GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 23, 2022

Junche Walangitan
Forest Beach Home Inc
P.O. Box 187
Watervliet, MI 49098

RE: License #: AL110006891
Investigation #: 2022A0579031
Forest Beach Home Inc

Dear Mr. Walangitan:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001
(269) 615-5050

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 #:** | AL110006891 |
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| **Investigation #:** | 2022A0579031 |
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| **Complaint Receipt Date:** | 07/25/2022 |
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| **Investigation Initiation Date:** | 07/25/2022 |
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| **Report Due Date:** | 09/23/2022 |
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| **Licensee Name:** | Forest Beach Home Inc |
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| **Licensee Address:** | 8021 Forest Beach Rd<br>Watervliet, MI 49098 |
| | |
| **Licensee Telephone #:** | (269) 463-8378 |
| | |
| **Administrator:** | Kanika Walangitan |
| | |
| **Licensee Designee:** | Junche Walangitan |
| | |
| **Name of Facility:** | Forest Beach Home Inc |
| | |
| **Facility Address:** | 8021 Forest Beach Road<br>Watervliet, MI 49098 |
| | |
| **Facility Telephone #:** | (269) 463-8378 |
| | |
| **Original Issuance Date:** | 11/16/1984 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 02/06/2022 |
| | |
| **Expiration Date:** | 02/05/2024 |
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| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED/ MENTALLY ILL/<br>DEVELOPMENTALLY DISABLED/ AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
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| Resident A was not supervised. | Yes |
| Resident A did not receive her insulin. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

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| 07/25/2022 | Special Investigation Intake<br>2022A0579031 |
| 07/25/2022 | Special Investigation Initiated - Letter<br>Complainant |
| 07/25/2022 | APS Referral |
| 07/26/2022 | Contact- Face to Face<br>Resident B, Resident C, Resident D, and Kanika Walangitan (Administrator) |
| 07/29/2022 | Contact- Document sent<br>Relative A1 |
| 07/30/2022 | Contact- Document sent<br>Anne Simpson, Recipient Rights |
| 08/02/2022 | Contact- Document received<br>Relative A1 |
| 08/25/2022 | Contact- Face to Face<br>Junche Walangitan, Licensee Designee |
| 09/23/2022 | Contact- Document sent<br>Watervliet Police Department |
| 09/23/2022 | Exit Conference<br>Kanika Walangitan, Administrator |

**ALLEGATION:**

**Resident A was not supervised.**

**INVESTIGATION:**

On 7/25/22 I received this complaint through the Bureau of Community Health Systems on-line complaint system. The complaint alleged Resident A was not checked on for over 12 hours and did not eat food since the day prior to her hospitalization on 7/13/22, even though she is diabetic, needed to have her blood sugar monitored, and insulin given appropriately.

On 7/25/22, I exchanged emails with the complainant who reported Resident A had died. This was the result of poor blood sugar monitoring and not receiving her insulin as required. These to facts led to hyperglycemic encephalopathy which caused her death.

On 7/25/22, I exchanged emails with adult protective services (APS) supervisor, Rebecca Brisboe. She confirmed there was case history with Resident A prior to her placement in an adult foster care (AFC) home but there was currently no active case and APS would not be investigating since the resident was now deceased.

On 7/27/22, I interviewed administrator Kanika Walangitan at the home. Ms. Walangitan stated Resident A was admitted from another AFC home. She stated Mr. Walangitan picked Resident A up without meeting her or doing a prior assessment of her. She stated Resident A came to the home with only her medications and forms for her pharmacy. She denied that an *Assessment Plan for AFC Residents* or any written assessment was completed for Resident A at the time of admission. Ms. Walangitan reported staff could not monitor Resident A's blood sugar because the blood sugar monitor Resident A wore gave results to a cell phone staff did not have access to. She reported Resident A ate very little in the 48 hours she was in the home. She stated on the morning that Resident A was hospitalized, Resident A ate so little that Mr. Walangitan told her that she could not have insulin. Resident A returned to her room where she was later found unresponsive. Ms. Walangitan denied knowledge of Resident A's supervision requirements.

On 7/30/22, I exchanged emails with recipient rights worker Anne Simpson. Ms. Simpson stated that she had requested an autopsy for Resident A and requested a death review to investigate Resident A's death. She reported Resident A was participant of Community Mental Health (CMH) services in May 2022 and reportedly was not doing well mentally or physically. Ms. Simpson reported efforts were made by CMH to see Resident A at Forest Beach Home in July 2022, but at the time Mr. Walangitan reported Resident A was in the hospital.

On 8/2/22, Relative A1 provided documentation from Resident A's 7/13/22 hospitalization. The documentation noted Ms. Walangitan told emergency

responders that she had not observed Resident A in over 18 hours from the time when 911 was called. The documentation noted Resident A's blood sugar registered below 20 and she was treated for hypoglycemia and remained unresponsive even with intervention.

On 8/25/22, I completed an interview with licensee designee Junche Walangitan at the home. Mr. Walangitan stated Ms. Walangitan was in contact with Resident A's previous placement about admitting Resident A to the home prior to Resident A's admission. He stated Resident A's previous placement did not mention any challenges or substantive needs for Resident A. Mr. Walangitan stated the day after Ms. Walangitan discussed accepting Resident A into the home, he received a phone call from Resident A's previous placement requesting that she be picked up immediately. He went to pick her up and did not discuss Resident A's needs with her or the previous placement. Mr. Walangitan stated he did not complete or obtain an assessment plan for Resident A. Resident A only had her prescriptions and pharmacy forms when she came to the home.

On 9/23/22, a police report was filed with the Watervliet Police Department.

| **APPLICABLE RULE** | |
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| **R 400.15303** | **Resident care; licensee responsibilities.** |
| | **(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.** |
| **For Reference: MCL 400.706** | **Definitions; P to Q** |
| | **(1) "Personal care" means personal assistance provided by a licensee or an agent or employee of a licensee to a resident who requires assistance with dressing, personal hygiene, grooming, maintenance of a medication schedule as directed and supervised by the resident's physician, or the development of those personal and social skills required to live in the least restrictive environment.** |
| | **(5) "Protection", subject to section 26a(2), means the continual responsibility of the licensee to take reasonable action to ensure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the resident's assessment plan states that the resident needs continuous supervision.** |

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| **For Reference: MCL 400.707** | **Definitions; R to T** |
| | **(7) "Supervision" means guidance of a resident in the activities of daily living, including 1 or more of the following:**<br><br>**(a) Reminding a resident to maintain his or her medication schedule, as directed by the resident's physician.**<br><br>**(b) Reminding a resident of important activities to be carried out.**<br><br>**(c) Assisting a resident in keeping appointments.**<br><br>**(d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.** |
| **For Reference: R 400.15102** | **Definitions.** |
| | **(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.** |
| **ANALYSIS:** | While there seems to be a lack of agreement between Mr. and Ms. Walangitan about the amount of information gathered from Resident A's previous placement before admission to their home, they do agree that she had prescriptions and pharmacy documentation in hand the day of admission.<br><br>In addition, both Mr. and Ms. Walangitan agree that neither themselves nor their staff completed a written assessment plan.<br><br>The home in general was unaware that Resident A was case managed through the local CMH, diabetic, monitored her blood sugar readings via her smart phone, was prescribed a medication regime to treat her diabetes, and required a level of |

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| | supervision to ensure her compliance with treatment and healthy wellbeing.<br><br>The home did not reasonably comply with this rule to develop an assessment plan to ensure Resident A's supervision, protection, and personal care needs were met. As a result, Resident A died within 48-hours of her admission to the home. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Resident A did not receive her insulin.**

**INVESTIGATION:**

On 7/25/22, I reviewed the website www.mayoclinic.org/diseases-conditions/diabetic-hypoglycemia/diagnosis-treatment. The area for Diabetic Hypoglycemia read:

> *"You have hypoglycemia when your blood sugar level drops below 70 mg/dL"...If you think your blood sugar may be dipping too low, check your blood sugar level with a blood glucose meter….. Eat or drink something that's mostly sugar or carbohydrates to raise your blood sugar level quickly. Pure glucose — available in tablets, gels and other forms — is the preferred treatment...Check your blood sugar level 15 minutes after eating or drinking something to treat your hypoglycemia. If your blood sugar is still low, eat or drink another 15 to 20 grams of carbohydrates. Repeat this pattern until your blood sugar is above 70 mg/dL…If you ignore the symptoms of hypoglycemia too long, you may lose consciousness. That's because your brain needs glucose to function. Recognize the signs and symptoms of hypoglycemia early, because if untreated, hypoglycemia can lead to:*
>
> - *Seizures*
> - *Loss of consciousness*
> - *Death*

The complainant reported Resident A's death was a result of not receiving prescribed insulin meant to manage her diabetes.

On 7/27/22, I requested to see Resident A's records. Ms. Walangitan denied having any records relating to Resident A and reported Resident A only came with her medication and forms for her pharmacy. I reviewed the medication and forms. Directions for use of Resident A's insulin were not included in the items available.

Ms. Walangitan reported staff could not monitor Resident A's blood sugar because her blood sugar monitoring device connected to a cell phone staff did not have access to.

Ms. Walangitan reported Resident A ate very little during the 48-hours she was at the home. In fact, she stated that the morning of 7/13/22, Resident A ate so little that Mr. Walangitan withheld her insulin at his own discretion.

Relative A1 provided documentation from the hospital that noted Resident A was treated for hypoglycemic encephalopathy.

Mr. Walangitan stated he did not develop a resident record for Resident A. He stated Resident A monitored her blood sugar herself, he and staff did not monitor it for her. Mr. Walangitan stated he gave Resident A her insulin as needed. He denied withholding Resident A's insulin on 7/13/22 and reported Resident A ate well that morning and her insulin was given appropriately. He could not explain how he knew when to appropriately give Resident A her insulin nor could he explain how he knew Resident A's insulin was given appropriately since there was no medication administration record (MAR) to reflect Resident A received it nor method to monitor her blood sugar levels. Mr. Walangitan did not discuss Resident A's prescription with her physician to ensure it was being provided correctly.

I inspected Resident A's pill pack on-site and did not see the prescription or physician order for Resident A's insulin or how to appropriately provide it to Resident A since Resident A's insulin was not included in the pack.

| **APPLICABLE RULE** | |
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| **R 400.15310** | **Resident health care.** |
| | **(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:**<br><br>**(a) Medications.** |
| **ANALYSIS:** | While there is a difference of opinion between Mr. and Ms. Walangitan regarding how much Resident A ate and any insulin she received the date of her death, the hospital documentation indicates little of each was provided to her since she had not likely been monitored throughout an 18-hour period at the home and her blood sugar level at the hospital registered below 20. |

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| | The home did not seek or gather additional information beyond the limited information carried by the resident the day of admission.<br><br>The home did not convey Resident A was uncooperative providing her medical information or that they even sought this information from her.<br><br>Without credible direction from a health care professional or the resident herself to develop a plan of care combined with the home not having the ability to read or monitor Resident A's blood sugar levels it would seem hypoglycemic encephalopathy was inevitable.<br><br>The home did not comply with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
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| **R 400.15209** | **Home records generally.** |
| | **(1) A licensee shall keep, maintain, and make available for department review, all the following home records:**<br><br>**(d) Resident records.** |
| **ANALYSIS:** | Ms. Walangitan and Mr. Walangitan reported no records for Resident A were obtained or completed prior to or during her admission to the home. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

Ms. Walangitan reported she did not have a *Resident Register* completed including Resident A. She completed the form while I was on-site after reviewing a calendar. She stated she had not gotten an update from the hospital regarding where Resident A would be discharged to and seemed unaware that Resident A was deceased.

| APPLICABLE RULE | |
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| **R 400.15210** | **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:**<br><br>**(a) Date of admission.**<br>**(b) Date of discharge.**<br>**(c) Place and address to which the resident moved, if known.** |
| **ANALYSIS:** | The home did not have resident register completed as required by this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

Ms. Walangitan reported an assessment plan was not completed for Resident A and was not available. She also reported Resident A was brought to the home without Mr. Walangitan meeting or assessing Resident A in anyway.

| APPLICABLE RULE | |
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| **R 400.15301** | **Resident admission criteria;** |
| | **(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:**<br><br>**(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**<br>**(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** |

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| **ANALYSIS:** | Interviews with Ms. and Mr. Walangitan revealed a general lack of understanding related to the needs of Resident A or that they even communicated to Resident A what their home could provide. Both administrator and licensee designee reported an assessment plan was not completed for Resident A. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

Ms. Walganitan reported a written resident care agreement was not completed for Resident A and was not available.

| **APPLICABLE RULE** | |
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| **R 400.15301** | **; resident care agreement.** |
| | **(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following:**<br>**(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.**<br>**(b) A description of services to be provided and the fee for the service.**<br>**(c) A description of additional costs in addition to the basic fee that is charged.**<br>**(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.**<br>**(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.**<br>**(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** |

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| | **(g) An agreement by the resident to follow the house rules that are provided to him or her.**<br>**(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.**<br>**(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.**<br>**(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315.**<br>**(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.**<br>**(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults** |
| **ANALYSIS:** | The home did not complete a written resident care agreement for Resident A. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

Ms. Walangitan stated she completed but did not send the incident report regarding Resident A's hospitalization. She then divulged that there were numerous incident reports she had not sent to licensing. She did not give a reason for why the reports were not sent.

Ms. Walangitan provided and I reviewed incident reports dating from October 2021 through July 2022. These reports met the requirements for department notification though they had not been submitted to the department. It is unknown if the reports were sent to the appropriate designated representatives.

| **APPLICABLE RULE** | |
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| **R 400.15311** | **Investigation and reporting of incidents, accidents, illnesses, absences, and death.** |
| | **(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster** |

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| | **care licensing division within 48 hours of any of the following:**<br><br>**(b) Any accident or illness that requires hospitalization.** |
| **ANALYSIS:** | Based on the interview completed and documents reviewed, there is sufficient evidence to support that the licensee did not send a written report to licensing within 48 hours of the hospitalization of Resident A or that of other residents since October 2021. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

During my onsite on 7/27/22, I observed signs of bed bugs in the home including stains on walls and resident pillows consistent with bed bug feces. I saw a dead bed bug on Resident B's room wall.

Ms. Walangitan stated the home has an infestation of bedbugs even though Mr. Walangitan regularly washes resident bedding and sprays for bedbugs himself. She stated the home has not been professionally treated for bedbugs since 2021.

On 7/29/22, I reviewed previous records for this home and found:

> SIR# 2020A0579039 dated 8/10/20 revealed live bedbugs were found in multiple resident rooms. On 8/6/20, Mr. Walangitan committed to have the home professionally treated for bedbugs. He agreed this would be done by 9/6/20.
>
> SIR# 2021A0579009 dated 12/09/20 revealed multiple residents reported, and I observed live bedbugs in resident rooms. Mr. Walangitan initially reported the home was professionally treated for bedbugs in September 2020 consistent with his 8/6/20 CAP. However, Mr. Walangitan admitted the home was not professionally treated following the previous investigation as initially agreed to. A provisional license was issued, and Mr. Walangitan agreed the home would be professionally treated for bedbugs and treatment would be maintained to ensure bedbugs did not return.

On 8/25/22, Mr. Walangitan reported live bedbugs in Resident C and Resident D's room. He reported he has been spraying bedbug treatment spray from the hardware store and washing residents' linens regularly. He stated he believes the home was last professionally treated for bedbugs at the beginning of 2022 or end of 2021. He could not remember and did not provide evidence of it having occurred as stated.

| **APPLICABLE RULE** |
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| **R 400.15401** | **Environmental health.** |
| | **(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.** |
| **ANALYSIS:** | I witnessed continued evidence of infestation on 7/25. The licensee designee confirmed continued infestation on 8/25.<br><br>The home has not adequately developed a pest control program as required by this rule. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br><br>Reference special investigation reports:<br><br>#2020A0579039 dated 7/31/20, licensing study report (LSR) dated 8/10/20, and corrective action plan (CAP) dated 8/6/20,<br><br>#2021A0579009 dated 12/9/20, LSR dated 1/27/21, and CAP dated 8/6/21, |

| **APPLICABLE RULE** | |
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| **R 400.15103** | **Licenses; effect of failure to cooperate with inspection or investigation.** |
| | **(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.** |
| **ANALYSIS:** | The home has suffered bed bug infestation at least since January of 2020. Previous investigations have determined that while Mr. Walangitan has provided CAPs agreeing to professional exterminator services, he did not comply and simply attempted to remedy the infestation himself. This continual noncompliance and failure to cooperate with fulfilling the terms he outlined in the CAPs has led to the issuance of a provisional license. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I observed the exterior stucco siding of the home to be bubbling and cracking in multiple, large sections along the perimeter of the home.

I observed the interior walls of the home to have stains from bed bug feces, dirt, and/or mold. The baseboard trim was peeling away from the walls in multiple resident rooms, exposing what appeared to be bed bug feces, dirt, and/or mold. Wallpaper in resident rooms was peeling away from the wall exposing patches of bed bug feces and/or mold.

I observed the carpet to be dirty and with a large strip of missing and frayed carpet in the resident dining room that presented as a tripping hazard.

I found a bin of what appeared to be liquid substance, tinted brown, with unknown brown substance at the bottom sitting open next to a resident's bed within a shared bedroom.

I observed what appeared to be dried human feces spread on the wall of a resident bathroom.

| **APPLICABLE RULE** | |
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| **R 400.15403** | **Maintenance of premises.** |
| | **(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.**<br><br>**(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.**<br><br>**(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.** |
| **ANALYSIS:** | Based on the observations made, there is sufficient evidence to support allegations that the home is not maintained to provide adequately for the health, safety, and wellbeing of occupants, the housekeeping standards do not present as comfortable, or orderly in appearance, and the floors and walls are not kept clean, easily cleanable, or in good repair. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 7/13/22, Resident A died at the hospital two days after her admission to the home.

| **APPLICABLE RULE** | |
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| **R 400.15305** | **Resident protection.** |

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| | **(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.** |
| **For Reference: R 400.706** | **Definitions; P to Q.** |
| | **(5) "Protection", subject to section 26a(2), means the continual responsibility of the licensee to take reasonable action to ensure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the resident's assessment plan states that the resident needs continuous supervision.** |
| **ANALYSIS:** | The licensee designee and administrator had oversite of Resident A's admission to the home, care during her stay, and ensured her hospitalization during a 48-hour period. The home did not comply with any administrative rules (AR) regarding the admittance of a resident to the home. The home did not:<br>A) Develop a written resident assessment<br>B) Develop a resident care agreement<br>C) Secure health information from the resident or her health care provider regarding her treatments or health needs such as diabetes management.<br>D) Seek assistance with understanding her medications needs and routines.<br><br>In addition, I became aware that the home did not comply with:<br>A) No resident record for Resident A as defined in AR 400.209<br>B) Maintaining a resident register as defined in AR 400.15210.<br>C) Reporting of incidents as defined in AR 400.15311.<br>D) Repeated violations of not maintaining a pest control program as defined in AR 400.15401.<br>E) Maintaining a healthy living environment as defined by AR 400.15403.<br><br>Lastly, the licensee designee and administrator provided licensing conflicting information on several occasions. During the bed bug investigation, the license designee openly |

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| | conveyed misleading information related to professional extermination services in conflict with AR 400.15103.<br><br>As this report conveys, the home has not reasonably complied with providing protection and safety as required by this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 9/23/22, I completed an exit conference with Ms. Walangitan who reported Mr. Walangitan was unavailable this afternoon. She did not dispute my findings and said she would likely agree to the recommendations regarding the status of the license. She requested to read the report and discuss the allegations with Mr. Walangitan before deciding how to proceed.

## IV. RECOMMENDATION

Revocation of the license is recommended.

Cassandra Duursma 9/23/22

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 9/23/22

Russell B. Misiak Date
Area Manager