GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Sharon Wotring
Assisted Living at Redwood Manor, LLC
9084 Garr Road.
Berrien Springs, MI 49103

June 7, 2024

RE: License #: AM110282191
Investigation #: 2024A0579024
Assisted Living at Redwood Manor, LLC

Dear Sharon Wotring:

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 responsible party 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 (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM110282191
Investigation #:	2024A0579024
Complaint Receipt Date:	05/09/2024
Investigation Initiation Date:	05/09/2024
Report Due Date:	07/08/2024
Licensee Name:	Assisted Living at Redwood Manor, LLC
Licensee Address:	9084 Garr Road. Berrien Springs, MI 49103
Licensee Telephone #:	(269) 408-0598
Administrator:	Teri Martin
Licensee Designee:	Sharon Wotring
Name of Facility:	Assisted Living at Redwood Manor, LLC
Facility Address:	9084 Garr Road Berrien Springs, MI 49103
Facility Telephone #:	(269) 408-0598
Original Issuance Date:	11/27/2006
License Status:	REGULAR
Effective Date:	06/07/2023
Expiration Date:	06/06/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Incident/Accident Report forms are not completed correctly.	Yes
There isn't a current menu in the home.	No
Funds Part II forms are not completed correctly.	No
Ms. Martin mixed her money and resident money.	Yes
Physician contact records are not maintained in the home.	No
Direct Care Workers do not complete the *Medication Administration Record* correctly.	No
Additional Findings	Yes

III. METHODOLOGY

05/09/2024	Special Investigation Intake 2024A0579024
05/09/2024	Special Investigation Initiated - Letter E-mail to complainant
05/09/2024	Contact - Document Sent Tasha Stewart, Office of Recipient Rights
05/10/2024	Contact - Face to Face Teri Martin, Administrator Anastasia Barry, Direct Care Worker
05/10/2024	Contact - Document Sent Tasha Stewart, Office of Recipient Rights
05/10/2024	Contact - Telephone call made Teri Martin, Administrator
05/10/2024	Contact - Document Received Teri Martin, Administrator
06/05/2024	Exit Conference Sharon Wotring, Licensee Designee Teri Martin, Administrator

ALLEGATION:

***Incident/Accident Report* forms are not completed correctly.**

INVESTIGATION:

On 5/9/24, I received this referral which alleged *Incident/Accident Report* (I/AR) forms are not completed correctly.

On 5/9/24, I contacted the complainant who reported Tasha Stewart from Riverwood Office of Recipient Rights would have more direct knowledge of the allegations.

On 5/9/24, I exchanged emails with Ms. Stewart. She reported while she was on-site, on 5/7/2024, Ms. Martin told her that a resident had fallen and was taken to the hospital in April 2024. She reported Ms. Martin stated an I/AR form was not completed because she was not feeling well at that time. She stated direct care worker (DCW), Anastasia Barry, did not have knowledge of how to complete an I/AR form and reported she would verbally report incidents to Ms. Martin and Ms. Martin would complete the form. She stated when she advised Ms. Barry that she needed to complete I/AR forms, Ms. Barry questioned the need for the forms and was not in agreement with Ms. Stewart's recommendations.

On 5/10/24, I completed an unannounced on-site investigation. Private interviews were completed with Ms. Martin and Ms. Barry.

Ms. Martin stated on or about 4/17/24, she, direct care workers, and residents became ill with a several days stomach virus. She stated at the time she was ill; Resident A had a fall. She stated initially Resident A appeared fine but the next day, Resident A did not appear to be herself, so she had Resident A taken to the hospital. She stated it was determined Resident A was dehydrated due to the illness and Resident A was treated. She stated she typically types I/AR forms, and she began this one but due to not feeling well, she did not complete it.

Ms. Martin stated Ms. Barry and DCWs complete I/AR forms as needed, although since Ms. Martin lives in the home, she is typically available to immediately respond to incidents/accidents so she will write them herself because she is directly involved. She stated when DCWs complete I/AR forms, they typically write them, and she will type them to maintain them electronically.

Ms. Barry reported she does not complete I/AR forms, Ms. Martin does. Ms. Barry stated if an incident/accident were to happen, she would tell Ms. Martin what happened, and Ms. Martin would complete the form. She stated there would be no need for her to complete I/AR forms because Ms. Martin does them.

On 5/10/24, I exchanged emails with Ms. Stewart discussing my interview with Ms. Barry. She responded that after explaining the need for I/AR forms, Ms. Barry expressed she did not feel they were necessary, and she was “too busy” to complete them. She confirmed Ms. Barry had the same demeanor I experienced when she interviewed her as well.

On 5/10/24, I completed a telephone interview with Ms. Martin expressing my concern for Ms. Barry’s demeanor after my interaction with her and following my discussion with Ms. Stewart. Ms. Martin stated although she typically is in the home to respond to incidents, Ms. Barry does know how to complete I/AR forms, so she is not certain why Ms. Barry said she was too busy or was dismissive like she was to Ms. Stewart and me.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	Ms. Martin acknowledged an *Incident/Accident Report* form was not completed for Resident A’s hospital treatment following a fall in April 2024. Based on the interviews completed, there is sufficient evidence that a written report was not sent to Resident A’s designated representative and Resident A’s responsible agency within 48 hours of Resident A going to the hospital for treatment in April 2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There isn’t a current menu in the home.

INVESTIGATION:

On 5/9/24, I reviewed the referral which alleged there isn’t a current menu in the home.

On 5/9/24, Ms. Stewart stated while she was at the home, she observed the food menu that was posted and available in the home was from April 2023. When Ms. Stewart asked, Ms. Barry stated, “We use [menus] more as a guide. We do fish Fridays and mac-n-cheese Thursdays, things like that.” She stated Ms. Martin reported she had taken the menu down to modify it on 5/5/24 which was why it was not posted. Ms. Stewart advised that the current menu needs to be available and posted and needs to be followed as written, not used as a general guide.

On 5/10/24, Ms. Martin reported on 5/5/24, she brought the current menus downstairs to modify the upcoming menus for the summer. She stated when Ms. Stewart came to the home, the April 2023 menu was posted because it was behind the April 2024 menu that she had taken down to use as a reference when modifying the new menu for the summer. She stated the menu was modified and is currently posted and she has the menu prepared for the upcoming months. She stated although they do tend to rotate items, such as having fish on Fridays, the menu reflects what is served.

I observed a current menu in the home. I observed Ms. Barry preparing lunch which was consistent with what was posted on the menu. I also observed the current calendar year and the previous calendar year’s menus.

Ms. Barry stated the current menu is posted in the home and while residents often have different types of fish on Fridays or different kinds of sandwiches for lunch, the menu accurately reflects what is being served each day.

APPLICABLE RULE	
R 400.15313	**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:	Ms. Stewart and Ms. Martin reported at the time Ms. Stewart was in the home, the menu was being modified so it was not posted at that time. While on-site I observed the current menu to be posted and observed menus for the current and previous calendar year. Ms. Martin and Ms. Barry reported the menus are posted and residents are served what is listed on the menu. Based on the interviews completed and observations made, there is insufficient evidence that menus are not posted at least one week in advance.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

***Funds Part II* forms are not completed correctly.**

INVESTIGATION:

On 5/9/24, I reviewed the referral which alleged *Funds Part II* forms did not have resident signatures on them.

On 5/9/24, Ms. Stewart stated she reviewed resident *Funds Part II* forms and found that the box for resident signatures said “see receipt” but there were no receipts available. She stated Ms. Martin reported residents are given their spending money each month and they are provided a receipt confirming they accepted the funds, but the receipts were not available in the home.

On 5/10/24, Ms. Martin reported they do not hold funds for residents; however, the monthly spending money residents receive come from the payments Ms. Wotring receives. She stated when residents accept their monthly spending money, she has them sign a slip in their own carbon copy receipt book which she uses in place of the box for signatures because it is more accessible to residents. She stated she did not have the receipt books available for Ms. Stewart because Ms. Wotring manages the funds from her own home at times. She stated she has the receipt books available today.

I observed that each resident had their own carbon copy receipt book which had large resident signatures. It appears completing the *Funds Part II* signature box would have been a challenge for several residents due to how they write their name. The receipt books had pages that each had the date and a signature for each month for the residents who receive spending money.

Ms. Barry denied involvement with resident funds.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(8) All resident fund transactions shall require the signature of the resident or the resident's designated representative and the licensee or prior written approval from the resident or the resident's designated representative.

ANALYSIS:	Ms. Stewart report she was unable to see resident signatures regarding funds while she was at the home and the *Funds Part II* said “see receipt” in the signature box with no receipts available. Ms. Martin reported the receipt books were not available while Ms. Stewart was onsite, but they are used in place of the signature line on *Funds Part II* to be more accessible for residents. I observed a carbon copy receipt book for each resident who receives spending money that had the resident’s signature indicating they received their spending money each month. Based on the interview completed and observation made, there is insufficient evidence that funds transactions done in the home did not have adequate resident signatures.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Ms. Martin mixed her money and resident money.

INVESTIGATION:

On 5/9/24, I reviewed the referral which alleged Ms. Martin used her personal money to purchase items for a resident and reimbursed herself with the resident’s funds.

On 5/9/24, Ms. Stewart stated when discussing resident funds, Ms. Martin stated she had ordered new clothing for a resident who does not have a debit card. She stated Ms. Martin reported she used her card to purchase the items and intended to take some of the resident’s cash to reimburse herself. She stated she advised Ms. Martin she should not be mixing her personal funds with resident funds.

On 5/10/24, Ms. Martin reported Ms. Stewart has already advised her that she cannot mix her funds with resident funds, and she will never do that again. She stated she did not have bad intentions; the resident just needed new clothing and did not have a debit card, so she used her own card and thought it would be fine to pay herself back with the resident’s cash. She stated this resident does not have the ability to regularly spend her monthly funds, so she discussed with Ms. Stewart that it may be beneficial to seek a payee for this resident, and that is something they will be doing in the future.

Ms. Barry denied involvement with resident funds.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Ms. Stewart and Ms. Martin reported Ms. Martin used her personal funds to purchase items for a resident so she could reimburse herself with the resident's cash. Ms. Martin reported she understands she cannot do this moving forward. She stated she did not have bad intentions; the resident did not have a debit card, so she used her own card to purchase items for the resident on Amazon. Based on the interviews completed, there is sufficient evidence that Ms. Martin used her own finances to purchase items for a resident with the intention of paying herself back with the resident's cash.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Physician contact records are not maintained in the home.

INVESTIGATION:

On 5/9/24, I reviewed the referral which alleged physician contact records are not maintained in the home.

On 5/9/24, Ms. Stewart stated she asked to see the record of physician contacts for residents, and several were not up to date, including one that stopped in April 2023. She stated Ms. Martin reported she types the records and prints them. Ms. Stewart recommended an up-to-date log be always available and handwritten by all direct care workers "in real time", and later be typed, if that is Ms. Martin's preference.

On 5/10/24, Ms. Martin reported she maintains a "real time" log of physician contacts for each resident on her computer. She stated she had the ability to immediately print a copy of the current log for Ms. Stewart, but Ms. Stewart would not accept it. She stated she maintains the log on her computer until there is a full page of contacts, she then prints the log to put in the resident's file when each page is full. She stated following Ms. Stewart's inspection, she printed the up-to-date log for residents.

I observed resident binders to have up-to-date physician contacts that were maintained for several years and thoroughly completed.

APPLICABLE RULE	
R 400.15316	**Resident records.**
	1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(iv) A record of physician contacts.**
ANALYSIS:	I observed up-to-date physician's contacts for residents in the home. Based on the observations made, there is insufficient evidence that a record of physician contacts is not maintained in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct Care Workers do not complete the *Medication Administration Record* correctly.

INVESTIGATION:

On 5/9/24, I reviewed the referral which alleged direct care workers do not complete the *Medication Administration Record* (MAR) correctly.

On 5/9/24, Ms. Stewart stated on 5/7/2024 at approximately 1:30 p.m., she was reviewing resident MARs, and it was observed that Ms. Barry did not initial as passing resident noon medications. Ms. Martin reported the medications were passed; Ms. Barry forgot to sign for them.

On 5/10/24, Ms. Martin reported Ms. Barry forgot to initial as passing resident noon medications on 5/7/24 which Ms. Stewart found approximately within the hour after

the medications were passed. She stated this was a mistake and she immediately had Ms. Barry correct this on the MAR.

I observed resident MARs. I did not find any missing initials on the current MARs.

I inquired about Ms. Barry's medication administration practices. Ms. Barry stated when passing medications, she takes the resident medication packages, gives them to all the residents at once, and then later initials for passing the medications. She stated she does not prepare one resident's medication at a time, does not ensure the correct medications are in the packages, and does not observe to make sure the residents take their medication before initialing the medications as passed as she "[doesn't] have time" to do that.

On 5/10/24, I discussed my interaction with Ms. Barry with Ms. Stewart. Ms. Stewart advised Ms. Barry reported the same thing to her when they discussed medications and she agreed that could be a factor as to why Ms. Stewart found missing initials on 5/7/24.

On 5/10/24, I expressed concern to Ms. Martin regarding Ms. Barry's medication passing practices and how that may have led to missing initials on the *MAR*. Ms. Martin reported she believes Ms. Barry was misunderstanding me as Ms. Barry also misunderstood Ms. Stewart's consultation regarding proper medication passing as well. Ms. Martin said after Ms. Stewart spoke to Ms. Barry, she had to explain that Ms. Barry does not have to count all resident medications every time she does medication passes, which is what she believed Ms. Stewart told her.

APPLICABLE RULE	
R 400.15312	**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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	I observed the current *Medication Administration Records* to be completed correctly with direct care worker initials. Based on the observations made, there is insufficient evidence that resident *Medication Administration Records* do not contain the initials of the person who administers the medications.

CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING

On 5/10/24, while interviewing Ms. Barry regarding her initials missing from the MAR on 5/7/24, Ms. Barry stated when passing medications, she takes the resident medication packages, gives them to all the residents at once, and then later initials for passing the medications. She stated she does not prepare one resident's medication at a time, does not ensure the correct medications are in the packages, and does not observe to make sure the residents take their medication before initialing the medications as passed as she "[doesn't] have time" to do that.

I inquired if Ms. Barry understood the "5Rs" of medication administration, which ensures medications are provide to the right resident, it is the right medication, right dose, right time, and right route. Ms. Barry reported she does not need to ensure the "5Rs" because Ms. Martin makes sure the medications are correct and she then gives them to the residents. I inquired how she was certain that she was giving the correct medications to residents if was not checking the *MAR* and medications. She stated Ms. Martin "does that" so she does not have to. I inquired how she was certain residents were not swapping medications, leaving them in a place that someone else can take them, or that she was giving residents their correct medications when she passes all the resident medications at once. She stated, "They don't do that."

Ms. Barry became confrontational and stated, "Do you want me to take two hours to pass medications? If I do all that, it'll take me two hours each time I pass medications. So, you're saying it is okay to take two hours to do meds then?" I advised her that she needed to ensure the medications were correct and correctly taken by each resident. She reported she was "too busy" and "[didn't] have time to do that." She continued to make statements indicating she had no intention of correctly passing medications and minimizing the seriousness of potential medication errors. I advised her that medication errors can lead to hospitalization or death of residents and that I had personally witnessed this happen so that was not exaggerated. Ms. Barry was dismissive of the importance of correct medication passing and my recommendations regarding how to appropriately pass medications to residents.

On 5/10/24, Ms. Stewart advised she had already stressed the importance of and educated Ms. Barry on correct medication passing this week and Ms. Barry was equally as dismissive to her and clearly not following that guidance based on my conversation with her today. She stated she is not surprised by Ms. Barry's response to me and shared in the concern that Ms. Barry may not be suitable to pass medications at this time.

On 5/10/24, I expressed concern to Ms. Martin regarding Ms. Barry's medication passing practices and her confrontational responses when discussing appropriate medication passing. Ms. Martin reported she believes it was a misunderstanding as Ms. Barry also misunderstood Ms. Stewart's guidance regarding proper medication passing as well. Ms. Martin stated she had to explain that Ms. Barry does not have to count all resident medications every time she passes medications, which is what she believed Ms. Stewart told her.

I advised based on my discussion with Ms. Stewart, who reported she already had the discussion I had with Ms. Barry days prior, and Ms. Barry's repeated responses that she is "too busy" or "[doesn't] have time" that Ms. Barry was being intentionally noncompliant and using the excuse that it was a misunderstanding because she is not interested in passing medication correctly. I inquired if and how Ms. Barry was trained on managing and administering medications. Ms. Martin reported she believes Ms. Barry completed trainings at InterAct in Kalamazoo but she is not certain. She stated she has personally trained Ms. Barry on medication passing and does not understand why Ms. Barry is saying she is "too busy", "doesn't have time". She stated she will observe Ms. Barry's medication passing, review her training, and decide if additional training is needed. I requested a copy of confirmation of Ms. Barry's medication training. The confirmation was not received at the time of this report disposition.

APPLICABLE RULE	
R 400.15312	**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.**
ANALYSIS:	I did not receive confirmation that Ms. Barry received appropriate training in the proper handling and administration of medications. Ms. Stewart and I both educated Ms. Barry on the "5Rs" of medication administration. Ms. Barry was dismissive and confrontational while discussing proper medication administration. Ms. Barry reported she "[doesn't] have time" to correctly administer medications and was dismissive of the serious impacts of potential medication errors when she gives all the residents their medications at once and does not check the medications or ensure residents take the medications correctly that she is passing.

	Ms. Martin initially minimized Ms. Barry's response to a repeated misunderstanding. After discussing the significant concern that I had for Ms. Barry's demeanor and seeming unwillingness to pass medications correctly, Ms. Martin agreed to supervise Ms. Barry and provide additional medication training if needed. Based on the interviews completed, there is sufficient evidence that Ms. Barry was not properly trained in the handling and administration of medications prior to passing medications to residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/10/24, while interviewing Ms. Barry regarding her initials missing from the *MAR* on 5/7/24, Ms. Barry stated when passing medications, she takes the resident medication packages, gives them to all the residents at once, and then later initials for passing the medications. She stated she does not prepare one resident's medication at a time, does not ensure the correct medications are in the packages, and does not observe to make sure the residents take their medication before initialing the medications as passed as she "[doesn't] have time" to do that. I inquired how she was certain residents were not swapping medications, leaving their medications in a place that another resident could take them, or that she was giving residents their correct medications when she passes all the resident medications at once. She stated, "They don't do that" and that Ms. Martin ensures the medications are correct.

On 5/10/24, Ms. Stewart advised she had already stressed the importance of correct medication passing to Ms. Barry who was equally as dismissive to her and reported to her that she "doesn't have time" to ensure each resident takes their medication correctly as she had also stated to me.

On 5/10/24, Ms. Martin stated she has personally trained Ms. Barry on medication passing and does not understand why Ms. Barry is saying she is "too busy", "doesn't have time" to correctly pass medications. She stated she will observe Ms. Barry's medication passing, review her training, and decide if additional training is needed.

APPLICABLE RULE	
R 400.15312	**Resident medications**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Ms. Barry reported she passes all the resident medications at the same time and does not observe each resident to ensure

	the medications are taken correctly, ensure they not exchanged between residents, or that they are not left in a place where a resident could find another resident's medication and take it. Based on the interviews completed, there is sufficient evidence that Ms. Barry does not take reasonable precautions to ensure prescription medications are not used by a person other than the resident for whom the medication is prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/10/24, while interviewing Ms. Barry regarding her initials missing from the *MAR* on 5/7/24, Ms. Barry stated when passing medications, she takes the resident medication packages, gives them to all the residents at once, and then later initials for passing the medications. She stated she does not observe to make sure the residents take their medication before initialing the medications as passed as she "[doesn't] have time" to do that.

On 5/10/24, Ms. Stewart advised she had already stressed the importance of correct medication passing to Ms. Barry who was equally as dismissive to her and reported to her that she "doesn't have time" to supervise each resident while taking their medications.

On 5/10/24, Ms. Martin stated she has personally trained Ms. Barry on medication passing and does not understand why Ms. Barry is saying she is "too busy", "doesn't have time" appropriately supervise residents taking their medication. She stated she will observe Ms. Barry's medication passing, review her training, and decide if additional training is needed.

APPLICABLE RULE	
R 400.15312	**Resident medications**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Ms. Barry reported she passes all the resident medications at the same time and does not supervise each resident in taking their medication. Based on the interviews completed, there is sufficient evidence that Ms. Barry does not supervising the taking of resident medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/5/24, I completed an exit conference including Ms. Wotring and Ms. Martin. A response was not received disputing my findings at the time of report disposition.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 5/29/24

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 6/4/24

Russell B. Misiak Date
Area Manager