STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

April 24, 2023

Meaghan Rinaldi
Emmaus Corp.
2447 N Williamston Rd
Williamston, MI 48895

RE: License #: AM330407985
Investigation #: 2023A1033032
Country Creek

Dear Ms. Rinaldi:

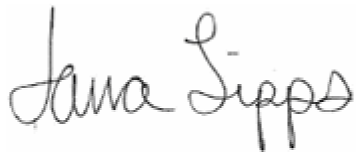
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

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.

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) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330407985
Investigation #:	2023A1033032
Complaint Receipt Date:	02/28/2023
Investigation Initiation Date:	02/28/2023
Report Due Date:	04/29/2023
Licensee Name:	Emmaus Corp.
Licensee Address:	2447 N Williamston Rd Williamston, MI 48895
Licensee Telephone #:	(517) 655-8953
Administrator:	Meaghan Rinaldi
Licensee Designee:	Meaghan Rinaldi
Name of Facility:	Country Creek
Facility Address:	2771 Lamb Rd Mason, MI 48854
Facility Telephone #:	(517) 676-1070
Original Issuance Date:	06/30/2021
License **Status:**	REGULAR
Effective Date:	12/31/2021
Expiration Date:	12/30/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 2/24/23, direct care staff, Kyle Kruizenga, threw away Resident B's lunch during scheduled outing.	Yes
On 2/24/23, direct care staff, Kyle Kruizenga, pushed Resident B from behind to get her to move faster out of the facility for a scheduled outing.	No
On 2/24/23, direct care staff, Kyle Kruizenga, forced Resident A to wear a mask and isolate in her room away from the other residents. He then told the other residents, "[Resident A] wants to get you all sick because she won't stay in her room".	Yes
Additional Findings	Yes

III. METHODOLOGY

02/28/2023	Special Investigation Intake 2023A1033032
02/28/2023	Special Investigation Initiated – Telephone call made- Interview with Complainant, via telephone.
02/28/2023	Contact - Telephone call made Interview with housekeeping staff member, Sandra Tryon, via telephone.
03/10/2023	Inspection Completed On-site Interview with Resident A, B, C, & D. Interview with direct care staff, Katie Kannawin & Tawney Bennett. Review of resident records initiated.
03/13/2023	Contact - Document Sent Email sent to Licensee Designee, Meaghan Rinaldi, requesting resident records and employee files for special investigation.
03/14/2023	Contact - Document Received Reviewed employee files and resident records emailed by Licensee Designee, Meaghan Rinaldi.
03/16/2023	APS Referral- Referral made to APS, via email, per protocol.
04/03/2023	Contact - Telephone call made Interview with licensee designee, Meaghan Rinaldi, via telephone.

04/03/2023	Exit Conference completed, via telephone, with licensee designee, Meaghan Rinaldi.
04/04/2023	Contact – Telephone call made Interview with direct care staff, Kyle Kruizenga, via telephone.
04/04/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

On 2/24/23, direct care staff, Kyle Kruizenga, threw away Resident B's lunch during scheduled outing.

INVESTIGATION:

On 2/28/23 I received an online complaint regarding the Country Creek adult foster care facility (the facility). This complaint alleged that on 2/28/23, during a resident outing to the movie theater, direct care staff, Kyle Kruizenga, threw away Resident B's lunch. On 2/28/23 I interviewed Complainant who stated it was reported to facility housekeeping staff member, Sandra Tryon, by Resident C, that during the outing on 2/28/23, Mr. Kruizenga threw away Resident B's lunch because she was not eating it fast enough.

On 2/28/23, I interviewed the facility housekeeping staff member, Sandra Tryon, via telephone. Ms. Tryon reported that she had been present at the facility on 2/25/23 and Resident C reported to Ms. Tryon that when they were on their outing to the movies on 2/24/23 that Resident B had not been eating quickly enough and Mr. Kruizenga threw away her lunch. Ms. Tryon did not observe the interaction between Mr. Kruizenga and Resident B on 2/24/23.

On 3/10/23 I completed an on-site investigation at the facility. I interviewed direct care staff, Katie Kannawin. Ms. Kannawin reported that she had been working the date of 2/24/23. Ms. Kannawin reported that the residents did have an outing to the movies on that date and that Mr. Kruizenga took the residents on this outing. Ms. Kannawin reported Mr. Kruizenga provides the transportation to all resident outings and appointments. She reported Mr. Kruizenga does not work direct care shifts at the facility but does take residents on outings. Ms. Kannawin reported she was unaware whether Mr. Kruizenga threw away Resident B's food during the outing on 2/24/23. She reported Resident B's *Person-Centered Plan* (PCP), through Community Mental Health, tells them to throw away her food if Resident B does not finish her meals within and hour of starting the meal. Ms. Kannawin reported that the staff use a timer when it is mealtime for Resident B. When the one-hour timer has elapsed the staff "toss" Resident B's food.

During on-site investigation, on 3/10/23, I interviewed direct care staff, Tawney Bennett. Ms. Bennett reported she was not aware of Mr. Kruizenga throwing away Resident B's lunch during the outing on 2/24/23. She reported Resident B does have a plan of care to use a timer when she eats her meals to limit her eating time to one-hour. Ms. Bennett reported if Resident B has not finished her food in this amount of time, then her food is taken away.

During on-site investigation, on 3/10/23, I interviewed Resident B. Resident B does demonstrate a slow response time when asked questions. If given adequate time to respond she does respond to questions in an appropriate manner. Resident B reported, "I have an hour timer to eat meals." She further reported, "I don't like the timer." Resident B reported that sometimes people are rude when she does not finish her meal on time. Resident B did not confirm that Mr. Kruizenga threw away her food during the outing on 2/24/23.

On 4/3/23 I interviewed licensee designee, Meaghan Rinaldi, via telephone. Ms. Rinaldi reported she spoke with Mr. Kruizenga regarding the outing on 2/24/23 and he reported to Ms. Rinaldi that Resident B had not yet finished her lunch and the movie was about to begin. Ms. Rinaldi reported Mr. Kruizenga stated that he had to give the rest of Resident B's lunch to the other residents as her one-hour timer had elapsed and she had not finished her food. Ms. Rinaldi reported that Resident B's PCP indicates that she is to receive a one-hour allotment of time to eat her meals. She reported that the staff are to use a timer with Resident B and when the time has elapsed then the staff is supposed to throw the meal away. She reported that this is how the staff have interpreted Resident B's PCP form.

On 4/4/23 I interviewed direct care staff, Kyle Kruizenga. Mr. Kruizenga reported he does recall taking the residents on an outing to the movies on 2/24/23. Mr. Kruizenga reported the movie was getting ready to begin and Resident B had not yet finished her lunch. He reported she had eaten most of the meal, but her one-hour timer had elapsed, and they needed to get into the theater. Mr. Kruizenga reported he gave the remaining portion of the meal to the other residents, and they went into the theater. Mr. Kruizenga reported that per Resident B's PCP the staff are supposed to limit her meals to one-hour and then take the meal from Resident B when the one-hour time frame has elapsed.

During on-site investigation, on 3/10/23, I reviewed the *Treatment Plan Annual/Initial* form for Resident B, which was dated, 10/19/22. On page 3, under section, *Objectives for Goal 3, 3.01*, it states, "[Resident B] would like to eat in meals in "an hour or less". [Resident B] would like staff assistance in cutting up the larger food items into smaller, bite size pieces. Staff will also provide verbal prompts for [Resident B] to start/continue eating. [Resident B] will have different meal options depending on the amount of time in between meals. One meal option will be shelf safe/quickly prepared that is safe to wait until she is ready. The other meal option would be hot food served fresh and following food safety guidelines. Staff have also provided a timer for [Resident B] to be able to keep track of the time. Progress will

be discussed in monthly visits with case manager and documented in PC logs." On page 5 of the PCP, under section, *Life Arrangement Preference*, it states, "Staff expressed concern that [Resident B] is most likely to get upset if she feels that she is rushed by staff when eating, but they have continued to develop effective prompts for [Resident B]". Also, on page 5, under section, *Other*, it states, "[Resident B] is delayed in talking and moving due to Schizophrenia catatonic type and OCD. With verbal (and slight physical) prompting and continued encouragement, [Resident B] can move a bit faster. [Resident B] does not respond well to timers or to being told to "hurry up"." The PCP did not identify, in any sections reviewed, the directive to throw away, or take away, Resident B's meal if the one-hour timer elapses and she has not finished her meal.

APPLICABLE RULE	
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:	Based upon interviews with Ms. Kannawin, Ms. Bennett, Mr. Kruizenga, Ms. Rinaldi, and Resident B, in addition to review of Resident B's PCP form it can be determined that the direct care staff at the facility are not providing protection as defined in the act and as specified in Resident B's PCP. Ms. Kannawin, Ms. Bennett, Mr. Kruizenga, and Ms. Rinaldi acknowledged that it is the process and expected procedure of the staff to remove Resident B's meals if she does not finish her meals within a one-hour time frame. Each individual reported having read this directive in Resident B's PCP form. Having reviewed Resident B's PCP form, dated 10/19/22, there is no written directive that states to take the meal away from Resident B if she has not finished the meal within one-hour. Furthermore, Resident B, verbalized that she feels there are staff who strictly enforce the one-hour time limit and have been rude to her when she has not finished her meal in this allotted time frame. Resident B verbally reported that she does not like the one-hour time frame that has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 2/24/23, direct care staff, Kyle Kruizenga, pushed Resident B from behind to get her to move faster out of the facility for a scheduled outing.

INVESTIGATION:

On 2/28/23 I received an online complaint alleging that on 2/24/23, Mr. Kruizenga, pushed Resident B, from behind, on her way to the car in an attempt to make her move faster. On 2/28/23 I interviewed Complainant who reported direct care staff members in the facility on this date were Ms. Kannawin and Ms. Tryon.

On 2/28/23 I interviewed Ms. Tryon via telephone. Ms. Tryon reported she has observed Mr. Kruizenga push Resident B from behind on several occasions in an attempt to make her move faster. She reported Resident B is rather slow moving due to her mental illness and requires extra time. Ms. Tryon reported she was at the facility on 2/24/23 when Mr. Kruizenga arrived to take the residents on an outing to the movies. Ms. Tryon reported she observed Mr. Kruizenga pushing Resident B from behind to the point that she was “running” toward the vehicle.

On 3/10/23 I completed an on-site investigation at the facility. I interviewed Ms. Kannawin regarding the allegation. Ms. Kannawin reported she was working on 2/24/23 when Mr. Kruizenga arrived to take the residents to a movie. She reported she did not observe Mr. Kruizenga push Resident B on this date. Ms. Kannawin reported she has never seen a direct care staff member push Resident B. She reported direct care staff will guide Resident B by holding her hand, but not pushing her. Ms. Kannawin reported she has seen Resident B’s family members push her from behind when they come to visit her.

During on-site investigation, on 3/10/23, I interviewed Ms. Bennett. Ms. Bennett reported that she has witnessed Mr. Kruizenga interact with Resident B and she has never seen him push Resident B from behind. Ms. Bennett reported she does not like the way Mr. Kruizenga verbally interacts with the residents, but she has never witnessed physical abuse or pushing.

During on-site investigation, on 3/10/23, I interviewed Resident A. Resident A reported she has not witnessed Mr. Kruizenga push Resident B.

During on-site investigation, on 3/10/23, I interviewed Resident B. Resident B has a delayed response with questions and did not answer the question, directly, when asked whether Mr. Kruizenga has pushed her from behind.

During on-site investigation, on 3/10/23, I interviewed Resident C. Resident C reported he has observed Mr. Kruizenga, guide Resident B by placing his hand on her back to provide direction. Resident C reported he has not observed or interpreted this action as seeming “mean.”

During on-site investigation, on 3/10/23, I interviewed Resident D. Resident D reported that he has never observed Mr. Kruizenga pushing Resident B to make her move faster. He reported all the direct care staff do tell Resident B to move faster, but he has not observed pushing. Resident D reported that he does not like the way Mr. Kruizenga speaks to the residents. He reported, “sometimes he gets mad at us, and I don’t like it when he gets mad at us.” He reported that this is referring to how Mr. Kruizenga speaks to the residents.

On 4/3/23 I interviewed licensee designee, Meaghan Rinaldi, via telephone. Ms. Rinaldi reported she has never observed Mr. Kruizenga push a resident at the facility. Ms. Rinaldi reported that it has never been reported to her, by a resident or a direct care staff member, that there is a concern Mr. Kruizenga is pushing Resident B to make her move faster. Ms. Rinaldi reported Mr. Kruizenga does have two resident rights reports filed against him due to negative verbal interactions with residents but not for physical abuse allegations.

On 4/4/23 I interviewed Mr. Kruizenga via telephone. Mr. Kruizenga reported he did take the residents on an outing to the movies on 2/24/23. He reported he does not push Resident B to make her move faster. Mr. Kruizenga reported he does put his hand on her back to “guide” her. He reported her family has suggested this as a way to encourage her to move as she will not move without guidance. Mr. Kruizenga denied ever pushing Resident B.

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:	Based upon interviews with Residents A, B, C, and D, Ms. Kannawin, Ms. Bennett, Ms. Tryon, Mr. Kruizenga and Ms. Rinaldi, there is not sufficient evidence to determine that Mr. Kruizenga pushed Resident B, from behind, to make her move more quickly. Although, statements from Ms. Bennett, Resident D, and Ms. Rinaldi suggest that Mr. Kruizenga may have history of negative verbal interactions with the residents, there is not adequate evidence to conclude that he pushed Resident B on 2/24/23.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 2/24/23, direct care staff, Kyle Kruizenga, forced Resident A to wear a mask and isolate in her room away from the other residents. He then told the other residents, [Resident A] wants to get you all sick because she won't stay in her room".

INVESTIGATION:

On 2/28/23 I received an online complaint alleging that, on 2/24/23, Mr. Kruizenga forced Resident A to wear a mask and isolate in her room away from the other residents. The complaint further alleged that Mr. Kruizenga then stated to the other residents, "[Resident A] wants to get you all sick because she won't stay in her room." On 2/28/23 I interviewed Complainant who reported Ms. Tryon and Ms. Kannawin were present in the facility on 2/24/23 during this alleged event.

On 2/28/23 I interviewed Ms. Tryon, via telephone. Ms. Tryon reported she had been present in the facility on 2/24/23 when Mr. Kruizenga arrived to take the residents for an outing to the movies. She reported when Mr. Kruizenga arrived, he quickly ushered Resident A to her room. She reported Mr. Kruizenga was "getting loud" with Resident A and she could hear Resident A crying. She reported Ms. Kannawin was working on this date and Ms. Kannawin stated, "He always makes her [Resident A] cry and it pisses me off". Ms. Tryon reported Mr. Kruizenga was upset with Resident A because she had been sick on this date, and she was sitting in the living room without a mask on. Ms. Tryon reported Mr. Kruizenga then returned to the living room and reported to the other residents, "[Resident A] does not care about them and wanted to get them sick". Ms. Tryon reported that after this incident, Ms. Kannawin went to Resident A and calmed her down, then explained she could come back out to the living room with the other residents.

On 3/10/23, during on-site investigation, I interviewed Ms. Kannawin. Ms. Kannawin reported that she recalled working on 2/24/23 at the time of the alleged incident. Ms. Kannawin reported she did state to Ms. Tryon, "He always makes her [Resident A] cry and it pisses me off", and she was referring to Mr. Kruizenga. Ms. Kannawin reported Mr. Kruizenga did arrive at the facility and made Resident A go to her room and wear a mask, due to a recent sinus infection she was currently exhibiting symptoms for. She reported she went to Resident A and explained she did not have to wear the mask or stay in her room.

During on-site investigation, on 3/10/23, I interviewed Ms. Bennett. Ms. Bennett reported that she worked the 3pm – 11pm shift at the facility on 2/24/23. She reported that Mr. Kruizenga arrived during her shift and required Resident A to put on a mask. Ms. Bennett reported Resident A had expressed to her that she does not like how Mr. Kruizenga speaks to her and that he forced her to stay in her room and wear a mask because she was ill. Ms. Bennett reported she has observed Mr.

Kruizenga interact with the residents, and she does not like how he interacts with them. She reported that he speaks to the residents in a rude manner.

During on-site investigation, on 3/10/23, I interviewed Resident A. Resident A reported that Mr. Kruizenga takes the residents on outings. She did not have additional information to share about Mr. Kruizenga on this date.

During on-site investigation, on 3/10/23, I interviewed Resident B. Resident B also reported that Mr. Kruizenga takes the residents on outings. She did not have any additional information to share about Mr. Kruizenga on this date.

During on-site investigation, on 3/10/23, I interviewed Resident D. Resident D reported Mr. Kruizenga takes the residents on outings. He reported that Mr. Kruizenga “gets mad at us and I don’t like it when he gets mad.” He reported Mr. Kruizenga does not physically harm the residents, but he does not like the way Mr. Kruizenga speaks to the residents.

On 4/3/23 I interviewed Ms. Rinaldi via telephone. Ms. Rinaldi reported that there have been two recent Office of Recipient Rights complaints through Community Mental Health, regarding Mr. Kruizenga. She reported that these complaints have reported that Mr. Kruizenga “yells” at the residents. She reported that Mr. Kruizenga has received disciplinary action related to these complaints.

On 4/4/23 I interviewed Mr. Kruizenga, via telephone. Mr. Kruizenga reported that he was at the facility on 2/24/23 to take residents to a movie. He reported Resident A was “coughing all over” and “bummed” that she could not go to the movies due to illness. He reported he did tell her she needed to wear a mask and she became upset with this directive. Mr. Kruizenga denied forcing Resident A to go to her room or yelling at Resident A on this date.

On 3/14/23 I received an email from licensee designee, Meaghan Rinaldi, containing Mr. Kruizenga’s employee file. I reviewed the employee file on 3/14/23. In Mr. Kruizenga’s employee file was a document titled, *Employee Warning*, which was dated for 6/28/22 and signed by Mr. Kruizenga. The document read, “Employee was reported to RR for yelling and using a nasty tone with several residents. RR report was substantiated. After already receiving a verbal warning, a written one is next.”

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated

	representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon interviews with Ms. Tryon, Ms. Kannawin, Ms. Bennett, Residents A, B, and D, Ms. Rinaldi, and Mr. Kruizenga, as well as review of Mr. Kruizenga's employee file, it can be established Mr. Kruizenga has a documented history of speaking with residents in a rude and derogatory manner. There were two direct care staff members, Ms. Kannawin and Ms. Tryon, who verbalized direct observations of the events on 2/24/23, as well as notations from Ms. Bennett, Ms. Tryon, Ms. Kannawin, Ms. Rinaldi, and Resident D that Mr. Kruizenga has a history of speaking to residents in a derogatory manner. Mr. Kruizenga is not treating the residents with dignity and respect in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/14/23 I received, via email, copies of employee files from licensee designee, Meaghan Rinaldi. The employee file for direct care staff, Katie Kannawin, was missing an updated certificate of current Cardiopulmonary Resuscitation training.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(c) Cardiopulmonary resuscitation.**
ANALYSIS:	After review of employee files, Ms. Rinaldi, was not able to provide documentation of current cardiopulmonary resuscitation training for Ms. Kannawin's file.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 3/14/23 I received an email from Ms. Rinaldi containing employee file documentation. Upon review of the employee files, direct care staff, Katie Kannawin and Tawney Bennett, did not have medical clearance authorization forms that were dated and signed by a physician, in their files.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	The employee files for direct care staff members Katie Kannawin and Tawney Bennett, did not contain complete, dated, and signed by a physician, medical clearance forms obtained within 30 days of employment.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 3/14/23 I received an email from Ms. Rinaldi containing employee file documentation. The employee file reviewed for direct care staff, Tawney Bennett, did not have documentation of direct care staff training completed.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(e)Verification of experience, education, and training.**
ANALYSIS:	After review of employee files, Ms. Bennett's file was lacking documentation of direct care staff trainings completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

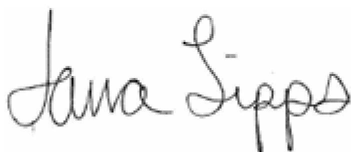
INVESTIGATION:

On 3/14/23 I received an email from Ms. Rinaldi containing resident records. The resident record for Resident C contained a *Health Care Appraisal* form that was dated for 11/18/21.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	After review of Resident C's resident record, it was noted that his *Health Care Appraisal* form was not updated annually as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan. No change to the status of the license recommended at this time.



04/18/23

Jana Lipps Date
Licensing Consultant

Approved By:

Dawn Timm 04/21/2023

Dawn N. Timm Date
Area Manager