GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 18th, 2023

Dean Bonesteel
Pineview Cottage, LLC
8121 Broken Ridge East
Harbor Springs, MI 49740

RE: License #: AH240389978
Investigation #: 2023A1021076
Pineview Cottage

Dear Mr. Bonesteel:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

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 #:** | AH240389978 |
| | |
| **Investigation #:** | 2023A1021076 |
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| **Complaint Receipt Date:** | 07/20/2023 |
| | |
| **Investigation Initiation Date:** | 07/20/2023 |
| | |
| **Report Due Date:** | 09/19/2023 |
| | |
| **Licensee Name:** | Pineview Cottage, LLC |
| | |
| **Licensee Address:** | 8121 Broken Ridge East<br>Harbor Springs, MI 49740 |
| | |
| **Licensee Telephone #:** | (810) 516-8928 |
| | |
| **Administrator/ Authorized Representative:** | Dean Bonesteel |
| | |
| **Name of Facility:** | Pineview Cottage |
| | |
| **Facility Address:** | 3498 Harbor-Petoskey Rd<br>Harbor Springs, MI 49740 |
| | |
| **Facility Telephone #:** | (231) 412-6069 |
| | |
| **Original Issuance Date:** | 08/03/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/03/2023 |
| | |
| **Expiration Date:** | 02/02/2024 |
| | |
| **Capacity:** | 40 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Facility unable to manage Resident B. | No |
| Facility restrained Resident B. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 07/20/2023 | Special Investigation Intake<br>2023A1021076 |
| 07/20/2023 | Special Investigation Initiated - Letter<br>left message with APS worker for additional information |
| 07/20/2023 | Contact - Telephone call made<br>interviewed administrator |
| 07/20/2023 | Contact-Telephone call made<br>McLaren Northern Michigan case manager Mike Morey |
| 07/20/2023 | Contact-Telephone call made<br>Interviewed McLaren Northern Michigan physician Andrew Ostosh |
| 07/21/2023 | Contact-Documents Received<br>Received Resident B's documents |
| 07/26/2023 | Contact-Telephone call made<br>Interviewed Staff Person 1 |
| 07/27/2023 | Contact-Telephone call made<br>Interviewed Staff Person 2 |
| 07/27/2023 | Contact-Telephone call made<br>Interviewed Relative C1 |
| 09/05/2023 | Contact-Telephone call made<br>Meeting held with authorized representative and area manager |
| 09/06/2023 | Contact-Documents Received<br>Received additional information |

| | |
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| 10/18/2023 | Exit Conference |

**ALLEGATION:**

**Facility unable to manage Resident B.**

**INVESTIGATION:**

On 07/20/2023, the licensing department received a complaint from Adult Protective Services (APS). APS reported concerns with facility ability to manage Resident B. APS reported Resident B has eloped from the facility, has hit other residents, and has hit staff members.

On 07/20/2023, I interviewed APS worker Lane Stopher by telephone. Mr. Stopher reported Resident B has had three emergency room visits since his admission to the facility. Mr. Stopher reported that the police have been involved due to Resident B's behaviors.

On 07/20/2023, I interviewed administrator Hilde Bonesteel by telephone. Ms. Bonesteel reported at time of admission Relative B1 did not report any behavior issues with Resident B. Ms. Bonesteel reported when Relative B1 completed the admission paperwork, Resident B was left in the common area of the facility. Ms. Bonesteel reported when the paperwork was completed, Relative B1 reported Resident B had no knowledge that he was to become a resident at the facility. Ms. Bonesteel reported Relative B1 told Resident B there were issues at the house and left Resident B at the facility. Ms. Bonesteel reported since admission to the facility, Resident B has been agitated, restless, and has attempted to elope from the facility. Ms. Bonesteel reported the facility attempted to contact Relative B1 for assistance with Resident B's behaviors but Relative B1 would not answer the phone. Ms. Bonesteel reported Resident B was not active with a physician and therefore it took time to find a physician to prescribe medications for behaviors. Ms. Bonesteel reported Resident B cannot move to the secure memory care unit because the unit is full. Ms. Bonesteel reported the facility did place Resident B in the memory care unit during the day for increased supervision which helped some with the behaviors.

I reviewed Resident B's Behavior Tracking Worksheet. The worksheet revealed the facility identified the following behaviors: combative behavior, confusion, exit seeking, hallucinations, and sundowning. With each behavior, the facility identified and implemented appropriate interventions to address and minimize the problem.

I reviewed observation notes for Resident B. The observation notes read,

*“06/30/23: Resident extremely confused/combative with care. Wandering halls. Observed to be fearful of new environment. Resident had no medication to ease his anxiety. Staff continued to try and support and reassure.*
*07/01/23: called for assistance at aprox 11:20pm he stated someone was trying to kill him.*
*07/01/23: staff reporting escalating behaviors. Pushing, grabbing wrist of caregivers, punching. Attempts to walk with resident reassure resident of safe environment continue.*
*07/01/23: (Resident B) moved in 6/30/23 following meeting with (Relative B1); Resident sat in chair with snacks and beverage outside private dining room where (Relative B1) was sitting. Resident did not participate in this initial meeting as we come to find out (Relative B1) did not intend to inform him that he would be moving into Pineview as a resident. When it came time for (Relative B1) to leave Director of Health and Wellness requested that we go together to inform (Resident B) of the intention for him to become a resident. (Relative B1) was very anxious and stated that would not be a good idea however, resident came walking down the hall toward her and she walked up to him. Informed him that there was a “problem with painters at the house and she had to go handle it.” (Relative B1) then turned and briskly walked away down the hallway as the staff, and I intervened with resident and showed him to the “Hotel room his (Relative B1) had arranged for them.” Resident was confused and anxious.*
*07/02/23: exit seeking, pulled fire alarm sent out to er around midnight.*
*07/02/23: resident elopement attempts; pulled fire alarm. Combative. Resident sent for evaluation/assessment due to “Aggressive Behaviors.” Not initially reported by (Relative B1). Especially when resident attempted to be redirected when leaving building. EMT’s verbalizing to staff that this happens all the time and the ER does not have room and will just send them back. Police officers apologized to staff for behavior of EMT and resident sent to ER for evaluation/stabilization of combative behaviors. Medication order sent to cover Ativan 0.5mg BID for 5 days.*
*07/5/23: awake 5am wondering halls.*
*07/08/23: Combative with staff walking to his room. Pushing; tightly gripping hand and wrist, threating to kill. After PRN remained combative twisting arms of caregiver.*
*07/08/23: PRN-rude to staff shoved her into the wall & pushing her when attempting to toilet him.*
*07/08/23: Care attempted again after PRN was given & he refused twisted (caregiver) wrist.*
*07/09/23: Eloped; exit seeking two times, monitor Q 15 mins.*
*07/09/23: Awake wandering in room and common area.*
*07/09/23: PRN- exit seeking did open front door and walk out side, redirected back into community.*
*07/09/23: Went out front door was able to redirect him back inside building. I was doing med pass. He is currently going to (memory care).*
*07/11/23: Telephone call placed to (Relative B1). Discussion relative to medications needed to assist with transition to AL/MC. Medical intervention for “sundowning” which includes tx for anxiety, agitation, and combative behaviors. Resident up ambulating in AL hallways. Brought back to MC and sat with Director while*

*(caregiver) take their breaks. Resident was given Allopurinal 100mg take ½ tab and Melatonin 10mg at 8pm. (caregiver) reports gave PRN Ativan 0.5 at 6:51pm. Resident was given Benadryl 25mg cap at 7:30pm. Resident was assisted with shower he would be ready to get up; do AM care then have breakfast before (Relative B1) came to take him to the clinic.*
*07/12/23: Punched (caregiver) this morning during care.*
*07/12/23: Resident was awaken by staff at 5:30am for an appointment with (Relative B1) was taking him following breakfast to get medication refilled. While dressing resident for the day it was reported that he shoved and punched staff member. Med list, direction, and physician visit sheet provided for (Relative B1) to take. Petoskey Clinic and Family Practice was unable to assist resident with need for medication script. (Relative B1) called with update. Suggested that she go to McLaren ER as they had the recent visit; explain situation that he needs medication coverage until his appointment on Friday. Resident went to ER and physician provided script for Ativan 0.5mg tablet, 1 tab po BID and as needed for anxiety.*
*07/12/23: While attempting to assist with ADL's dressing caregiver was shoved and pinched. Resident attempting to leave community; combative behaviors continued. Resident went out the door when another resident was attempting to come in. Resident resisted and was physically aggressive with attempt to return him into the building. Available PRN medication had been utilized.*
*07/14/23: Very combative; undressing in lobby. Initially took 3 care staff to assist resident to his room. Then took two additional male staff to come assist resident into bed due to resident punching, scratching and kicking caregivers.*
*07/14/23: Resident went to first visit with new care provider. (Resident B) returned with orders for Seroquel 25mg 1x's daily, Ativan 0.5mg 2x's daily. Resident had a good lunch upon his return but then began escalating around 3pm and ended up being extremely confused and combative at app 4:45pm. Assistance was called to get resident into his bed. Calls had been placed before this for increase in medications available for behaviors. Gave all medication available at 4:45pm. Call back from provider with orders for Ativan .5mg BID scheduled and Ativan .5mg BID PRN. Also sending orders to Hometown for ABH 1/25.1mg BID PRN.*
*07/15/23: Resident sent to ER. Staff reporting to director that they were not able to control aggressive behaviors with meds in place. Discussed with ER physician the need to have "tools" medications to assist with maintaining the safety of this resident the staff and the other residents. Until able to get him stabilized it would not be safe to return him to the community. ER doctor did change from Seroquel to Zyprexa and add additional PRN medications to assist in community in attempts to keep resident from harming himself, other residents, staff, and property. ER doctor also recommends that (Relative B1) come in and sit with resident during "sundowning hours" as his behaviors are so extreme. Until medications have had time to get to therapeutic levels. Multiple attempts made to reach (Relative B1) to initiate assistance to have her come be with him. Unable to reach (Relative B1) by phone.*
*07/18/23: PRN-Hallucinating reaching for things that are not there.*
*07/18/23: Awake all night.*
*07/18/23: Questionable hallucinations? Awake throughout the night*
*07/18/23: Was in MC from 5am till 7:45am."*

| APPLICABLE RULE | |
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| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| **For Reference:** | **Definitions.** |
| | **(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.** |
| **ANALYSIS:** | Resident B admitted to the facility on 06/30/23. At the time of admission, it was not known that Resident B had any behaviors. From day of admission, Resident B exhibited exit seeking behaviors, hallucinations, restlessness, combativeness, and anxiety. The facility acted appropriately and ensured the protection and safety of Resident B by completing and implementing a Behavior Tracking Worksheet to address and minimize the behaviors. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Facility restrained Resident B.**

**INVESTIGATION:**

Mr. Stopher reported Resident A had a bruise on his arm, but (Relative B1) and facility confirmed origin of bruise was not from restraints. Mr. Stopher reported a bruise was found on Resident B's back and Resident B had skin breakdown. Mr. Stopher reported the bruise and skin breakdown is to believe to be from the care received at the facility.

On 07/26/2023, I interviewed staff person 1 (SP1) by telephone. SP1 reported she provided care to Resident B. SP1 reported Resident A had no bruises and no skin breakdown. SP1 reported Resident A was combative with staff and was not receptive to care. SP1 reported Resident A also kept falling. SP1 reported one evening Resident B was placed in a wheelchair with a seatbelt to prevent him from

getting up and falling. SP1 reported Resident B was able to remove the seat belt and get out of the wheelchair.

On 07/27/2023, I interviewed SP2 by telephone. SP2 statements were consistent with those made by SP1.

I reviewed observation notes for Resident B. The notes read,

*“07/17/2023: Observed on floor in his room during 15 min checks. 07/17/2023:” Cabinet tripped over in residents bathroom. Resident observed on his knees holding onto skin. Quarter skin abrasion to left knee.”*

| **APPLICABLE RULE** | |
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| **MCL 333.20201** | **Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.** |
| | **(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the 4 health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.** |
| | **2 (l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician. In case of a chemical** |

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| | **restraint, the physician shall be consulted within 24 hours after the commencement of the chemical restraint.** |
| **ANALYSIS:** | Interviews conducted revealed Resident B was placed in a wheelchair with a seat belt as a restraint method. By placing Resident B in this wheelchair with the seatbelt, Resident B's movement was restricted in the facility. There was no physician order for the use of the seatbelt that specified reasoning and timeframe for the use of the seatbelt. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

I reviewed Resident C's service plan. The service plan read,

*"Has a tendency to grab when combative-please use mitts or socks on hands.*"

| **APPLICABLE RULE** | |
|---|---|
| **MCL 333.20201** | **Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.** |
| | **(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the 4 health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.** |
| | **2 (l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical** |

| | |
|---|---|
| | **restraints, except those restraints authorized in writing by the attending physician for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician. In case of a chemical restraint, the physician shall be consulted within 24 hours after the commencement of the chemical restraint.** |
| **ANALYSIS:** | Review of Resident C's service plan revealed care staff were instructed to use gloves or mitts when providing care to Resident C. By placing gloves or mitts on Resident C's hands it restricts the use of Resident C's hands. There was no physician order for the use of the gloves that specified reasoning and timeframe for the use of the gloves. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

I reviewed the admission agreement for Resident B. The admission agreement and service plan were signed by Relative B1.

Ms. Bonesteel reported Relative B1 did provide durable power of attorney paperwork for Relative B1 to make decisions for Resident B.

I reviewed the DPOA paperwork for Resident B. The paperwork read,

> *"This healthcare durable power of attorney only becomes effective when I can't make my own medical decisions. My agent and my attending physician will decide when I can't make decisions for myself."*

| **APPLICABLE RULE** | |
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| **R 325.1922** | **Admission and retention of residents.** |
| | **(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.** |
| **ANALYSIS:** | Review of Resident B's paperwork revealed the DPOA was not active, as two physicians did not state Resident B lacked decision making capacity. The facility had Relative B1 sign the admission agreement and not Resident B. Therefore, the |

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| | admission agreement is not valid as it was not appropriately signed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
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| **R 325.1922** | **Admission and retention of residents.** |
| | **(2) The admission policy shall specify all of the following:**<br>**(c) That the individual seeking admission and his or her authorized representative, if any, shall participate in the development of the individual's service plan.** |
| **ANALYSIS:** | Review of Resident B's admission documents revealed Resident B has no activated DPOA and therefore Resident B was to assist in the development of the service plan. Therefore, the facility did not appropriately develop Resident B's service plan. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

Upon review of Resident B's admission documents, there was no evidence of tuberculosis (TB) screening. Ms. Bonesteel reported that Relative B1 was to bring back TB test results but never did.

| **APPLICABLE RULE** | |
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| **R 325.1922** | **Admission and retention of residents.** |
| | **(7) An individual admitted to residence in the home shall have evidence of tuberculosis screening on record in the home that was performed within 12 months before admission. Initial screening may consist of an intradermal skin test, a blood test, a chest x-ray, or other methods recommended by the public health authority. The screening type and frequency of routine tuberculosis (TB) testing shall be determined by a risk assessment as described in the 2005 MMWR ?Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005? (http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf) , Appendices B and C, and any subsequent guidelines as published by the centers for disease control and prevention. A home,** |

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|---|---|
| | **and each location or venue of care, if a home provides care at multiple locations, shall complete a risk assessment annually. Homes that are low risk do not have to conduct annual TB testing for residents.** |
| **ANALYSIS:** | Review of Resident B's admission documents revealed the facility had no record of tuberculosis screening for Resident B. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

Mr. Stopher reported Resident B was admitted to the hospital on 07/19/2023 from the facility. Mr. Stopher reported the facility contacted emergency medical services (EMS) for transfer to the hospital because the facility could not manage the behaviors of Resident B. Mr. Stopher reported the facility has refused to accept Resident B back to the facility.

On 07/20/2032, I interviewed McLaren Northern Michigan case manager Mike Morey by telephone. Mr. Morey reported Resident A is currently on a social work hold and he is actively trying to find a new placement for Resident B. Mr. Morey reported the facility is refusing to accept Resident B back to their care and therefore Resident B is left in the emergency room. Mr. Morey reported he is working on finding a new placement for Resident B but that it will not happen today.

On 07/20/2023, I interviewed McLaren Northern Michigan physician Andrew Ostosh by telephone. Mr. Ostosh reported Resident B has been in the emergency room for 47 hours. Mr. Ostosh reported Resident B admitted to the hospital due to behaviors at the facility. Ostosh reported the emergency room adjusted medications and Resident B is medically cleared to leave the emergency room but cannot leave due to no place to go.

Ms. Bonesteel confirmed statements by Mr. Morey and Mr. Ostosh that the facility would not accept Resident B back to their care. Ms. Bonesteel reported Resident B is violent and she cannot accept him back.

On 07/31/2023, Resident B was discharged from the emergency room to another facility.

Relative C1 reported Resident C was admitted to the facility for quite some time. Relative C1 reported Resident C had behaviors and was transferred to the local hospital on 04/09/2023. Relative C1 reported the facility refused to accept Resident C back into their care.

I reviewed McLaren Northern Michigan hospital paperwork for Resident C. The paperwork read,

*04/09/2023: Patient signed out to me by outgoing ED provider. Has a history of dementia, has been at Pineview cottage and has had increasing behavioral disturbances there. They sent him here because they apparently cannot handle him anymore. Since that they reduced his trazodone dose recently at night. In speaking with (Relative C1) who was available later she reports that patient has been in Pineview cottage since June of last year, he has an advancing dementia, patient is reported to be more confused in the morning, (Relative C1) reports that this has been going on for months, reports that when the patient wakes up at first he does not want to do what other people want him to do and that this tends to improve after a period of time, she reports that she has been noticing this as well she has been trying to get the staff at Pineview cottage to get them to change how they are interacting with him, she has reported that she is trying to get them to come and wake him up and to then go see some other staff members and to then come back to the patient after a little while. I did speak with the case manager at Pineview cottage,(SP3), she reports that the patient will not allow them to do care, the patient has been punching and screaming, reports that he is a risk to staff members, he has been refusing his medications. This morning patient punched a staff member in the stomach and grabbed another by the arm. She reports that they had previously given the (Relative C1) 30 days to find a new living arrangements for the patient but was not able to do so therefore they report that they cannot take the patient back and are requesting another disposition for the patient. Pineview cottage has recently held the patient's trazodone, they report that the thought process was that he was groggy in the morning and they thought that this was possibly why he was refusing his medications, patient has been on trazodone for some time they cut his dose in half.*

*04/10/2023: Aggressive behavior and agitation may in part be due to metabolic encephalopathy. Patient may be able to return to previous residence after UTI has been treated. Seen by CM today. Pineview cottage will not take him back. No local facilities able to take him. Referrals done to Mission point Detroit, neuropsych Indiana."*

| **APPLICABLE RULE** | |
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| **R 325.1922** | **Admission and retention of residents.** |
| | **(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident:**<br>**(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.** |

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|---|---|
| **ANALYSIS:** | Interviews conducted and review of documents revealed Resident B and Resident C was transported to the emergency room due to increased behaviors and the emergency room cleared the residents for discharge. However, the facility refused to accept the residents back to their care. The emergency room is not a discharge location and therefore the residents were improperly discharged. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 08/22/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 08/31/2023
Updated 10/17/2023

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section