GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 27, 2022

Miranda Labarge
1357 Terrace St
Muskegon, MI 49442

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|---|---|
| RE: License #: | AS610407159 |
| Investigation #: | 2022A0356004 |
| | Cottage House Retreat |

Dear Mrs. Labarge:

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. 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. If 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

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| **License #:** | AS610407159 |
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| **Investigation #:** | 2022A0356004 |
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| **Complaint Receipt Date:** | 11/23/2021 |
| | |
| **Investigation Initiation Date:** | 11/24/2021 |
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| **Report Due Date:** | 01/22/2022 |
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| **Licensee Name:** | Miranda Labarge |
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| **Licensee Address:** | 1357 Terrace St<br>2171 Monte Dr<br>Muskegon, MI 49442 |
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| **Licensee Telephone #:** | (231) 375-0060 |
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| **Administrator:** | Miranda LaBarge |
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| **Licensee Designee:** | Miranda LaBarge |
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| **Name of Facility:** | Cottage House Retreat |
| | |
| **Facility Address:** | 2171 Monte Dr.<br>Fruitport, MI 49442 |
| | |
| **Facility Telephone #:** | (231) 375-0060 |
| | |
| **Original Issuance Date:** | 05/24/2021 |
| | |
| **License Status:** | REGULAR |
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| **Effective Date:** | 05/24/2021 |
| | |
| **Expiration Date:** | 11/23/2021 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL, AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
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| The licensee, Miranda LaBarge fails to communicate with Resident A's legal guardian. | No |
| Resident A's foot care is not being completed as required. | Yes |

## III. METHODOLOGY

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| 11/23/2021 | Special Investigation Intake<br>2022A0356004 |
| 11/24/2021 | Special Investigation Initiated - Telephone<br>Kristina Genson, legal guardian. |
| 11/24/2021 | Contact - Telephone call made<br>Health West, Laura Ritchie and case manager, Carlie. |
| 11/24/2021 | Contact - Document Received<br>Documents received. |
| 11/29/2021 | Contact-Document Received<br>Emailed information from K. Genson with an additional allegation. |
| 12/01/2021 | Contact - Telephone call received<br>Laura Ritchie, Health West supervisor. |
| 12/01/2021 | Contact-Document Received<br>Photos of Resident A's nails-K. Genson. |
| 12/08/2021 | Contact - Face to Face<br>Miranda LaBarge-Licensee Designee. |
| 12/13/2021 | Contact - Telephone call made<br>Jerry Hendrick-area manager. |
| 12/13/2021 | Contact - Telephone call made<br>Miranda LaBarge-LD |
| 01/04/2022 | Contact - Document Sent<br>Resident A, healthcare appraisal. |
| 01/19/2022 | Contact - Telephone call made<br>Case manager, Health West, Carly Campbell & Laura Ritchie. |

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| 01/25/2022<br>01/27/2022 | Exit Conference-Licensee Designee, Miranda LaBarge. |

**ALLEGATION: The licensee, Miranda LaBarge fails to communicate with Resident A's legal guardian.**

**INVESTIGATION:** On 11/23/2021, I received an email from Kristina Genson, Resident A's legal guardian. Ms. Genson reported that the Licensee, Miranda LaBarge's lack of communication with her is a major issue that needs to be addressed. Ms. Genson reported not only is Ms. LaBarge's communication with her extremely poor, but Ms. LaBarge is now communicating with another relative (Relative #1) who is Resident A's sibling. Ms. Genson explained that Relative #1 has been assisting her (Ms. Genson) with fielding telephone calls from Resident A as she has been calling more often and Relative #1 told Resident A and Ms. LaBarge that Resident A should call her with any issues to "give Kristina a break." Ms. Genson reported that neither Relative #1 nor Ms. LaBarge informed Ms. Genson about this change in communication. Ms. Genson reported that while she appreciates Relative #1's efforts to relieve stress, Relative #1 is not Resident A's legal guardian and Ms. LaBarge should not be taking instruction from Relative #1. Ms. Genson reported that Ms. LaBarge should not be discussing any issues regarding Resident A with anyone other than herself as Resident A's legal guardian and if Ms. LaBarge cannot reach her for any reason, she should reach out to the responsible agency, HealthWest.

Ms. Genson reported that Ms. LaBarge had previously been communicating with her via text messages which Ms. LaBarge initiated in May of 2021 due to the fact that Ms. Genson was having issues reaching Ms. LaBarge at the facility. Ms. Genson stated she had to leave messages with staff and then Ms. LaBarge claimed she never received the messages. Ms. Genson reported that she told Ms. LaBarge how difficult it was to reach her, so Ms. LaBarge gave her mobile phone number to Ms. Genson, and they began texting. Ms. Genson reported after several text communications, Ms. LaBarge abruptly stopped responding to text messages at the end of June 2021. Ms. Genson stated Ms. LaBarge never responded to another text after June 28th 2021 and she did not contact Ms. Genson to discuss alternative ways to communicate. Ms. Genson reported she has asked Ms. LaBarge to simply reply to text messages so she (Ms. Genson) knows she received the information as it was Ms. LaBarge who initiated text messages to begin with. Ms. Genson reported Ms. LaBarge refuses to reply via text and does not answer her cell phone when Ms. Genson calls.

Ms. Genson stated she has a "pick up list" with family members on the list who are allowed to pick Resident A up and those who are not allowed. Ms. Genson stated she must have communication with Ms. LaBarge if that list changes so Ms. LaBarge knows who, at that given date and time, are able to pick Resident A up from the facility and those who are not. Ms. Genson reported an incident that occurred on 11/20/2021 regarding other family members who wanted to pick Resident A up from

the facility for upcoming holidays and church on Sundays. Ms. Genson reported she texted Ms. LaBarge at 1:17p.m. and did not get a response by 7:20p.m. so she texted Ms. LaBarge again, and at 7:53p.m. she (Ms. Genson) drove up the road to call Ms. LaBarge on the facility landline and the call went straight to a fax machine. Ms. Genson stated she has poor reception at her cottage and prefers to text because if she has to make a telephone call, she has to drive up the road for reception. Ms. Genson stated she called again, and Ms. LaBarge answered the facility landline and requested that Ms. Genson call back as the phone was still on the fax line. Ms. Genson stated this is an issue because anyone that needs to leave a message on the land line cannot if the fax machine is on. Ms. Genson stated she called back five times because it kept going to the fax before she was able to reach Ms. LaBarge. Ms. Genson reported that in the meantime, she also called Ms. LaBarge's cell phone which was not answered. Ms. Genson stated when she was able to reach Ms. LaBarge, she reminded her that they had been communicating via mobile phone and that was the easiest and best way for her (Ms. Genson) to communicate. Ms. Genson stated Ms. LaBarge told her that she (Ms. Genson) had to call and only call her (Ms. LaBarge) on the landline at the facility. Ms. Genson reported she needs to be able to reach Ms. LaBarge to get responses in a timely manner for pickups and appointments. Ms. Genson reported she should not have to keep reaching out to Ms. LaBarge in various ways to verify if she received messages and information. Ms. Genson stated there are times when she only has texting capability due to service area or work.

On 11/24/2021, I contacted Ms. Genson and confirmed receipt of the complaint information and confirmed the main concern of this complaint is the communication difficulties between Ms. Genson and Ms. LaBarge. Ms. Genson reported that Ms. LaBarge missed a meeting with her in March 2021 at HealthWest and after a few days of no calls from Ms. LaBarge, she (Ms. Genson) had to reach out to Ms. LaBarge and reschedule the meeting. Ms. Genson reported when she asked Ms. LaBarge if she forgot about the meeting and Ms. LaBarge stated she was "too busy running two homes."

On 11/29/2021, I received an email from Ms. Genson with additional information that she requested be added to the lack of communication or no communication complaint. Ms. Genson reported Thanksgiving did not go well because Relative #2 arrived at the facility to pick Resident A up and Ms. LaBarge told Relative #2 that she had not received permission from Ms. Genson for Relative #2 to pick Resident A up. Ms. Genson stated she had to leave her cottage and drive up the road in order to get service when she would have been able to get and send texts with Ms. LaBarge if she could communicate with her in that manner. Ms. Genson stated a voicemail did ring in from Ms. LaBarge stating that Relative #2 had come to pick Resident A up and that Ms. LaBarge needed permission. Ms. Genson stated she had given Ms. LaBarge permission the pervious Saturday and Ms. LaBarge stated she did not receive that text. Ms. Genson stated she reminded Ms. LaBarge that they had spoken over the telephone about it. Ms. Genson reported that she believes licensing rules require that licensees communicate with guardians in the guardians' preferred

choice of communication and “I choose text or email because Miranda has hung up on me on three occasions now.”

On 11/29/2021, I received, from Ms. Genson, and reviewed copies of the text messages between Ms. Genson and Ms. LaBarge beginning 05/24/2021 and ending on 07/29/2021. Ms. LaBarge responded to Ms. Genson’s texts up until 06/29/2021 and for the next month of texts, Ms. Genson was texting Ms. LaBarge and there was no response from Ms. LaBarge.

On 12/01/2021, I interviewed Laura Ritchie, HealthWest supports coordinator supervisor via telephone. Ms. Ritchie stated she is aware of the communication conflict between Ms. Genson and Ms. LaBarge. Ms. Ritchie stated she and Carly Campbell, Resident A’s supports coordinator attempted in August or September of 2021 to get Ms. Genson and Ms. LaBarge together to get an agreement on how the two would effectively communicate and what method they agreed on to use in order to keep information flowing and provide them with alternatives if things were not working for one or the other. Ms. Ritchie stated the facility landline was what Ms. LaBarge wanted Ms. Genson to use and if she (Ms. LaBarge) could not answer the telephone, Ms. Genson could leave a message and if Ms. LaBarge needed to call back, she would contact Ms. Genson. Ms. Ritchie stated Ms. LaBarge was not interested in the proposed meeting. Ms. Ritchie stated there have not been any problems with communication between HealthWest and Ms. LaBarge.

On 12/08/2021, I interviewed Ms. LaBarge at the facility. Ms. LaBarge stated she prefers Ms. Genson to call the facility telephone which is a landline. Ms. LaBarge stated she has made it clear to Ms. Genson that she would like to communicate via telephone rather than text or emails. Ms. LaBarge stated her cell phone is her personal cell phone and it is what she uses for personal communication and texting. Ms. LaBarge stated she has a personal cell phone and a business landline located in the facility. Ms. LaBarge stated she prefers to handle business calls regarding residents via the facility landline. Ms. LaBarge stated there is always someone, either herself or staff, at the facility and if the residents are out of the home at day programming and she or staff are out of the facility, they will be back by 3:00p.m. and will get messages and return telephone calls if necessary. Ms. LaBarge stated she does not regularly look at or read the emails that come on her personal cell phone unless someone tells her they emailed her. Ms. LaBarge stated she prefers to communicate by telephone and stated she has talked to Ms. Genson about her desire to communicate in this way. Ms. LaBarge confirmed that she did exchange text messages with Ms. Genson for a while in the spring of 2021 until Ms. Genson began to get “crazy with me” via text so she cut it off and requested Ms. Genson communicate by telephone via the facility landline.

Ms. LaBarge stated Ms. Genson has spelled out on Resident A’s assessment plan, who can communicate with Resident A as well as who can pick her up and who cannot. Ms. LaBarge stated on a Sunday, Relative #3 came to pick Resident A up but she (Ms. LaBarge) did not have permission for Resident A to go with Relative #3.

Ms. LaBarge stated Ms. Genson wants to be called and notified every time Resident A is picked up by someone not on the list and Ms. LaBarge is trying to accommodate that, but it is ever changing. Ms. LaBarge stated she called Ms. Genson on Thanksgiving Day to check and see if Relative #2 could pick Resident A up. She had to leave a message as Ms. Genson had not notified her (Ms. LaBarge) that it was ok for Relative #2 to pick Resident A up. Ms. LaBarge stated she tries to keep communication between herself and Ms. Genson "strictly business" but sometimes the amount of communication Ms. Genson requires is difficult to maintain.

On 12/08/2021, I reviewed Resident A's Assessment Plan for AFC Residents signed by Ms. LaBarge on 03/02/2021, Ms. Genson, guardian on 04/16/2021 and Susan Griswold, HealthWest supports coordinator (previous) on 03/02/2021. The assessment plan documents that Resident A participates in social and program activities with family and friends and documents those as Relative #1, Relative #4, Relative #5 and Ms. Genson. The document states Relative #4 cannot pick Resident A up. There is no mention of Relatives #2 or #3 as persons that can pick Resident A up for social or program activities and therefore, Ms. LaBarge stated she is careful as to who Resident A leaves the facility with and contacts Ms. Genson when there are questions as to who should be picking Resident A up and who should not.

On 01/25/2022, I conducted an Exit Conference with Licensee Designee, Miranda LaBarge via telephone. Ms. LaBarge accepted the information, analysis and conclusion of this applicable rule.

| **APPLICABLE RULE** | |
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| **R 400.14201** | **Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.** |
| | (11) A licensee, direct care staff, and an administrator shall be willing to cooperate fully with a resident, the resident's family, a designated representative of the resident and the responsible agency. |
| **ANALYSIS:** | Resident A's guardian (Ms. Genson) stated she prefers to communicate with the licensee (Ms. LaBarge) via text or email but Ms. LaBarge refuses to do so.<br><br>Ms. LaBarge stated that she prefers to communicate with Ms. Genson, using the facility telephone.<br><br>Based on the investigative findings, there is communication between Ms. Genson and Ms. LaBarge, however it is not the mode Ms. Genson prefers. While this rule states that the licensee shall be willing to cooperate with the resident's family |

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| | and designated representative it does not dictate how Ms. LaBarge is to communicate with Ms. Genson. Therefore, a violation of this applicable rule is not established. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION: Resident A's foot care is not being completed as required.**

**INVESTIGATION:** On 11/29/2021, Ms. Genson emailed an additional allegation and reported Relative #1 had Resident A over the weekend of 11/27 & 11/28/2021 and sent Ms. Genson some concerning photographs of Resident A's feet. Ms. Genson reported that Resident A's toenails have not been attended to in a long time. Ms. Genson reported the former owner of this facility used to have a podiatrist come into the facility every 6-8 weeks to tend to residents' nail care. Ms. Genson reported that if Ms. LaBarge decided not to continue that service for some reason, she (Ms. Genson) should have been informed so alternative arrangements could have been made. Ms. Genson stated Ms. LaBarge does not complete basic care for Resident A such as getting her toenails trimmed and kept up.

On 12/01/2021, Ms. Genson sent an email and provided a photograph of Resident A's foot reportedly taken on the 11/27-11/28/2021 weekend. The photo shows a foot with long, overgrown toenails, two of which, the big toe and the 4th toenails beginning to curl around the end of the toe.

*On 12/01/2021, Ms. Genson included an email with the photo stating, 'It appears that the podiatrist is no longer visiting the home? Miranda should have notified me of the condition of (Resident A's) toenails so that I could make arrangements for them to be cared for if the podiatrist is no longer visiting the home. (Relative #1) took these photos and asked (Resident A) if her feet hurt in her shoes due to the length of her toenails and (Resident A) said yes. This is where (Resident A) has trouble communicating her issues and why the licensee should be reporting that grooming of toenails needs to be addressed. It is a basic grooming and health item that Miranda should be monitoring. Diane (the former Licensee) had scheduled visits from a podiatrist. I spoke to Diane on Tuesday, and she stated that Miranda was aware of this. This was never stated on (Resident A's) assessment plan. It was just an ongoing service. I understand that this possibly releases Miranda, but she should have communicated that she was not going to continue that service. Most importantly, regardless of the service being discontinued Miranda should be notifying me of the need for (Resident A's) toenails to be trimmed.'*

On 12/08/2021, I interviewed Ms. LaBarge at the facility. Ms. LaBarge stated when she first bought this facility and began running it in February 2021, there was a podiatrist that came to the home and trimmed two of the residents' nails, Resident A being one of them. Ms. LaBarge stated the podiatrist retired during the summer months and there was never another podiatrist that replaced him. Ms. LaBarge stated she does not know who set the podiatrist service up and thought when the

podiatrist retired, he would refer the case on to another doctor to pick up where he left off, but another podiatrist has not shown up and Ms. LaBarge has not followed-up on it. Ms. LaBarge stated Resident A is independent with her grooming and care so unless Resident A says something about her toenails, she (Ms. LaBarge) would not necessarily be looking at Resident A's toenails since Resident A is able to complete her grooming care independently. Ms. LaBarge stated Resident A has her own clippers and has possession of those clippers, so she has access to the tools she needs to trim her own toenails. Ms. LaBarge stated she has never prompted or needed to prompt Resident A to clip her own nails or keep up on her own personal care, she just does it. Ms. LaBarge stated she did not notice Resident A's toenails were overgrown when Resident A took showers, because Resident A does not require assistance from staff with grooming, personal care, or showering. Ms. LaBarge stated she is available to assist Resident A if she needs help but does not perform personal care or grooming for Resident A. Ms. LaBarge stated she would remind and prompt Resident A to shower and perform personal grooming if she needed it but she did not prompt Resident A because Resident A typically completes her ADL's (activity of daily living) on her own and does not require reminding or prompting. Ms. LaBarge stated the podiatry services were set up prior to her owning this facility and since the podiatrist is a doctor, she thought HealthWest, or Ms. Genson set the service up and they were in charge of maintaining medical services for Resident A. Ms. LaBarge stated when the services of the podiatrist stopped, she assumed the case manager and/or legal guardian were aware of it and would arrange for a continuation of the service as they saw necessary. Ms. LaBarge acknowledged that she did not follow-up on why the services ended or if the services should continue and did not notify Ms. Genson or HealthWest that the service was no long in place.

On 12/08/2021, I reviewed Resident A's Assessment Plan for AFC Residents signed by Ms. LaBarge on 03/02/2021, Ms. Genson, guardian on 04/16/2021 and Susan Griswold, HealthWest supports coordinator (previous) on 03/02/2021. The assessment plan documents that Resident A requires help with grooming (hair care, teeth, nails, etc.) and explains the help required as "needs prompting." The assessment plan documents that Resident A requires help with personal hygiene and explains the help required as "needs reminders."

On 12/09/2021, Ms. LaBarge called and stated she looked at Resident A's toenails and they are overgrown. Ms. LaBarge asked Resident A while on the phone how her toenails are cared for and clipped. Resident A responded by telling Ms. LaBarge that "a doctor comes and cuts them for me." Ms. LaBarge asked whose responsibility it is to set up a podiatry service since it appears as though the one that was coming to the facility did not refer his services to another provider when he retired. I informed Ms. LaBarge that either the supports coordinator, the guardian or she (Ms. LaBarge) can set this service up and the legal guardian should approve the service for Resident A.

On 12/13/2021, I spoke to Ms. LaBarge via telephone. Ms. LaBarge stated she has not set up a podiatrist to come into the facility yet, but Resident A will be seeing a foot/ankle specialist this week 12/13/2021-12/17/2021, with her HealthWest supports coordinator, Carly Campbell.

On 01/04/2022, I received and reviewed Resident A's health care appraisal. The appraisal is dated 06/16/2021 and signed by Ashley Groendyk, PAC (Physician Assistant). The appraisal documents Resident A as fully ambulatory and does not document any information regarding Resident A's feet or toes as having any concerns or issues.

On 01/24/2022, I interviewed Ms. Ritchie (HealthWest supports coordinator supervisor) via telephone. Ms. Ritchie stated she does not know who set podiatry services up in the facility or how long those services were available to Resident A in the facility or when the service ended.

On 01/25/2022, I interviewed Diane Wildrom, former licensee. Ms. Wildrom stated she set up the podiatry services in the home long before Resident A lived there, and she did it as a service to residents and to help the families, so they did not have to make time to take the resident out for foot care. Ms. Wildrom stated she informed Ms. LaBarge of the podiatrist services so she was aware of it and the podiatry services were performed in the facility when Ms. LaBarge became the licensee. Ms. Wildrom stated Ms. LaBarge changed the telephone number of the facility once she became the licensee, and it is possible that the podiatrist could no longer reach the home via telephone in order to set the dates for service. Ms. Wildrom stated she had never been told by the podiatrist that he planned to retire. Ms. Wildrom stated Resident A was capable of showering and grooming herself, but she (Ms. Wildrom) had to prompt and remind Resident A to perform her ADL's, because she would be resistant to getting cleaned up sometimes yet, there were other times where Resident A would shower and groom herself without prompts. Ms. Wildrom stated she never clipped Resident A's toenails; they were always cut by the podiatrist. Ms. Wildrom stated she did not know if Resident A was capable of clipping her own toenails.

On 01/27/2022, I conducted an Exit Conference with Licensee Designee, Ms. LaBarge via telephone. Ms. LaBarge stated since podiatry services are performed by a doctor, she thought the legal guardian, or the case manager would be the person to set up and continue that service once it ended. Ms. LaBarge acknowledged that she did not inform the guardian or the case manager that the service had ended but also thought they were the ones who set that service up and would keep it active. Ms. LaBarge stated Resident A is independent with grooming and has access to her own nail clippers. Ms. LaBarge stated she will submit an acceptable corrective action plan.

| APPLICABLE RULE | |
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| **R 400.14303** | **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:** | Ms. Genson reported Resident A's toenails were overgrown and not cared for. She reported a podiatrist used to go into the facility and cut Resident A's toenails however, this service was ended without her knowledge and no alternative arrangements were made by the licensee.<br><br>A photo of Resident A's foot taken over the weekend of 11/27/21 & 11/28/2021 shows Resident A's toenails overgrown to the point where two of the toenails were beginning to curl around the end of the toe.<br><br>Ms. LaBarge confirmed a podiatrist previously came to the home and trimmed Resident A's toenails. The podiatrist retired during the summer months, and no arrangements were made for a replacement. Ms. LaBarge stated Resident A is independent with her grooming and she did not notice that Resident A's toenails were long and overgrown.<br><br>Resident A stated a doctor comes to the home and cuts her toenails; she does not cut them.<br><br>A review of Resident A's health care appraisal dated 06/16/2021 does not document any concerns regarding Resident A's toes or feet.<br><br>A review of Resident A's assessment plan dated 03/02/2021 documents that Resident A requires prompts with grooming including nailcare but does not indicate that Resident A requires personal/direct assistance.<br><br>According to the resident assessment plan, Resident A is capable of performing grooming ADL's with prompting. However, it is not clear as to whether or not Resident A is capable of keeping her toenails cut and groomed as a podiatrist always performed that task. Ms. LaBarge reported the podiatry services to the home abruptly stopped and acknowledged that she did not follow-up as to why the service ended and did not inform the guardian of the services ending. Further, Ms. LaBarge reported she did not prompt Resident A with grooming |

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| | tasks including nail care because Resident A always did it on her own and did not need prompting. However, based on Resident A's assessment plan, Resident A did require prompts to perform grooming tasks. Therefore, a violation of this applicable rule is established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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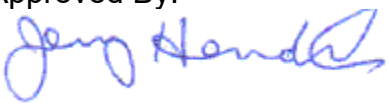
| Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged. |

01/27/2022

Elizabeth Elliott Date
Licensing Consultant

Approved By:



01/27/2022

Jerry Hendrick Date
Area Manager