used as Resident A was no longer able to manipulate the safety belt on her own.

On 10/22/2021, I reviewed a written statement related to the allegations and provided by direct care staff Jason Milliman, dated 10/19/2021. Mr. Milliman documented on his written statement that while he was working at an adjacent facility (directly north of this facility approximately 30yds) he observed a vehicle enter the shared driveway and observed two individuals visit with the staff at this facility for approximately 5-15 minutes. Mr. Milliman documented on his written statement that two to five minutes after the vehicle left, staff from this facility ran to the facility he was working at and yelled for help. Mr. Milliman documented on his written

statement that he ran over to this facility and started performing CPR on Resident A until EMS arrived.

On 10/21/2021, I reviewed a written statement related to the allegations and provided by direct care staff Heather Schrock, dated 10/19/2021. Ms. Schrock documented on her written statement that she was changing another resident's clothes with direct care staff Tasha Williams was helping another resident in the shower. Ms. Schrock documented on her written statement that after providing this resident with assistance and entering the dining room, she observed Resident A with a purple face. Ms. Schrock documented on her written statement that she yelled for Ms. Williams to help and got Resident A out of the chair and removed the seat belt from Resident A's neck. Ms. Schrock documented on her written statement that Resident A's face was no longer purple but identified that Resident A was unconscious. Ms. Schrock documented on her written statement that she called 911 and told Ms. Williams to get help from the adjacent facility. Ms. Schrock documented on her written statement that she administered chest compressions to Resident A as directed by 911 dispatch. Ms. Schrock documented on her written statement doing rotations of chest compressions with Ms. Williams and Mr. Milliman until EMS arrived. Ms. Schrock documented on her written statement that EMS was successful in getting Resident A to breathe and Resident A was transported to Sturgis Hospital.

On 10/21/2021, I reviewed the written statement related to the allegations and provided by direct care staff Tasha Williams, dated 10/19/2021. Ms. Williams documented on her written statement that she had taken another resident into the bathroom to shower, and that Ms. Schrock had taken another resident into a bedroom to do personal care while Resident A was at the dining room table. Ms. Williams documented on her written statement that when Ms. Schrock entered the dining room, she saw Resident A and called Ms. Williams for help. Ms. Williams documented on her written statement that she and Ms. Schrock undid Resident A's seatbelt and called 911 and administered chest compressions until EMS arrived.

On 10/21/2021, I reviewed the written statement related to the allegations and provided by staff member Amanda Warner. Ms. Warner documented on her written statement that direct care staff Jason Milliman requested to speak with her and licensee designee, Mr. Michael Houck. Ms. Warner documented on her written statement that Mr. Milliman explained to her that he was sitting outside with another resident when he saw a vehicle arrive at this facility and observed two men meeting with direct care staff Heather Schrock and Tasha Williams outside of this facility for approximately five to ten minutes. Ms. Warner documented in her written statement that Mr. Milliman reported the vehicle stayed in the driveway for approximately 20 to 30 minutes before leaving. Ms. Warner documented on her written statement that Mr. Milliman informed her that shortly after this, Ms. Heather Schrock ran out of the facility and screamed for help.

On 10/21/2021, I reviewed the written statement provided by licensee designee Mr. Michael Houck. Mr. Houck documented on his written statement that direct care staff

Leeta Merriman came to his office to inform him that after learning Resident A had choked and was taken to the hospital after arriving at this facility, Mr. Heather Schrock had commented to Ms. Merriman that she had found Resident A after she and Ms. Williams had met with one of her “guys” to buy some “weed” and that Resident A always does this to her (Ms. Schrock) when she is “high.”

On 10/21/2021, I reviewed the *Incident / Accident Report* related to the allegations, dated 10/19/2021. Direct care staff Heather Schrock documented the following:

> “While Heather Schrock and Tasha Williams were doing personal care on the other two consumers [Resident A] slid down in a wheelchair. When staff came out to help her up realized her seat belt on her wheelchair was choking [Resident A]. [Resident A] was unconscious.”
>
> “Staff got [Resident A] out of her chair and got seat belt off. Called 911 and was directed to start chest compressions. JM (Jason Milliman) came to assist from Polaris until EMT came on site and continued. HM (Home manager) called and consumer was transported to Sturgis hospital. Supervisor called director, guardian and then staff to follow up. [Resident A] was seen at Sturgis hospital and treated for UTI and possible aspiration. Home supervisor is investigating situation with director and will follow up.”

On 10/25/2021, I reviewed the *Medical Case Notes* for Resident A, dated 10/19/2021, which described the following: “[Resident A] went to Sturgis Hospital when staff found her unresponsive. [Resident A] had her labs done and X-rays for her chest, neck, and back, MRI was done. Labs showed a Urinary Tract Infection and small aspiration in her lungs. [Resident A] was discharge with antibiotics after receiving a dose at the hospital.”

On 12/06/2021, I interviewed direct care staff Tasha Williams regarding the allegations. Ms. Williams acknowledged working with direct care staff Heather Schrock when the allegations occurred. Ms. Williams reported that prior to assisting another resident with a shower, Resident A was in her wheelchair and clarified that Resident A was secured in her seat belt as she “scooted” through the facility independently and “relaxing”. Ms. Williams reported that while she was in the bathroom assisting a resident in the shower with the door closed, Ms. Schrock informed her that Resident A had choked, and Ms. Williams went to assist. Ms. Williams clarified that Resident A was between the office and her room, and she and Ms. Schrock thought that they could hear Resident A if she needed assistance. Ms. Williams reported that Resident A always has the seat belt locked and in place when Resident A is in her wheelchair. Ms. Williams reported this belt prevents Resident A from falling out of the wheelchair. Ms. Williams acknowledged the seat belt for Resident A was very long in length and clarified that she had informed her supervisor that Resident A could now again open the belt, as Resident A was being transported to Kalamazoo when she undid her seatbelt. Ms. Williams denied ever going outside of the facility prior to Resident A choking on her seatbelt. Ms. Williams

reported that she understood that another staff reported seeing her outside but denied this had occurred, stating that she was in the bathroom assisting the other resident prior to the allegations.

On 12/06/2021, I interviewed staff member Amanda Warner regarding the allegations. Ms. Warner reported that Resident A had no lasting side effects from the allegations and Resident A's health had improved to where Resident A was again capable of undoing her seat belt as staff had observed Resident A doing so while being transported in the van. Ms. Warner also reported that a smaller wheelchair was ordered and obtained for Resident A. I observed the new wheelchair for Resident A and found it to be comparable in size to Resident A. Resident A was observed in this facility with no visible marks or bruises or injuries.

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:	During an unannounced investigation on-site, staff member Amanda Wagner reported a decline in Resident A's weight and cognitive abilities due to age, and clarified that Resident A was no longer capable of unfastening the seat belt attached to her wheelchair. Ms. Wagner reported that because of this decline, a prescription to use a Hoyer lift instead of a wheelchair was obtained for Resident A, and staff were instructed on the use of this Hoyer lift. Written statements obtained from direct care staff Tasha Williams and direct care staff Heather Schrock indicated Resident A was alone and unsupervised in the dining room of the facility by both direct care staff members while in her wheelchair prior to sliding down in her wheelchair and asphyxiating on the attached seat belt. During an interview, direct care staff Tasha Williams reported that Resident A was in the dining room alone and in her wheelchair "relaxing" prior to sliding down in her wheelchair and asphyxiating on the attached seat belt. A review of the *Assessment Plan for AFC Residents* for Resident A documented that Resident A is to use a wheelchair for mobility and is a "stand and pivot" with staff assistance. Despite being aware that Resident A could no longer manipulate her safety belt and having an alternative order to use a Hoyer lift when transferring, Resident A was improperly supervised and left alone in her wheelchair, secured by her safety belt while not

	being transferred or provided with staff assistance. While improperly supervised, Resident A slid down in this wheelchair and asphyxiated on her safety belt, to the point of requiring resuscitation, emergency medical care and hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee. **(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.**
ANALYSIS:	During an unannounced investigation on-site, staff member Amanda Wagner reported a decline in Resident A's weight and cognitive abilities due to age, and clarified this decline was being addressed by Resident A's primary physician with medication adjustments. Ms. Wagner reported that as a result of this decline, Resident A was no longer capable of unfastening the seat belt attached to her wheelchair. Ms. Wagner reported that a prescription to use a Hoyer lift instead of a wheelchair was obtained for Resident A. While at the facility, I observed the wheelchair equipped with a seat belt for Resident A and determined its dimensions were incompatible for Resident A's current size. During this unannounced investigation on-site, authorization from a licensed physician ending or modifying Resident A's use of a wheelchair that was too large and equipped with a seatbelt that Resident A was incapable of releasing was not available. I reviewed a prescription from Dr. Bruce Hyde requesting a fitted wheelchair safety belt which was not obtained until 10/20/2021. I reviewed a prescription from Dr. Bruce Hyde that allowed for Resident A's use of a Hoyer lift for transferring which was dated 10/18/2021. I reviewed the *Assessment for AFC Residents* for Resident A which still identified the use of a wheelchair but did not reflect that a Hoyer lift should be utilized or the reason for when a Hoyer lift would be utilized. During this investigation I verified with staff member

	Amanda Warner, direct care staff Tasha Williams and licensee designee Michael Houck that on 10/19/2021, Resident A was found by direct care staff in her wheelchair slid downward and asphyxiated by her wheelchair seatbelt which she did not or could not remove or release. An authorization by a licensed physician and or an updated *Assessment Plan for AFC Residents* ending Resident A and direct care staff's utilization of an ill-fitting wheelchair and a seat belt that could not be removed or released by Resident A contributed to the life-threatening injury of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	During this investigation, licensee designee Michael Houck disclosed that direct care staff Tasha Williams and Heather Schrock were reportedly observed outside of the facility prior to Resident A being asphyxiated by the seat belt fastened to her wheelchair. During an interview, staff member Amanda Wagner reported that she was unaware why Resident A was in her wheelchair at the time of the allegations and reported confronting staff who had informed her that Resident A was placed in her wheelchair so that she would not move or get hurt while direct care staff were outside. During an interview, direct care staff denied being outside of the facility prior to the allegations and reported that prior to entering a bathroom to assist another resident, Resident A was in the dining room secured in her wheelchair with a seat belt as she "scooted" through the facility independently and "relaxing". Direct care staff Heather Schrock was unable to be interviewed. I reviewed the *Behavior Treatment Plan* for Resident A and confirmed the *Behavior Treatment Plan* for Resident A identified that Resident A required the use of a seatbelt on this wheelchair to prevent Resident A from attempting to transfer herself on her own or get

	out of her wheelchair without assistance. As such, there is not enough evidence that direct care staff used Resident A's wheelchair and seatbelt to immobilize Resident A while they went outside.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, I recommend modification of this license to a first six month provisional license for quality of care violations.

12/08/2021

Eli DeLeon Date
Licensing Consultant

Approved By:

12/16/2021

Dawn N. Timm Date
Area Manager