GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 16, 2022

Mary Black
Scotland Manor Enterprises, LLC
1357 N. River Road
St. Clair, MI 48079

RE: License #: AS740282833
Investigation #: 2023A0617010
River's Edge Assisted Living

Dear Mrs. Black:

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. A previous recommendation of revocation was made in confirming letter dated 07/22/2021, which remains in effect. 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Kristine Cilluffo

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740282833
Investigation #:	2023A0617010
Complaint Receipt Date:	11/12/2022
Investigation Initiation Date:	11/14/2022
Report Due Date:	12/12/2022
Licensee Name:	Scotland Manor Enterprises, LLC
Licensee Address:	1357 N. River Road St. Clair, MI 48079
Licensee Telephone #:	(810) 329-1112
Administrator:	Mary Black
Licensee Designee:	Mary Black
Name of Facility:	River's Edge Assisted Living
Facility Address:	1427 Oakland St. Clair, MI 48079
Facility Telephone #:	(810) 329-1112
Original Issuance Date:	10/26/2006
License Status:	1ST PROVISIONAL
Effective Date:	02/16/2021
Expiration Date:	08/15/2021
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Unknown staff dropped Resident E and broke her leg.	No
Resident E was observed to have a huge cut down her chest.	No
Medications are not being passed correctly and by untrained staff.	Yes
There is not adequate food and residents are unfed.	No
Residents in facility are cold and dirty.	No
David Black is not supposed to be around residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/12/2022	Special Investigation Intake 2023A0617010
11/14/2022	APS Referral Referral received from Adult Protective Services (APS)
11/14/2022	Special Investigation Initiated - Letter Email to and from APS Supervisor, Jennifer Perrin. APS investigation is assigned to Steven Dutcher.
11/14/2022	Contact - Telephone call received Received message from Complainant. Returned call.
11/15/2022	Contact - Telephone call made TC to Complainant. Allegations are regarding both River's Edge and Scotland Manor. Received text messages from Complainant and returned messages.
11/15/2022	Contact - Document Sent Email to APS Supervisor, Jennifer Perrin and APS Worker, Steven Dutcher
11/16/2022	Inspection Completed On-site Completed unannounced onsite investigation with Area Manager, Denise Nunn and Adult Foster Care (AFC) Licensing Consultant, Eric Johnson. Interviewed Staff, Latisha Sanchez and observed Resident A, Resident E and Resident F.
11/16/2022	Contact - Telephone call received Received phone call and text messages from Complainant. Returned call and messages.

11/16/2022	Contact - Telephone call received Received message from APS Worker, Steven Dutcher. Returned call.
11/18/2022	Contact - Document Sent Email to Mary Black. Requested documents.
11/22/2022	Contact- Document Sent Email to and from APS Worker, Steven Dutcher
11/23/2022	Contact- Telephone call made Left message for Resident E's Guardian. Received return call.
11/23/2022	Exit Conference Attempted Exit Conference with Mary Black by phone. Unable to leave message. Sent email to Mary Black with findings.

ALLEGATION:

- **Unknown staff dropped Resident E and broke her leg.**
- **Resident E was observed to have a huge cut down her chest.**

INVESTIGATION:

I received a complaint regarding River's Edge Assisted Living on 11/14/2022. It was alleged that Resident E has a broken leg and is wearing a boot. An unknown staff broke her leg on an unknown date due to dropping her. On 11/11/2022, Resident E was observed to have a huge cut down her chest. Staff at the facility were doing wound care on her, which they should not have been doing. There was a letter there from the owner, David Black, asking that Resident E be sent by ambulance. There is a concern for Resident E in the facility as residents were cold and dirty. There is not adequate food in home and the residents are unfed.

A second complaint was received on 11/14/2022. It was alleged that the owner is David Black, who is a felon due to tax fraud. He is not supposed to be around the residents. On 11/11/2022, the three residents were dirty and cold in the home. They were unfed as there is not adequate food in the home. There was one primary caregiver in the home, who has worked 160 hours since moving in on November 1st. She had her daughter there helping and was not being paid to train. The daughter was passing out medication and doing insulin injections. This facility is not following state law, but David Black stated that he does not have to because he is a private attorney and does not have a state license. There is a concern about the welfare of the three adult residents.

On 11/14/2022, I received phone call from Complainant. The Complainant stated that residents are being abused and neglected. Complainant stated that they are scared for

residents. The Complainant stated that owner, David Black, is a felon and should not be around the residents. He is being threatening to staff. Staff has worked 144 hours in one week and not been paid. Medications are not being passed correctly. A staff's daughter who was in- training was passing medications.

On 11/16/2022, I completed an unannounced onsite investigation. I interviewed Staff, Latisha Sanchez and observed Resident A, Resident E and Resident F.

On 11/16/2022, I interviewed Staff, Latisha Sanchez at River's Edge Assisted Living. She stated that she has worked at the home for about one month. Ms. Sanchez stated that Resident E fell at her home and broke her leg. She stated that she was brought to River's Edge to heal. The injury did not occur at River's Edge. She stated that Resident E has cut on her stomach from a surgery. The bandages are changed by staff twice per day. Resident E does not have a nurse who comes to the home.

On 11/16/2022, I interviewed Resident E at the home. Resident E stated that she fell and broke her leg. Resident E has dementia and could not provide details on how she fell or surgery that caused the injury.

On 11/16/2022, I interviewed Mary Black at Scotland Manor. Ms. Black was visibly upset and indicated that she felt like she was going to pass out. Ms. Black stated that she believed allegations were being made by a staff who allegedly assaulted her. The state police were present at Scotland Manor when we arrived, and Ms. Black stated that she was making a police report against the staff. I informed Ms. Black that I would send her an email requesting documents for this special investigation.

On 11/18/2022, I sent an email to Mary Black requesting a staff list and phone numbers to interview additional staff regarding allegations. Ms. Black has not responded or provided any of the requested information.

On 11/22/2022, I sent an email to APS Worker, Steven Dutcher. He stated that that he did not see any evidence at this time to support allegations, however, the investigation is on-going.

On 11/23/2022, I Interviewed Resident E's Power of Attorney by phone. He stated that Resident E passed out and fell at her own home a couple months ago. She had double fractures in her ankle. He stated that Resident E did not break her leg at River's Edge. Resident E has a wound from a prior surgery where an infection has been an "on-going battle". He stated that Resident E had the wound prior to moving into River's Edge. He indicated that he plans on moving Resident E out of River's Edge next Tuesday or Wednesday to continue treatment at home. He stated that he does not believe the caregivers at River's Edge are 100 percent qualified to deal with residents with dementia due to how they have spoken to Resident E. He felt that Resident E gets enough food to eat at the home.

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:	There is not enough information at this time to determine that staff at River's Edge broke Resident E's leg by dropping her. Staff, Latisha Sanchez and Resident E both stated that her broken leg was due to a fall before she was admitted to River's Edge. Ms. Sanchez also reported that Resident E's wound is from a surgery and bandages are changed twice daily by staff. Resident E's power of attorney confirmed that her injuries occurred prior to moving into River's Edge.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Medications are not being passed correctly and by untrained staff.

INVESTIGATION:

On 11/16/2022, I interviewed Staff, Latisha Sanchez at River's Edge Assisted Living. Ms. Sanchez stated that she is trained to pass medications from experience working at other homes. She stated that there is a mother and daughter who work at River's Edge named Janet and Marion. The mother has worked at the home for three weeks and the daughter has worked at home for two weeks. She stated that they both pass medications. Ms. Sanchez stated that staff are not initialing medication logs regularly. She also stated that weekly pill containers are being used for medications. During the onsite investigation, I observed a blue basket with weekly pill containers inside. Ms. Sanchez stated that she will notify families when a resident needs a refill on medications. Ms. Sanchez stated that none of the current residents receive insulin injections.

On 11/16/2022, I reviewed Resident F's medications and medication log. The medication log provided by Staff, Latisha Sanchez for Resident F did not have his name, month or year. The medication log only included instructions for use for Resident F's Latanoprost .05% eye drops eye drops. The medication log was missing initials for the following medications:

Vitamin D3 1000 units 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15
Pravastatin 40 mg 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15
OS-CAL 500/200 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15

Losartan 25 mg 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15
Lactobacillus Acidophilous (no dosage listed) 5 pm- 11/01- 11/08, 11/10-11/11, 11/14-11/15
Folic Acid 4 mg 5 pm- 11/01- 11/08, 11/10-11/11, 11/13-11/15
Glimepiride 2 mg 8 am- 11/01-11/13, 11/16
Aspirin (no dosage listed) 9pm- 11/01-11/08, 11/10-11/11, 11/14-11/15
Latanoprost .05% eye drops 9 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15
Abilify 5 mg 9 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15
Clonidine .1 mg 9 am- 11/01-11/13, 11/16
Clonidine .1 mg 12 pm- 11/01-11/06, 11/11-11/13, 11/15
Clonidine .1 mg 9 pm- 11/01-11/08, 11/10-11/11, 11/15
Omeprazole 20 mg 9 am- 11/01-11/08, 11/10-11/13, 11/16
Actos 80 mg 9 am- 11/01-11/08, 11/10-11/13, 11/16
Imdur ER 30 mg 9 am- 11/01-11/08, 11/10-11/13, 11/16
Omeprazole 20 mg 6 am- 11/01-11/08, 11/10-11/13, 11/16
Preservision Areds (no dosage) 9 am- 11/01-11/08, 11/10-11/13, 11/16
Preservision Areds (no dosage) 5 pm- 11/01-11/08, 11/10-10/11, 11/13-11/15

During the onsite inspection, Resident F did not have the following medications listed on his medication log in the home: Latanoprost .05% eye drops eye drops, Lactobacillus Acidophilous or OS-CAL 500/200.

During the onsite inspection, I observed that the pill bottle for Resident F's Omeprazole 20 mg indicated to take one capsule by mouth daily. Omeprazole 20 mg was listed on Resident F's medication log twice to administer at 6 am and 9 am. Resident F's mediation log listed Vitamin D3 1,000 units. I observed that Resident F's bottle of Vitamin D3 pills was 50 mcg (2,000 I.U.) soft gels. Resident F's Lorazepam .5 mg was not listed on the medication log.

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

ANALYSIS:	Medications are not being kept in their original pharmacy supplied containers. During the onsite investigation, I observed a blue basket with weekly pill containers inside. Staff, Latisha Sanchez, confirmed they are used for resident medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During the onsite inspection, I observed that the pill bottle for Resident F's Omeprazole 20 mg indicated to take one capsule by mouth daily. Omeprazole 20 mg was listed on Resident F's medication log twice to administer at 6 am and 9 am. Resident F's mediation log listed Vitamin D3 1,000 units. I observed that Resident F's bottle of Vitamin D3 pills was 50 mcg (2,000 I.U.) soft gels. Resident F did not have the following medications listed on his medication log in the home: Latanoprost .05% eye drops eye drops, Lactobacillus Acidophilous or OS-CAL 500/200.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Confirming Letter dated 07/22/2021 and SIR #2022A0604030 dated 10/05/2022**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Resident F's medication log only included label instructions for use of Resident F's Latanoprost .05% eye drops. During the onsite, the medication log was missing initials for the following medications: Vitamin D3 1000 units 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15 Pravastatin 40 mg 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15 OS-CAL 500/200 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15 Losartan 25 mg 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15 Lactobacillus Acidophilous (no dosage listed) 5 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15 Folic Acid 4 mg 5 pm- 11/01- 11/08, 11/10-11/11, 11/13-11/15 Glimepiride 2 mg 8 am- 11/01-11/13, 11/16 Aspirin (no dosage listed) 9pm- 11/01-11/08, 11/10-11/11, 11/14-11/15 Latanoprost .05% eye drops 9 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15 Abilify 5 mg 9 pm- 11/01-11/08, 11/10-11/11, 11/14-11/15 Clonidine .1 mg 9 am- 11/01-11/13, 11/16 Clonidine .1 mg 12 pm- 11/01-11/06, 11/11-11/13, 11/15 Clonidine .1 mg 9 pm- 11/01-11/08, 11/10-11/11, 11/15 Omeprazole 20 mg 9 am- 11/01-11/08, 11/10-11/13, 11/16 Actos 80 mg 9 am- 11/01-11/08, 11/10-11/13, 11/16 Imdur ER 30 mg 9 am- 11/01-11/08, 11/10-11/13, 11/16 Omeprazole 20 mg 6 am- 11/01-11/08, 11/10-11/13, 11/16 Preservision Areds (no dosage) 9 am- 11/01-11/08, 11/10-11/13, 11/16 Preservision Areds (no dosage) 5 pm- 11/01-11/08, 11/10-10/11, 11/13-11/15 Resident F's Lorazepam .5 mg was not listed on the medication log.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference confirming letter dated 07/22/2021 and SIR #2022A0604030 dated 10/05/2022**

ALLEGATION:

There is not adequate food and residents are unfed.

INVESTIGATION:

On 11/16/2022, I completed an unannounced onsite investigation at River's Edge Assisted Living. I interviewed Staff, Latisha Sanchez. Ms. Sanchez stated that there is enough food in the home to prepare meals for the residents. She stated that they do not follow a menu. During the onsite investigation, I observed a menu on the refrigerator, however, Ms. Sanchez stated that the menu is not used. She stated that she plans meals based on what food is available in the home. I observed an adequate amount of food in the cupboards and refrigerator.

On 11/16/2022, I interviewed Resident F during the onsite. He stated that he always gets food to eat.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	There is not enough information to determine that residents are unfed. During the onsite investigation, I observed an adequate amount of food in the cupboards and refrigerator. Staff, Latisha Sanchez, stated that she has enough food available to prepare meals for residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.

ANALYSIS:	During the onsite inspection, I observed a menu posted on the refrigerator. Staff, Latisha Sanchez, stated that the menu is not utilized. She prepares meals based on what food is available in home.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR dated 12/07/2020 and CAP dated 02/16/2021 and Confirming Letter dated 07/22/2021**

ALLEGATION:

Residents in facility are cold and dirty.

INVESTIGATION:

On 11/16/2022, I completed an unannounced onsite investigation at River's Edge Assisted Living. I observed Resident A, Resident E and Resident F. The residents appeared to be appropriately groomed and did not appear dirty. The home was warm, and residents did not appear to be cold. Staff, Latisha Sanchez, stated that the heat has been working. She stated that residents are regularly showered. Ms. Sanchez said they follow the shower schedule posted on the refrigerator. The schedule indicated that residents are showered twice per week, Resident A- Wednesday/Sunday, Resident E- Tuesday/Saturday and Resident F- Monday/Friday.

On 11/16/2022, I interviewed Resident F at the home. He stated that staff are cooperative and doing a wonderful job. Resident F said that he has lived in the home for about a month, and it is going "quite well". He stated that he gets his medicine and always has food to eat. Resident F stated that the home is heated. He indicated that the electricity did go off briefly over the weekend, however, the issue was quickly corrected.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	There is not enough information to determine that residents are dirty and not receiving showers. On 11/16/2022, I completed an unannounced onsite investigation and the residents were adequately groomed. Staff, Latisha Sanchez, stated that they follow a schedule which indicated residents are showed two times per week.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	There is not enough information to determine that residents are cold. On 11/16/2022, I completed an unannounced onsite investigation, and the home was an adequate temperature. None of the residents appeared to be cold. Staff, Latisha Sanchez, indicated that the heat is working in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

David Black is not supposed to be around residents.

INVESTIGATION:

A workforce background check exclusion notice was received for David Black (the husband of Mary Black) on 11/10/2020. Mr. Black is not eligible to work in a job that involves direct access or provides direct services to a patient or resident in an adult foster care before 12/15/2025.

Mr. Black has been present at Scotland Manor during the last two unannounced onsite investigations on 07/26/2022 and 11/16/2022. On 07/26/2022, David Black was present at River's Edge Assisted Living and later at Scotland Manor during unannounced onsite investigations. On 07/26/2022, I interviewed David Black. He stated that he was not involved with River's Edge Assisted Living and was working in the yard. He stated that he was getting ready for boat races.

During the onsite investigation on 11/16/2022, Latisha Sanchez, indicated that she contacted David Black notifying him that licensing was present in the home because she could not get ahold of Mary Black. The complainant alleged that David Black has access to residents and resides at Scotland Manor.

APPLICABLE RULE	
MCL 400.713	**License required; application; forms; investigation; on-site evaluation; issuance or renewal of license; disclosures; maximum number of persons; stating type of specialized program; issuance of license to specific person at specific location; transferability of license; sale of facility; notice; items of noncompliance; refusal by department to issue or renew license; conditions; unlicensed facility; violation as misdemeanor; penalty; receipt of completed application; issuance of license within certain time period; inspections; report; criminal history and records check; storage of fingerprints in automated fingerprint identification system database; convictions; "completed application" defined.**
	(3) Before issuing or renewing a license, the department shall investigate the activities and standards of care of the applicant and shall make an on-site evaluation of the facility. On-site inspections conducted in response to the application may be conducted without prior notice to the applicant. On-site inspections conducted for renewing a license may be conducted within 12 months before the expiration date of the current license without impact on the license renewal date or the license fee. Subject to subsections (9), (10), and (11), the department shall issue or renew a license if satisfied as to all of the following: **(e) The good moral character of the licensee or licensee designee, owner, partner, director, and person responsible for the daily operation of the facility. The applicant is responsible for assessing the good moral character of the employees of the facility. The person responsible for the daily operation of the facility shall be not less than 18 years of age.**
ANALYSIS:	David Black has direct access to residents at River's Edge Assisted Living and Scotland Manor. A workforce background check exclusion notice was received for David Black on 11/10/2020. Mr. Black is not eligible to work in a job that involves direct access or provides direct services to a patient or resident in an adult foster care before 12/15/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/18/2022, I sent an email to Mary Black requesting documents for River's Edge Assisted Living and Scotland Manor special investigations. I requested Ms. Black to fax or email the documents by 11/22/2022.

I requested the following documents for River's Edge Assisted Living:

- Resident Register
- Guardian names and phone numbers
- Staff list and phone numbers
- Resident assessment plans
- Any records regarding Resident E broken leg and wound
- Verification of medication training for staff passing medications

As of 11/23/2022, Mary Black has not provided any of the requested documents to licensing.

I attempted to complete an exit conference with Licensee, Mary Black, by phone on 11/23/2022. I was unable to leave a message. I sent Ms. Black an email with the findings and also notified her that a copy of special investigation report would be mailed once approved.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(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:	Licensee, Mary Black, has not cooperated with providing records/documents needed for this special investigation to licensing. On 11/18/2022, I sent email to Mary Black requesting records by 11/22/2022. As of 11/23/2022, no records or response has been received.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0604030 dated 10/05/2022**

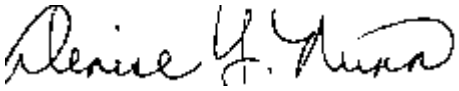
IV. RECOMMENDATION

A recommendation of revocation of the license was made in Confirming Letter dated 07/22/2021, which remains in effect.

11/23/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



11/23/2022

Denise Y. Nunn — Date
Area Manager