GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 5, 2023

Mickey Bauchan
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #:	AS250010703
Investigation #:	2023A0123059
	Berneda Home

Dear Mickey Bauchan:

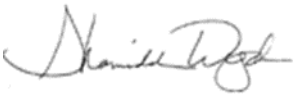
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010703
Investigation #:	2023A0123059
Complaint Receipt Date:	07/17/2023
Investigation Initiation Date:	07/19/2023
Report Due Date:	09/15/2023
Licensee Name:	Michigan Community Services, Inc.
Licensee Address:	5239 Morrish Rd. Swartz Creek, MI 48473
Licensee Telephone #:	(810) 635-4407
Administrator:	Sarah Burns
Licensee Designee:	Mickey Bauchan
Name of Facility:	Berneda Home
Facility Address:	5142 Berneda Drive Flint, MI 48506
Facility Telephone #:	(810) 736-5841
Original Issuance Date:	11/02/1983
License Status:	REGULAR
Effective Date:	06/19/2022
Expiration Date:	06/18/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 07/12/23, Resident A was taken to the ER (emergency room) for abdominal pain. Resident A was found to have two rib fractures and bruising to his right side. The AFC home was unable to provide an explanation of how it happened. On 07/11/23, sometime during second shift is when Resident A was injured.	Yes
On 07/18/23, at 3:15 am, area supervisor Sarah Burns found staff Cannessa Andrews and Jimise Gill both asleep in the living room.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/17/2023	Special Investigation Intake 2023A0123059
07/17/2023	APS Referral Information received regarding APS referral.
07/19/2023	Special Investigation Initiated - Telephone I spoke with adult protective services worker Tiffany Williams.
07/19/2023	Inspection Completed On-site I conducted an unannounced on-site visit.
07/20/2023	APS Referral Information received regarding APS referral.
08/01/2023	Contact - Telephone call made I spoke with staff Sarah Burns via phone.
08/14/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Jimise Gill.
08/14/2023	Contact - Telephone call made I left a voicemail requesting a return call from staff Cannessa Andrews.
08/14/2023	Contact - Telephone call received I spoke with staff Jimise Gill via phone.

08/15/2023	Contact- Document Received Requested documentation received via email from administrator Sarah Burns.
08/17/2023	Contact- Telephone call made I spoke with Resident A's Genesee Health System's case manager Tiffany Atwell via phone.
08/17/2023	Contact- Telephone call made I left a voicemail requesting a return call from staff Laverne Harlston.
08/17/2023	Contact- Telephone call made I left a voicemail requesting a return call from assistant manager Doris Williams.
08/17/2023	Contact- Telephone call received I spoke with staff Doris Williams via phone.
08/21/2023	Contact- Telephone call received I received a voicemail from staff Laverne Harlston.
08/24/2023	Contact- Telephone call made I interviewed staff Laverne Harlston via phone.
08/25/2023	Contact- Document Sent I sent an email requesting documentation from Sarah Burns.
08/29/2023	Contact- Document Received I received an email response from Sarah Burns.
08/30/2023	Contact- Telephone call made I made a follow-up call to the facility and spoke with staff Jeremy Chatman.
08/30/2023	Contact- Telephone call made I interviewed staff Cannessa Andrews via phone.
08/31/2023	Contact- Telephone call made I made a follow-up call with Sarah Burns.
08/31/2023	Exit Conference I conducted an exit conference with licensee designee Mickey Bauchan.

ALLEGATION: On 07/12/23, Resident A was taken to the ER for abdominal pain. Resident A was found to have two rib fractures and bruising to his right side. The AFC home was unable to provide an explanation of how it happened. On 07/11/23, sometime during second shift is when Resident A was injured.

INVESTIGATION: On 07/19/2023, I spoke with adult protective services investigator Tiffany Williams via phone. Tiffany Williams stated that Resident A is non-verbal. Resident A has a bruise on his back, and there is no explanation from the staff in regard to the cause of the injury. Assistant home manager Doris Williams told Tiffany Williams that the bruise was red and about the size of a quarter when staff Doris Williams saw it. Tiffany Williams stated that when she saw the bruise it was much larger, and per the medical records the bruise was about four inches. Resident A is not a one-on-one but has dementia and forgets to walk.

On 07/19/2023, I conducted an unannounced on-site visit at the facility. I made a face to face with Resident A. Resident A was sitting in his wheelchair. He appeared clean and appropriately dressed. Resident A was not responsive to any questioning and appeared to be limited verbally. During this on-site, I observed all six residents who appeared clean and appropriately dressed.

On 07/19/2023, I interviewed staff Jeremy Chatman at the facility. Staff Chatman denied having any knowledge of how Resident A ended up with broken ribs. Staff Chatman stated that none of the residents in the home can tell what happened due to limited verbal skills. Resident A is now a fall risk.

On 07/19/2023, I interviewed staff Loretta Wallace at the facility. Staff Wallace stated that she was the first staff to notice that Resident A had a bruise on 07/11/2023 while toileting Resident A during second shift about 6:45 pm. The bruise was on Resident A's lower left side of the back and was about the size of a half-dollar. Staff Wallace stated that the next day on 07/12/2023 during first shift, Resident A went to the hospital. Resident A returned home the next day (on 07/13/2023). By then, the bruising was up his back and around his side. Staff denied knowing how it happened. Resident A has dementia and has been declining. Staff Wallace stated that on a good day, Resident A can still walk around.

On 07/19/2023, during this on-site inspection, I obtained a copy of Resident A's *Health Care Appraisal* dated for 02/27/2023. The *Health Care Appraisal* states Resident A was fully ambulatory, and diagnosed with depressive disorder, anxiety disorder, and dementia with behavioral disturbances. His *Assessment Plan for AFC Residents* dated 01/12/2023 was reviewed as well, and does not indicate use of a wheelchair, only a CPAP machine at night.

A copy of Resident A's Hurley Medical Center's After *Visit Summary* dated for 07/13/2023 states that Resident A "*has been evaluated in the ER and found to have two rib fractures. He should use the inventive spirometer provided in the ER to take deep breaths and prevent complications such as pneumonia*." The reason noted for

the hospital visit was abdominal pain, and the diagnoses were noted to be abdominal pain and fracture of multiple ribs.

A copy of Resident A's progress notes for 07/12/2023 was obtained during this on-site inspection as well. Third shift notes (07/11/2023-07/12/2023) indicates no issues during the shift. Progress notes for first shift 07/12/2023 notes that Resident A refused self-care, it was noted he had a bruise on his left side and on top of his left foot. Second shift notes indicated that Resident A went to the hospital at 12:45 pm by ambulance, and that Staff Doris Williams went to the hospital with Resident A.

On 08/01/2023, I interviewed area manager/administrator Sarah Burns via phone. Staff Burns stated that they cannot prove when Resident A broke his ribs. Resident A does plop himself down hard when he sits in his wheelchair and could have hit the side of his wheelchair. Resident A's physician stated that this was a possible cause of the fractures. On 07/11/2023, staff first noticed Resident A's bruise on second shift. On 07/12/2023, Staff Burns stated that she received a call that Resident A was acting uncomfortable and in pain. Staff thought it may have been a urinary tract infection because he was not urinating during bathroom time, and when he did, it was dark and had a strong odor. Staff Burns stated that she went to the facility to assess Resident A, and while there, Resident A put himself on the floor. Resident A was asked to point where the pain was, and Resident A pointed to his lower left abdomen. Resident A was uncomfortable in whatever position he was in. A call was made to 911 for an ambulance. Resident A was sent to the hospital. Staff Doris Williams met Resident A at the hospital and found out he had broken ribs. Staff Williams thought the bruise may have been from the arm of Resident A's wheelchair, so Staff Williams spoke with a physician about how Resident A plops down in his wheelchair. Staff Burns stated that staff who worked first shift on 07/11/2023 did not see a bruise on Resident A, but second shift on 07/11/2023 did. There were no reported falls during that time frame, and the bruise lines up with the side of his wheelchair.

On 08/16/2023, I received a copy of the *AFC Licensing Division- Incident/Accident Report* was obtained. The incident report is dated 07/12/2023 at 12:30 pm and states the following:

"[*Resident A] was complaining his stomach was hurting. He kept grabbing his lower left side stomach. He didn't want to walk, he didn't want to stay in bed, he didn't want to stay in his wheelchair, he didn't want to stay on the couch. He was just very uncomfortable. He kept putting himself down on the floor. Staff noticed [Resident A's] urine was dark and had a strong odor. Staff checked vitals, all within normal limits, Staff called Supervisor, She came to the home and send him to the hospital to be checked out. Continue to follow IPOS (Individual Plan of Service) and health and safety and any discharge instructions*"

The incident report notes that Resident A was sent to Hurley Medical Center about 1:00 pm and was diagnosed with two rib fractures on his left side. Resident A was

admitted for observation at 11:50 pm on 07/12/2023 and was sent home at 8:30 am on 07/13/2023.

On 08/17/2023, I spoke with Resident A's Genesee Health System's case manager Tiffany Atwell via phone. She denied having any personal care concerns regarding Resident A. She stated that the staff sought medical care timely. Staff found Resident A in his closet, and there was a broken shelf, so staff thought he may have been confused thinking the closet was the bathroom. Resident A may have gotten hurt on the broken shelf. The same day this incident occurred; Resident A went to the hospital. She stated that she believes staff Loretta Harlston accompanied Resident A to the hospital.

On 08/17/2023, I interviewed assistant home manager Doris Williams via phone. Staff Williams stated that she worked on 07/11/2023 from 12:00 pm to 8:00 pm, which is the day before Resident A was sent to the hospital. She stated that she got called to the bathroom by another staff person who was doing personal care to Resident A. Staff Williams was shown Resident A's bruise, and Staff Williams instructed the staff person to write an incident report. Staff Williams stated that she is not sure if the bruise is related to the broken ribs, and that the bruise was the size of a 50-cent piece. She stated that there were no signs of pain. Resident A has difficulty walking due to his dementia and forgetting how to walk. Resident A had been transported to the bathroom at that time via wheelchair. Staff Williams stated that she went to the hospital with Resident A on 07/12/2023 between 12:00 pm and 1:00 pm. She stated that she was called in to work that day. She stated that she heard that Resident A plopping down in his wheelchair was a possible cause of the broken ribs. Staff Williams stated that as soon as Resident A indicated signs of pain, he was immediately sent to the hospital.

On 08/24/2023, I interviewed staff Lavern Harlston via phone. Staff Harlston reported that she worked on 07/11/2023 (first shift), but was not assigned to Resident A, and did not see the bruise. She stated that Resident A slept during the shift, and nothing was unusual. Staff Harlston stated that she worked first shift on 07/12/2023. At the beginning of the shift, Resident A was lying in bed and was hollering out in pain. She stated that she went to Resident A's room to pass medication, and he appeared to be in pain. She stated that staff got Resident A up and got him to his wheelchair. During breakfast, Resident A kept grabbing his side. She stated that this was around 8:45 am – 9:00 am. She stated that while Resident A was receiving personal care that morning, he kept sliding off of his wheelchair. Staff got him to the floor and provided him pillows. Resident A had a bruise on his left side, and on his foot. The bruise at that time on his foot was about the size of a 50-cent piece, and on the side of his left flank was the size of an apricot. Staff Harlston stated that Resident A was on the floor until supervision arrived at the home and 911 was called. She stated that Resident A was on the floor for about an hour and a half. She stated that the on-call home manager was called first. Staff Harlston stated that staff who worked third shift the night prior did not report anything during shift change about Resident A being in pain. She stated that no one knows

how Resident A injured himself. She stated that the EMT's arrived at the home at about 10:30 am. She stated that to her knowledge this is the first incident of Resident A being injured to this extent and reported that Resident A is on hospice.

On 08/25/2023, I sent administrator Sarah Burns an email requesting a copy of Resident A's progress notes for first, second, and thirds shifts on 07/11/2023, as well as a copy of Resident A's wheelchair script. In this email, I also asked Staff Burns to clarify what time staff called her on 07/12/2023 to report Resident A being in pain.

On 08/29/2023, I received an email response from Staff Burns. The email included the requested documentation. Staff Burns also noted in the email that she received a call on 07/12/2023 from staff Lavern Harlston at about 12:00 pm. She stated that she arrived at the facility a few minutes later, and the ambulance arrived at the home around 12:25 pm. She stated that she went to the facility to see if she could just take Resident A to an Urgent Care at that time because they thought Resident A just had a UTI (urinary tract infection).

An Incident/Accident Report dated for 07/11/2023 was reviewed. The incident report written by staff Loretta Wallace states:

Under *Explain What Happened/Describe Injury (if any)* it says:

"*Client needed assistance changing after soiling himself staff obtained clean cloths and brief and when changing him and noticed bruising on hip (left) towards back and buttox."*

Under *Action taken by Staff/Treatment Given* it says*:*

"*IR written book documented in staff told during shift change/observe and document*"

Under *Corrective Measures Taken to Remedy and/or Prevent Recurrence* it says:

"Make sure client has assistance for moving around the house, follow IPOS, watch how he sits in w/c be careful of arm of chair."

A copy of a wheelchair script for Resident A was obtained. It is dated 04/05/2023. It was prescribed due to Alzheimer's, dementia, and frequent falls by Samasandrapalya Kiran, MD. PC.

Staff shift progress notes were obtained. On 07/11/2-23 during first shift (6:00 am to 2:00 pm) staff noted that Resident A had no new marks or bruises. The staff notes for first shift were signed by staff Jeremy Chatman.

Staff shift progress notes for 07/11/2023 during second shift (2:00 pm to 10:00 pm) it notes that Resident A "*has a bruise on left side between back and hip*." The notes also indicate that his urine was very strong and dark. The staff notes for second shift

were signed by staff Loretta Wallace.

Staff shift notes for 07/11/2023 during third shift noted that Resident A did not have any new marks/bruises, all bed checks were completed, and Resident A was toileted as needed. The staff notes for third shift were signed by staff Jasmine Phillips.

On 08/30/2023, I made a follow-up call to the facility. I spoke with staff Jeremy Chatman who worked first shift on 07/12/2023. She stated that from what she can recall, she was not the assigned staff to Resident A on 07/12/2023. She stated that his assigned staff that day assisted Resident A with personal care. Resident A then ate breakfast and laid down. Resident A was assisted back into his wheelchair, and at that time Staff Chatman observed Resident A to be in visible pain, and Resident A was complaining of his stomach hurting. She stated that the other staff person (Staff Harlston) called the assistant home manger twice, then called staff Sarah Burns, and Staff Burns arrived sometime between 11:00 am and 12:00 pm. Staff Chatman stated that breakfast is usually served between 7:00 am and 7:30 am and sometimes residents sleep in. First shift starts at 6:00 am.

On 08/31/2023, I spoke with staff Sarah Burns via phone. Staff Burns stated that she was informed that on 07/12/2023, Resident A received some Tylenol, laid back down, kept wanting to go to the bathroom, but was still in pain. Staff tried different positions, and nothing was helping. She stated that staff followed Resident A's standing orders and called her (Staff Burns). She stated that Resident A had pain spurts that were on and off, and they thought it may have been spasms, and UTI related. Resident A was grabbing his groin area, not his side. She stated that she did not know about the bruise until later, and it was purple and the size of a golf ball. She stated that the bruise did line up with the arm of the wheelchair. Staff Burns stated that the EMT's were confused. She stated that Resident A did not have a UTI, he was dehydrated and received fluids at the hospital.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Staff Jeremy Chatman, Staff Loretta Wallace, administrator Sarah Burns, staff Doris Williams, and staff Lavern Harlston were interviewed. Staff interviewed did not have an explanation for how Resident A obtained fractured ribs. Staff Laverne Harlston reported that at the start of her shift on 07/12/2023, Resident A was hollering out in pain as she was doing medication passing. Staff Harlston stated that Resident A kept grabbing his side during breakfast time as well. Staff Harlston stated that breakfast was around 8:45 am to 9:00 am,

	and the EMT's arrived around 10:30 am. Staff Harlston stated that she contacted supervision, and supervision responded to the home, prior to EMS being contacted. Administrator Sarah Burns reported that she arrived at the facility on 07/12/2023 around 12:00 pm. The EMT's were called and arrived at the home about 12:25 pm. Staff Chatman reported that she worked first shift on 07/12/2023, and that Staff burns arrived at the home sometime between 11:00 am and 12:00 pm. She reported that Staff Harlston contacted management several times prior to EMS being contacted. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 07/18/23, at 3:15 am, area supervisor Sarah Burns found staff Cannessa Andrews and Jimise Gill both asleep in the living room.

INVESTIGATION: On 07/19/2023, I conducted an unannounced on-site visit at the facility. I made a face-to-face with Resident A. Resident A was sitting in his wheelchair. He appeared clean and appropriately dressed. Resident A was not responsive to any questioning and appeared to be limited verbally. During this on-site, I observed all six residents who appeared clean and appropriately dressed.

On 07/19/2023, I interviewed staff Jeremy Chatman at the facility and reported working first shift. Staff Chatman denied having any knowledge of any staff sleeping during third shift.

On 07/19/2023, I interviewed staff Loretta Wallace at the facility. She denied having any knowledge of staff sleeping on third shift.

On 07/19/2023, I obtained a copy of the facility's personnel policy regarding sleeping on duty, which is noted in section 38. The policy says, "*Sleeping on duty is strictly prohibited.*"

On 08/01/2023, I interviewed area manager Sarah Burns via phone. Sarah Burns reported she did a pop-up visit at the home due to suspicions that third shift staff were sleeping on shift. On 07/18/2023, Staff Burns stated she arrived at the home around 3:15 am. All of the lights in the home were observed to be off except the office light. The television was on. Staff Burns stated that she went around the house to look through the windows, and observed one staff person in the recliner asleep, and the other staff person's feet. Both staff were covered with blankets. Staff Burns

stated that she entered the front door, and the alarm to the home had not been set. Resident A was awake sitting on the floor with a coloring book and pencils. Staff Burns then checked on Resident B, who she says has to be repositioned every two hours. Resident B's brief was wet, and it was not warm, so it appeared to have been a while since the last bed check. Resident B has a bedsore and should be checked every four hours during the night. Staff Barns stated that she repositioned Resident B and changed his brief. The other residents were observed by Staff Barns to be all sleeping, and dry. She took Resident A to the bathroom and laid him back down in bed. Staff Burns stated that after providing personal care, she went to the living room, and staff Jimise Gill and staff Cannessa Andrews were still asleep. Staff Burns heard Resident A moving, so she checked on Resident A again, then put him in his recliner chair. At this point, Staff Burns reported being in the home for approximately 45 minutes. Staff Burns tapped hard twice, one at a time to wake staff up. Staff Burns terminated them both immediately. She stated that Staff Gill and Staff Andrews were not just taking a nap. They "went to bed" as they had their shoes off, phone(s) plugged in, etc.

After the interviewed with Staff Burns, sent a photo, and identified Staff Jimise Gill and Staff Cannessa Andrews as the two staff in the photo. Both staff were reclined in the living room recliner chairs. They both had blankets over them, the television was on, and both staff appeared laying on their sides sound asleep.

On 08/14/2023, I interviewed staff Jimise Gill via phone. Staff Gill stated that she and Staff Cannessa Andrews did bed checks around 3:00 am. They sat down, watched television, and dozed off. At about 3:45 am staff Sarah Burns caught them. Staff Gill and Staff Andrews were sent home around 4:00 am. Staff Gill stated this was the first time she dozed off on a shift. She stated that she worked in the home for two years.

On 08/30/2023, I interviewed staff Cannessa Andrews via phone. Staff Andrews stated that she and Staff Gill had completed their duties. All of the residents were in bed asleep. She had laid down due to not feeling well and being cold. She stated that she and Staff Gill dozed off for about 40 minutes. They were awakened by Staff Burns who relieved them of the duties at 4:00 am. She stated that Staff Burns told them she had been there for a half hour. She stated that she later received a call that she was being let go of her employment.

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(1) A licensee shall have written policies and procedures that include all of the following: **(b) Resident care related prohibited practices.**
ANALYSIS:	On 07/18/2023, administrator Sarah Burns reported observing staff Cannessa Andrews and staff Jimise Gill both asleep while working third shift. Staff Burns entered the home, checked, and

	provided personal care to residents before waking both Staff Gill and Staff Andrews. She reported she terminated both immediately afterwards. Staff Burns provided a photo that shows both Staff Gill and Staff Andrews asleep in the facility's living room. On 07/19/2023, during my on-site, I obtained a copy of the staff's personnel policy regarding sleeping on duty, which is strictly prohibited. On 08/14/2023, I interviewed staff Jimise Gill. She admitted that she and Staff Andrews were caught sleeping while working third shift by Staff Burns. On 08/30/2023, I interviewed staff Cannessa Andrews who admitted to sleeping while on duty. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/19/2023, during an on-site inspection, I obtained a copy of Resident A's *Health Care Appraisal* dated for 02/27/2023. The *Health Care Appraisal* states Resident A was fully ambulatory, and diagnosed with depressive disorder, anxiety disorder, and dementia with behavioral disturbances. His *Assessment Plan for AFC Residents* dated 01/12/2023 was reviewed as well, and does not indicate use of a wheelchair, only a CPAP machine at night.

On 08/25/2023, I sent administrator Sarah Burns an email requesting a copy of Resident A's progress notes for first, second, and thirds shifts on 07/11/2023, as well as a copy of Resident A's wheelchair script.

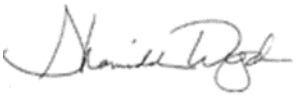
On 08/29/2023, I received an email response from Staff Burns. The email included the requested documentation. A copy of a wheelchair script for Resident A was obtained. It is dated 04/05/2023. It was prescribed due to Alzheimer's, dementia, and frequent falls by Samasandrapalya Kiran, MD. PC.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	During the course of the investigation, I obtained a copy of Resident A's *Assessment Plan for AFC Residents* dated 01/12/2023. Resident A's wheelchair script is dated 04/05/2023. Resident A's assessment plan was not updated to reflect the use of this assistive device. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/31/2023, I conducted an exit conference with licensee designee Mickey Bauchan via phone. I informed Mickey Bauchan of the findings and conclusions of this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).



09/05/2023

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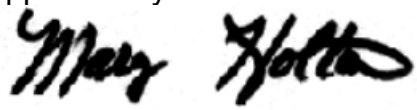
Shamidah Wyden Date
Licensing Consultant

Approved By:



09/05/2023

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Mary E. Holton Date
Area Manager