GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2024

LaToshia Baruti
Vintage Specialized Services LLC
P.O. Box 541
Leslie, MI 49251

RE: License #: AS380390596
Investigation #: 2024A0007023
Creekside Residential Care

Dear LaToshia Baruti:

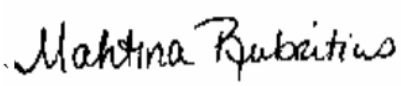
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**
**BUREAU OF COMMUNITY AND HEALTH SYSTEMS**
**SPECIAL INVESTIGATION REPORT**
**THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE**

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS380390596 |
| | |
| **Investigation #:** | 2024A0007023 |
| | |
| **Complaint Receipt Date:** | 04/15/2024 |
| | |
| **Investigation Initiation Date:** | 04/18/2024 |
| | |
| **Report Due Date:** | 06/14/2024 |
| | |
| **Licensee Name:** | Vintage Specialized Services LLC |
| | |
| **Licensee Address:** | 207 E. Bellevue St.<br>Leslie, MI 49521 |
| **Licensee Telephone #:** | (313) 567-0709 |
| | |
| **Administrator:** | LaToshia Baruti |
| | |
| **Licensee Designee:** | LaToshia Baruti |
| | |
| **Name of Facility:** | Creekside Residential Care |
| **Facility Address:** | 2055 Perrine Road<br>Rives Junction, MI 49277 |
| **Facility Telephone #:** | (517) 574-2401 |
| | |
| **Original Issuance Date:** | 03/05/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/05/2023 |
| | |
| **Expiration Date:** | 03/04/2025 |
| | |
| **Capacity:** | 5 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>TRAUMATICALLY BRAIN INJURED<br>ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| On 3/13/2024, Resident A made accusations that one of his peers in the AFC home inappropriately touched him on an unknown date in the AFC home. Resident A presented as being manic and acting erratically that caused the AFC home to refuse to take him back until a new mental health evaluation was completed. There is a concern about Resident A's observed fear, and a concern of returning him back to the home. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/15/2024 | Special Investigation Intake - 2024A0007023 |
| 04/15/2024 | APS Referral Received. |
| 04/16/2024 | Contact - Telephone call made to Devin Pickett, APS. |
| 04/18/2024 | Special Investigation Initiated - On Site - Unannounced - Face to face contact with LaToshia Baruti, Licensee Designee, Alyceson Williams, Resident B, Resident C, Resident D, and Patrick Edwards, DCW. |
| 05/29/2024 | Contact - Face to Face - Devin Pickett, APS. Case discussion and information received. |
| 06/03/2024 | Contact - Telephone call made to the Facility. |
| 06/03/2024 | Exit Conference conducted with LaToshia Baruti, Licensee Designee. |
| 06/03/2024 | Contact - Telephone call made - Interview with Alyceson Williams, DCW. |

**ALLEGATION:**

**On 3/13/2024, Resident A made accusations that one of his peers in the AFC home inappropriately touched him on an unknown date in the AFC home. Resident A presented as being manic and acting erratically that caused the AFC home to refuse to take him back until a new mental health evaluation. There is a concern about Resident A's observed fear, and a concern of returning him back to the home.**

**INVESTIGATION:**

On April 16, 2024, I spoke with Devin Pickett, Adult Protective Services Worker. Devin Pickett informed me that Resident A was no longer in the facility, and it was likely that he would not be returning. Resident A was claiming that he was touched by the other residents. Devin Pickett interviewed the other residents in the facility.

According to Devin Pickett, Resident B didn't want to talk but informed him (Devin Pickett) that Resident A exposed himself lots of times, and that Resident A tried to touch him (Resident B), but he failed. Resident B told direct care staff, Alyceson Williams, who told Resident A to stop and go to his room. Resident B denied Resident A ever touched him (Resident B) or that he touched Resident A. Resident B stated that he never showed Resident A his privates. Resident B denied that any of the other residents did things like that.

Devin Pickett stated that he also interviewed Resident C, who reported that Resident A was showing his (Resident A) privates to him (Resident C). Resident C denied being touched by Resident A or touching Resident A. Resident C denied exposing himself to Resident A. Resident C also denied that anything inappropriate happened between he and the other residents.

During the interview with Resident D, he reported to Devin Pickett that Resident A touched his chest without his shirt on. This occurred in Resident D's bedroom. Resident D reported that Resident A touched his privates with his clothes on. Resident D stated that he never touched Resident A in anyway. Resident D appeared uncomfortable, and informed Devin Pickett that he did not tell staff; and that was the first time he had told anyone that it happened. Resident D denied that Resident A exposed himself.

According to Devin Pickett, during the interviews, all three residents (Resident B, Resident C, and Resident D), reported that Resident A was creating issues in the facility, and he was the instigator of sexual advances. All the residents reported that things were better since Resident A was gone.

Devin Pickett also informed me that Resident A was interviewed in Macomb County, by APS (name unknown), and provided me with information regarding that interview. Macomb County APS Worker met with Guardian A1, Guardian A2, and Resident A.

Macomb County APS Worker questioned whether Resident A was having problems at Creekside, and he indicated that he was having problems. Resident A indicated that there had been some physical touching, and that Resident B, Resident C, and Resident D have touched his “penis and balls.” Resident A reported to Macomb County APS that the residents would touch him over his clothes, or they will go through the waistband area of his pants and underwear to complete skin to skin contact between their hands and his genitals. This happened more than five times. Resident A stated that “it is always happening.” Macomb County APS prompted Resident A to think about only one incident and he was given time to think. When Macomb County APS attempted to gather specific information, such as weather conditions, if it was near a holiday, day or night, etc.. Resident A could not recall. Resident A stated that an incident occurred in the house, in a room, but not a bedroom; however, he did not know what room it was or the color of the room, if there was furniture etc. Resident A could not recall when the first time or last time was that someone touched him. Resident A then indicated that he could not recall any of the times that he was touched.

Devin Pickett also spoke with Jahnna Kopah, from Macomb County ORR, who interviewed Resident A. According to Devin Pickett, Jahnna Kopah, could not get any specific information from Resident A, as he often answered that he did not know, when asked questions. Johnna Kopah also confirmed that it was advised by Dr. Prasad that Resident A be hospitalized at that time, but Guardian A1 was refusing.

Devin Pickett informed me that the case was still pending, but that he was leaning towards denying the case. In addition, that he was waiting to hear back from the trooper (name unknown) who was also investigating this case.

Devin Pickett stated that a safety plan had been put into place, and Resident A was now in Macomb County, where he will remain with his parents (Guardian A1 & Guardian A2), until another placement could be found.

On April 18, 2024, I conducted an unannounced on-site investigation and made face to face contact with LaToshia Baruti, Licensee Designee, Alyceson Williams, Resident B, Resident C, Resident D, and Patrick Edwards, DCW.

Upon arrival to the facility, LaToshia Baruti, Licensee Designee, was cooperative with the investigation. She explained that Alyceson Williams, DCW, whose role in the facility was the Clinical Care Coordinator also had information regarding the compliant. LaToshia Baruti also provided me with a written timeline of the order of incidents. LaToshia Baruti and Alyceson Williams informed me that Resident A’s father, Guardian A1, informed them that Resident A would be going on a Leave of Absence between 7-10 days. The leave of absence would begin on February 24, 2024.

LaToshia Baruti voiced concerns as in the past, when Resident A has gone on a leave of absence, he has psychotic episodes, and there was a concern that Resident A was not given his medications as prescribed. There was also a concern that Resident A's father does not like to give him the prescribed medications.

According to LaToshia Baruti, Resident A was scheduled to see his psychiatrist, Dr. Prasad on March 6, 2024; however, the appointment was changed to February 22, 2024, so that Resident A could be seen by the psychiatrist, prior to going on leave with Guardian A1 and Guardian A2.

On February 21, 2024, Resident A was also seen by his case manager, Nyasia Perdue, to document Resident A's clinical baseline prior to going on a leave of absence with his parents (Guardian A1 & Guardian A2).

On Saturday, February 24, 2024, after a community outing, Guardian A1 and Guardian A2 picked up Resident A, and they were given a seven-day supply of his prescribed medications, along with a medication receipt and instruction sheet.

On March 4, 2024, Alyceson Williams contacted Guardian A1 to request an update as to when Resident A would return to the facility; as there was a concern that Guardian A1 had not called for additional medications, and Resident A had missed two days of his medication. Guardian A1 stated to Alyceson Williams that he had been meaning to call but did not. Alyceson Williams provided Guardian A1 with information regarding policies and procedures, as related to readmittance to the facility. This included a negative Covid test and for the resident to be stable on their medications.

During the phone conversation, Guardian A1 provided Alyceson Williams with the following timeline:

- 2/25/24 - Resident A attended a family baby shower.
- 2/26/24- Resident A seemed okay per Guardian A1.
- 2/27/24 - Per Guardian A1, Resident A complained of seeing and feeling bugs on his body.
- 2/28/24 - Per Guardian A1, Resident A continued to complain of feeling bugs on his body and seeing bugs.
- 2/29/24 -Per Guardian A1, Resident A ate two packages of uncooked hot dogs and a bowl of potatoes. Guardian A1 stated he forgot to lock the refrigerator.
- 3/1/24 - Resident A complained of stomach pain and had fever. Guardian A1 gave enemas and MiraLAX for complaints of severe abdominal pain and a fever.

- 3/2/24 - Resident A continued to complain of stomach pain, Guardian A1 stated he gave Resident A additional enemas without success. Resident A was taken to Henry Ford Hospital that evening around 9:00 p.m.

- 3/3/24 - Resident A had labs, abdominal imaging and a Covid test, which was positive for Covid-19. Resident A was discharged from the hospital between 7:00 a.m. and 8:00 a.m.

- 3/4/24 Creekside Residential Care staff delivered all medications to Guardian A1. Guardian A1 was informed of Creekside's policies and procedures regarding readmittance.

- 3/12/24 - Alyceson Williams spoke to Guardian A1 for an update. Guardian A1 stated Resident A was doing okay, as related to the Covid-19 diagnosis. Resident A was continuing to report that he felt like bugs were crawling all over him. Guardian A1 stated that Resident A "has been asking God for forgiveness for his sins for touching and looking a male balls." Alyceson Williams informed Guardian A1 that this was the first time she had heard anything like this, and she would be speaking to her administrator.

- 3/13/24 -Guardian A1 left a voicemail at the facility stating he was getting ready to bring Resident A back to the facility.

- On this same day, Guardian A1 contacted LaToshia Baruti, Licensee Designee, to inform that he was getting ready to bring Resident A to the facility. LaToshia Baruti informed Guardian A1 that he must present a negative Covid test, that was processed by a certified medical facility or pharmacy. LaToshia Baruti also informed that Resident A needed to be psychiatrically stable and on his medications. LaToshia Baruti reminded Guardian A1 that Resident A was still seeing and feeling bugs crawling all over him. Guardian A1 stated that he was not seeing bugs anymore, he just feels them on his body. LaToshia Baruti informed that those could be signs of instability and Guardian A1 needed to have Resident A evaluated before bringing him back to the facility.

- Guardian A1 then stated "[Resident A] is just going through some things right now and he is asking God to forgive him because whatever is going on over there, he's been seeing male balls and male breast, and he just wants forgiveness." Guardian A1 also stated "I don't know what's going on over there, but is everyone over there having sex with each other?"

- According to LaToshia Baruti, once Guardian A1 started making these serious allegations of sexual inappropriateness among residents, she told him she would have to do an investigation. In addition, she would get the Clinical Team, Recipient Rights, and Licensing involved. Guardian A1 could not understand why LaToshia Baruti could not accept Resident A back into the facility that day.

LaToshia Baruti told him those were serious allegations and they needed to be investigated.

- LaToshia Baruti contacted Macomb County CMH Recipient Rights and the Contract Manager, Lifeways Community Mental Health Agency, and a complaint was also made to Adult Protective Services. For these reasons and the serious allegations, they may not be able to accept Resident A back into the facility.

LaToshia Baruti stated that she called and set up an appointment with Dr. Prasad for Resident A to be seen. Resident A saw the doctor (3/21/24) and he was very violent, screaming and smelling of feces. LaToshia Baruti stated that Dr. Prasad said that Resident A could not return to the facility in that condition; he recommended that Resident A go into the hospital to get stabilized or go home with his parents and get his mediations adjusted. According to LaToshia Baruti, Dr. Prasad recommended that Resident A go into the psychiatric hospital, and Resident A yelled "No, you said they're going to put me in a strait jacket!" Resident A then started talking about being abused in the facility. Guardian A1 was told to make a complaint with ORR.

According LaToshia Baruti, Resident A has a history of acting out sexually. Dr. Prasad told Guardian A1 that he needed to do something to address these issues.

LaToshia Baruti stated that on April 4, 2024, Guardian A1 picked up Resident A's belongings. LaToshia Baruti reported that she spoke with Devin Pickett from APS, who stated he would be closing the case. MSP was also investigating, but the investigation had not been finalized yet.

While at the facility, I interviewed Resident C, and he informed me that he's been living at the facility for three years. When asked how he got along with Resident A, Resident C replied, "Not good." Resident C informed that when he was on his phone, Resident A was always looking at his phone too. Resident C also informed that there were some things that Resident A did that makes him uncomfortable. Resident C informed that Resident A exposed himself to him (Resident C). This happened in the living room, while staff were in the kitchen. Resident C informed that Resident A has not touched him in his personal space or private areas. Resident C also stated that Resident A used the bathroom on himself, they have seen feces everywhere, and that Resident A uses the bathroom with the door open.

I then interviewed Resident B, who reported that Resident A touched him inappropriately and Resident A showed him (Resident B) his "privates and balls." When asked where Resident A touched him, Resident B pointed to his chest/breast area, and informed that he was touched on top of his clothes. Resident B reported that this happened in the living room, while staff were in the kitchen. According to Resident B this happened "a lot." When asked if he told staff, Resident B stated that he told Patrick (Edwards), DCW, who sent Resident A to his room. Resident B informed that Resident A did not touch his other private areas (penis or buttocks). Resident B reported that he did not touch Resident A. According to Resident B,

Resident A exposed his privates to Resident B, “lots of times” in the living room, while they were watching television. Resident A would also “fart” at the table and staff would redirect him. Resident B also stated that Resident A would touch his feet, and he (Resident B) told Resident A to stop but he wouldn’t. Resident B stated once he told staff, then Resident A would stop.

I also interviewed Resident D, and he informed that Resident A touched him inappropriately. When asked where, Resident D pointed towards his genitals, and informed that it happened over his clothing. This occurred while they were walking in the hallway. Resident D reported that he told staff (name unknown), and Resident A was told not to do that again. Resident D stated that this happened one time. Resident D informed that Resident A exposed himself once, by pulling his pants down. Resident D reported to see Resident A’s private parts when he pulled down his pants in the hallway. This was reported to staff (name unknown) who told Resident A to “quit.”

I also interviewed Patrick Edwards, Direct Care Worker, who reported to be employed in the facility for about two years. Patrick Edwards stated that Resident A has never said anything about him being touched inappropriately by the other residents. Resident A has been redirected for touching the other residents, but not in a sexual manner. According to Patrick Edwards, Resident A required 24-hour eyes on supervision and there are always adequate staff on duty. Patrick Edwards stated that none of the other residents have disclosed that Resident A touched them inappropriately. Patrick Edwards stated that they had to supervise Resident A closely, as he eats his own feces. Resident A also picks on people and requires redirection often.

I spoke with LaToshia Baruti, Licensee Designee again. She informed me that Resident A has been diagnosed with Prader-Willi Syndrome. In addition, that Resident A has a history of rectal picking and acting out sexually towards staff and residents. LaToshia Baruti stated that they always have three staff on duty during the day shifts as Resident A requires one-to-one supervision. LaToshia Baruti stated that she called APS because these allegations were serious, and she wanted them investigated. According to LaToshia Baruti, Devin Pickett, APS, stated that he was recommending that Resident A does not return to the facility. LaToshia Baruti also stated that no discharge notice was given. LaToshia Baruti stated that currently, Resident A is the psychiatric hospital.

As a part of this investigation, I reviewed the *Behavior Treatment Plan,* created by Sparks Behavioral Services*, LLC,* for Resident A. It was noted that the plan addressed the following target behaviors: Verbal aggression, antagonizing others, rectal digging, fecal consumption, and inappropriate sexual behavior. Regarding supervision, it was noted that Resident A was to receive one-to-one, line of sight staffing in the home and in the community. One-to-one staffing includes supervision when Resident A is in the bathroom and his bedroom. This is due to risks of fecal consumption and rectal digging.

During this investigation, Devin Pickett, APS, provided me with information regarding his investigation. Devin Pickett spoke with Trooper Jarchow of MSP regarding the investigation. Trooper Jarchow reported to Devin Pickett that they would not be seeking any charges, as it was the Trooper's opinion that there would not be enough to pursue charges, given the conditions and capacities of the residents; it wouldn't be prudent.

Devin Picket also informed that while it appeared that there were some sexual activities attempted, Resident A instigated the activity. Resident A also has a history of these behaviors. Resident A will remain with Guardian A1 and Guardian A2 until another home can be located. The allegations were not substantiated by APS.

On June 3, 2024, I called the facility to speak with Alyceson Williams. LaToshia Baruti informed me that she was not available at that time and provided a contact number for her.

On June 3, 2024, I conducted the exit conference with LaToshia Baruti, Licensee Designee. We discussed the investigation, the findings, and my recommendations. She appeared to be in disbelief regarding the information that was gathered during the interviews with the residents; and questioned if the residents were telling the truth. LaToshia Baruti stated that they do a lot of redirecting with Resident A. The residents don't go in each other's rooms.

LaToshia Baruti stated that the allegations were "egregious," and she was the one who filed the complaint because she wanted the information investigated. When Guardian A1 made the statement about Resident A asking for forgiveness from God because he been seeing male balls and male breast, and when Guardian A1 stated "I don't know what's going on over there, but is everyone over there having sex with each other?" She knew the information had to be investigated. LaToshia Baruti stated that she could not accept Resident A back until the allegations were addressed. Furthermore, she did not understand why Guardian A1 would want to send Resident A back if the situation were unsafe. LaToshia Baruti stated that she is not an absentee licensee, and she staffs the facility appropriately. She stated that there are three staff on duty, two can be in the kitchen and one in the common area with Resident A.

LaToshia Baruti expressed that she did not agree with the finding regarding the lack of staff supervision and stated that people entrusted her to care for their family members. She expressed concern with how this would appear to people in the community. While she didn't agree with the findings, she stated she was willing to submit a written corrective action plan to address the established violation.

During the exit conference, I also provided technical assistance regarding the requirements for residents readmittance to the home. I informed her that she is still responsible and that is the resident's home; and even with the positive Covid-19

diagnosis, she would either need to ask the family to keep the resident or she would need to make provisions to care for the resident in the facility. I also informed her that residents have a choice and do not have to take medications. In the future, she would need to accept the resident back into the home and take the resident to seek psychiatric treatment (if deemed appropriate), rather than providing readmittance stipulations to the guardian or responsible agency.

On June 3, 2024, I spoke with Alyceson Williams, as I had some follow-up questions. Regarding the staffing pattern, she stated that when Resident A resided in the home, there were three staff on each shift. We discussed the information gathered during the investigation and the concern that staff would be in the kitchen when some of the incidents occurred. We also talked about the location of the kitchen and design, and how if the staff were in the kitchen, they would not be able to provide the line-of-sight supervision while the residents were in the living room. Alyceson Williams stated that usually there was one staff person in the kitchen and two staff outside the secured kitchen with eyes on the residents.

Alyceson Williams stated they constantly had to redirect Resident A when he was at the table and in the common areas of the home. Alyceson Williams gave an example that Resident A would make a joke and then pull down his pants and expose his backside or his genitals. According to Alyceson Williams, Resident A does not know personal boundaries. Staff would redirect him and ask if he needed personal time or space. Staff would verbally redirect him, then Resident A would yell, say things that were untrue, and blame his actions on others.

Regarding Resident A using the bathroom with the door open, Alyceson Williams stated that Resident A tries to expose himself and if he sees an opportunity, he will expose himself. Alyceson Williams stated they follow the BTP regarding toileting and supervise Resident A while still maintaining privacy.

According to Alyceson Williams, Resident A never disclosed to her that he was being touched by the other residents. She denied that Resident B reported to her that Resident A tried to touch him (Resident B), and she told Resident A to stop and to go to his room.

| **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:** | Macomb County APS Worker interviewed Resident A. Resident A indicated that there had been some physical touching, and that Resident B, Resident C, and Resident D have touched his "penis and balls." However, Resident A could not recall specific information. Resident A could not recall when the first time or last time was that someone touched him. Resident A then indicated that he could not recall any of the times that he was touched.<br><br>According to Devin Pickett, Jahnna Kopah, ORR, interviewed Resident A and she could not get any specific information from Resident A, as he often answered that he did not know, when asked questions.<br><br>During the interviews, Devin Pickett informed that all three residents (Resident B, Resident C, and Resident D), reported that Resident A was creating issues in the facility, and he was the instigator of sexual advances. Resident B, Resident C, and Resident D denied touching Resident A.<br><br>During my interviews with Resident B, Resident C, and Resident D, they all reported that inappropriate interactions were occurring, including that either Resident A was exposing himself, attempting to touch them or touching them.<br><br>While the exact dates were unknown, Resident B and Resident C reported that the incidents happened in the living room, while staff were in the kitchen.<br><br>A review of the *Behavior Treatment Plan,* created by Sparks Behavioral Services*, LLC,* for Resident A reflected that Resident A was to receive one-to-one, line of sight staffing in the home and in the community. One-to-one staffing includes supervision when Resident A is in the bathroom and his bedroom. This is due to risks of fecal consumption and rectal digging.<br><br>Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that Resident A was touched inappropriately by other residents in the facility.<br><br>However, there is a preponderance of the evidence to support the allegations that there has been a lapse in the level of supervision provided to the residents. There have been multiple incidents in which Resident A has either exposed himself, and/or attempted to, or touched, other residents. |

| | |
|---|---|
| | Due to his diagnoses, Resident A required one-to-one staffing, in the line of sight; staff should be available to intervene, and redirect, and prevent Resident B, Resident C, and Resident D from experiencing these situations. Resident A was not provided with the supervision he required.<br><br>Resident A, Resident B, Resident C, and Resident D were not treated with dignity and their personal needs, including protection and safety, were not attended to at all times, in accordance with the provisions of the act. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

6/4/2024

_____

Mahtina Rubritius Date
Licensing Consultant

Approved By:

06/04/2024

_____

Dawn N. Timm Date
Area Manager