GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 19, 2024

Gagandeep Mann
JP Managed Services, Inc.
Suite A
2316 John R
Troy, MI 48083

RE: License #: AL630295441
Investigation #: 2024A0605036
Sun Valley Senior Living

Dear Gagandeep Mann:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (248) 975-5053.

Sincerely,

Frodet Dawisha

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd.
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630295441
Investigation #:	2024A0605036
Complaint Receipt Date:	07/30/2024
Investigation Initiation Date:	07/30/2024
Report Due Date:	09/28/2024
Licensee Name:	JP Managed Services, Inc.
Licensee Address:	Suite 3 2710 Rochester Road Rochester Hills, MI 48307
Licensee Telephone #:	(248) 497-4391
Administrator/Licensee Designee:	Gagandeep Mann
Name of Facility:	Sun Valley Senior Living
Facility Address:	2316 John R Troy, MI 48084
Facility Telephone #:	(248) 689-7755
Original Issuance Date:	09/13/2010
License Status:	1ST PROVISIONAL
Effective Date:	04/26/2024
Expiration Date:	10/25/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are new staff at this facility. Only two caregivers working 12-hour shifts: one working day shift and one working night shift. There are residents who require Hoyer lifts which is a two-person assist.	Yes
Staff threw away all the food in the home and replaced the food with smaller portions and not proper consistency. There is minimal food in the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/30/2024	Special Investigation Intake 2024A0605036
07/30/2024	Special Investigation Initiated - On Site Conducted unannounced on-site investigation
07/30/2024	Contact - Document Received Received email from Dr. Gursharan Dhillon
07/31/2024	Contact - Document Sent Email to Dr. Gursharan Dhillon
08/01/2024	Contact - Document Sent Email to licensee designee Gagan Mann, Dr. Dhillon, and current owner Lijo Antony
08/15/2024	Contact - Telephone call made Left message for licensee designee Gagan Mann and spoke with new owner Lijo Antony
08/15/2024	APS Referral Adult Protective Services (APS) referral made
08/22/2024	Contact - Telephone call made Left message for Gagan Mann and Dr. Dhillon
08/22/2024	Contact - Document Sent Email sent to Gagan Mann, Dr. Dhillon and Lijo Antony

08/22/2024	Contact - Telephone call received Follow up with Dr. Dhillon
08/26/2024	Contact - Document Received Email from Ms. Mann
09/03/2024	Contact - Telephone call made Discussed allegations with Resident A's durable power of attorney (DPOA) and left message for registered nurse (RN) with Compassionate Hospice and current owner of facility Lijo Antony
09/03/2024	Contact – Telephone call received Compassionate Hospice RN
09/03/2024	Contact – Telephone call made APS Worker Jordan Walker
09/03/2024	Contact – Telephone call made Miracle Home Care owner
09/03/2024	Exit Conference Left message for Gagandeep Mann with my findings

ALLEGATION:

There are new staff at this facility. Only two caregivers working 12-hour shifts: one working day shift and one working night shift. There are residents who require Hoyer lifts which is a two-person assist.

INVESTIGATION:

On 07/30/2024, intake #201851 was received regarding insufficient staffing and lack of food with improper consistency. Sun Valley Senior Living was placed on a 1st provisional license on 04/26/2024 due to quality-of-care violations.

On 07/30/2024, I conducted an unannounced on-site investigation at Sun Valley Senior Living. I was greeted by Jamie Smith who stated she is part of Senior Living Consultant and Community Development that recently purchased this facility on 07/26/2024. The purchaser was Lijo Antony. Ms. Smith was unaware of the department's involvement with this facility and that this facility was on a provisional license. Ms. Smith stated there are six residents residing at this facility with only two direct care staff (DCS) plus a cook providing care to the residents. I requested to speak with the residents.

I interviewed Resident A in her bedroom. Resident A is aware there are new staff at this facility which she is not happy with. The staff tell Resident A, “you have to go to bed

around 9:30PM," when she usually is up at that time watching TV. She stated there are a total of two DCS working here and only one works at a time. She did not know their names but stated, "they live upstairs."

I interviewed Resident D in her bedroom. Resident D has been living here for a couple of years. There are about two to three staff new staff here, but she believes they go home. She too does not know their names and had no other information regarding the allegations.

I only observed Resident F as she is non-verbal. Resident F had a private duty aid April with Miracle Home Care sitting with her in her bedroom. Resident F had good hygiene and was sitting in her wheelchair dressed appropriately for the day. April reported that Resident F receives four hours of private duty aid Tuesdays, Wednesdays, and Fridays. The private duty aide assists with feeding, bathing, and changing Resident F. In addition, the aide ensures that Resident F is kept hydrated. April reported that when she arrived, she noticed new staff at this facility but does not have any additional information to provide.

I attempted to interview Resident G, but she was sleeping and did not wake when I called out her name several times. She had good hygiene and dressed appropriately for the day.

I interviewed Residents H and I who are brothers and share a bedroom. Resident H is wheelchair bound and Resident I is fully ambulatory. Resident I stated that the staff are "nice," but he does not know their names, nor does he know if they live upstairs. Resident I stated, "I do not like that there are no activities here. I like to go outside walking and do some gardening." I was unable to gather any information from Resident H due to his disability.

I interviewed Imani Burlin who was hired today as the cook. He has not completed any trainings, background checks, communicable tuberculosis (TB) or medical yet. However, he stated he has worked in a restaurant prior to this job. Mr. Burlin stated his only job is to cook and not to provide care to the residents. He had no other information to provide regarding the allegations.

I interviewed DCS Aaliyah Salmon regarding the allegations. Ms. Salmon began employment here on 07/26/2024. She and DCS Natalie Christie who is her mother began the same day providing care to the residents and cooking unsupervised. There are two shifts: 7AM-7PM and 7PM-7AM. There is only one DCS per shift. She has not had her training, background check, nor TB completed yet. The only resident that is a two-person assist is Resident F who requires a Hoyer lift. Ms. Salmon has not seen Resident F or any of the other residents' assessment plans. She stated she does not have any further information regarding the allegations.

I interviewed DCS Natalie Christie. Ms. Christie began employment on 07/26/2024. She and Ms. Salmon are the only DCS working at this facility plus the cook. There are two

shifts: 7AM-7PM and 7PM-7AM. She and Ms. Salmon work alone during their shifts without any supervision. There are six residents living here and only Resident F is a two-person assist with a Hoyer lift. She has not seen the assessment plans and has not completed training, background checks, nor her TB. She stated she does not have any further information to provide.

I interviewed Lijo Antony who arrived shortly after to the facility. Mr. Antony purchased this facility from Gagandeep Mann on 07/26/2024. He was aware that this facility was on a provisional license. He is making physical modifications to the building as he no longer wants this facility to be an adult foster care (AFC) facility. He is looking into getting approved for an exception for Homes for the Aged (HFA). Mr. Antony and Ms. Smith stated that a majority of the resident records are missing and that I can request the information via email.

On 07/30/2024, an email was received from Dr. Gursharan Dhillon who is licensee designee's husband. Dr. Dhillon stated that he sold Sun Valley Senior Living to Lijo Antony and wants his license to close.

On 07/31/2024, I emailed Dr. Dhillon advising him that I cannot close his license due to this special investigation.

On 08/01/2024, I sent an email to Jamie Smith, licensee designee Gagan Mann, Dr. Dhillon and Mr. Antony requesting DCS Natalie Christie and Aaliyah Salmon's trainings, background checks, TB, staff schedule and all the residents' assessment plans to be emailed to my no later than 08/07/2024.

On 08/15/2024, I followed up with Lijo Antony regarding the documents requested. He stated all the files were missing and that this facility is a "shit show," given the condition Mr. Antony purchased it as. He will continue looking for the documents requested. Mr. Antony stated his HFA exception has been approved. He would like Sun Valley Senior Living's license to be closed. I advised him that I cannot close a license during a special investigation. He acknowledged.

On 08/15/2024, I made a referral to Adult Protective Services (APS). The case is being investigated by APS worker Jordan Walker.

On 08/22/2024, I sent another follow-up email to Jamie Smith, Gagan Mann, Dr. Dhillon and Mr. Antony advising that I was still in receipt of all the documents requested on 08/01/2024.

On 08/22/2024, I left the licensee designee Gagan Mann several messages with no return calls.

On 08/22/2024, I received a call from Dr. Dhillon stating that Ms. Mann is out of town. I advised Dr. Dhillon that there are repeat quality-of-care violations regarding the

allegations pertaining to insufficient staffing and food. He stated, “go ahead and revoke the license.” I advised him that I needed to speak with Ms. Mann. He acknowledged.

On 08/26/2024, I received an email from licensee designee Gagan Mann stating the following: “Please close Sun Valley AFC license. JP Manage Services has been sold. Sun Valley license was maintained by JP Manage Services. It is no longer needed.”

On 09/03/2024, I contacted Resident A’s durable power of attorney (DPOA A) regarding the allegations. Family members have been visiting Resident A every other day. They are aware that there are new owners at this facility, but there are concerns about staffing. Resident A reported to DPOA A that whenever Resident A requires assistance at night, Resident A pulls the call light, but no one shows up. The staff informed Resident A that the call light does not work but have done nothing to address the issue. Resident A requires full care with her activities of daily living such as transfers and toileting. Resident A also reported that the staff does not socialize with the residents whereas the previous staff did. There are only two DCS working; one per shift. This concerns the DPOA A since Resident A does not receive care when she requires it.

On 09/03/2024, I contacted Compassus Hospice registered nurse (RN) who provides services to Resident A. The RN stated that depending on the day, Resident A can be a one or a two-person assist. There is concern that there is only one DCS per shift. She has no other information regarding the new owners and the staff.

On 09/03/2024, I interviewed the owner of Miracle Home Care that is currently providing private duty caregiving services to Resident F. Resident F receives four hours of caregiving services three days a week. The private duty caregivers change, bathe, feed, and ensure that Resident F is hydrated. There were past concerns of Resident F being dehydrated. Resident F is a two-person assist during transfers so there is a concern if there is only one DCS working per shift. Whenever the private duty caregiver arrives at this facility, Resident F is already in her wheelchair.

On 09/03/2024, I followed up with APS worker Jordan Walker. Mr. Walker is still investigating these allegations.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ

	or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006, but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on my investigation, DCS Natalie Christie, Aaliyah Salmon and the cook Imani Burlin did not have background checks completed prior to providing unsupervised direct care to Residents A, D, F, G, H, and I. Ms. Christie and Ms. Salmon began employment on 07/26/2024 and Mr. Burlin began on 07/30/2024. They all reported not completing background checks prior to working unsupervised at this facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0605015 dated 03/29/2024 and CAP dated 04/22/2024**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation, due to DCS Natalie Christie, Aaliyah Salmon and the cook Imani Burlin not having their criminal history checks completed, it is unknown if they are eligible to provide adult foster care to Residents A, D, F, G, H, and I; therefore, they are not suitable to meet the residents' physical, emotional, intellectual, and social needs until their criminal history checks are completed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0605015 dated 03/29/2024 and CAP dated 04/22/2024**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based on my investigation, DCS Natalie Christie, Aaliyah Salmon and the cook Imani Burlin stated that they have not completed the following trainings: reporting requirements, first aid, cardiopulmonary resuscitation, personal care, supervision, and protection, resident's rights, safety and fire prevention and prevention and containment of communicable diseases prior to providing unsupervised direct care to Residents A, D, F, G, H, and I.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	DCS Natalie Christie, Aaliyah Salmon and the cook Imani Burlin did not have verification that their communicable tuberculosis was completed prior to their employment at this facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0605015 dated 03/29/2024 and CAP dated 04/22/2024**

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on the information I gathered, Resident A and Resident F are a two-person assist according to Resident A's RN with Compassus Hospice and Resident F's private duty agency Miracle Home Care. However, there is only one DCS per shift. Resident A's DPOA A stated that Resident A informed them that when Resident A pulls the call light at night for assistance, no staff comes to help. Therefore, there is insufficient staff per shift to provide for the supervision, personal care, and protection of the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0605007 dated 01/25/2024, CAP dated 02/14/2024**

APPLICABLE RULE	
R 400.15209	**Home records generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(d) Resident records.**
ANALYSIS:	During my on-site investigation on 07/30/2024 the resident records were not available for my review. I also made several email requests to licensee designee Gagan Mann and her husband, Dr. Gursharan Dhillon for these records but never received them.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on my investigation, there is insufficient staff on shift to provide for the personal needs, including protection and safety of Residents A, D, F, G, H, and I. There is only one DCS per shift and both Resident A and Resident F require two-DCS for transfers.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2022A0465012 dated 01/05/2022, CAP dated 04/11/2022** **Reference SIR #2024A0605007 dated 01/25/2024, CAP dated 02/14/2024**

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: **(f) Assessment plan.**
ANALYSIS:	During my on-site investigation on 07/30/2024 Residents A, D, F, G, H, and I assessment plans were not available for my review. I also made several email requests to licensee designee Gagan Mann and her husband, Dr. Gursharan Dhillon for these records but never received them.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff threw away all the food in the home and replaced the food with smaller portions and not proper consistency. There is minimal food in the facility.

INVESTIGATION:

On 07/30/2024, I interviewed Jamie Smith regarding the allegations. Ms. Smith stated that the food in the refrigerator located in the kitchen was thrown out because the refrigerator does not work. There are two other refrigerators in the pantry along with a freezer. Ms. Smith stated that the new company uses Grove Menus that provides a weekly grocery list of what needs to be purchased based on the weekly menu. She stated there is currently enough food in the facility for the residents.

On 07/30/2024, I interviewed Resident A regard the food. Resident A stated there is food, but that the consistency of the food is the same as it was with the last owners. For lunch, they served pork chops. Resident A was unable to eat the pork chops because “it was hard to chew.” She only ate her mashed potatoes.

On 07/30/2024, I interviewed Resident D regarding the food. Resident D stated, “food is not great, but I get enough to eat.” She did not provide any further information.

On 07/30/2024, I interviewed Resident I regarding the food. Resident I stated that he too has trouble chewing the food because “it’s hard to chew.” Whenever this happens, he asks for peanut butter and jelly sandwiches. He too had no other information to provide.

On 07/30/2024, I interviewed Imani Burlin in the kitchen regarding the food. He confirmed that the food had been thrown out because the refrigerator in the kitchen does not work. He also reported that the stove is not working too. Being that today is his first day, he has yet to cook but will follow the menu that is printed out and placed on the refrigerator.

Mr. Burlin showed me around the kitchen. I observed a bag full of fruits and vegetables sitting on the kitchen counter with flies flying inside the bag. I pointed the flies to Mr. Burlin, who stated he will take care of the bag. I observed the pantry and there was a refrigerator full of food and there was some food in the freezer.

On 07/30/2024, I interviewed DCS Aaliyah Salmon regarding the food. She stated that prior to Mr. Burlin being hired as the cook, she and DCS Natalie Christie were preparing all the meals. She completed her nutrition and food training but did not have the records to confirm it was completed. They followed the menu and stated that they were informed that Resident D requires her food to be cut up, Resident F requires her food to be pureed, Resident G is lactose tolerant. She too confirmed that the food was thrown out due to the refrigerator not working but that they went shopping and there was plenty of food for the residents. Groceries are purchased based on the menu for that week. She does not know anything about the pork chops being hard to chew.

On 07/30/2024, I interviewed DCS Natalie Christie regarding the food. She too confirmed that the food was thrown out because the refrigerator was not working. She and Ms. Salmon prepared food yesterday and followed the menu. She reported that there is enough food for the residents, and she does not know anything about the pork chops being hard to chew. Groceries are generated weekly based on the menu. She did not have any further information to provide.

On 09/03/2024, I interviewed Resident A’s DPOA A regarding the food. Resident A continues to complain about the food. It is a little better but concerns that there is not enough food and the consistency of the food. The DPOA A did not have any further details.

On 09/03/2024, I interviewed the owner of Miracle Home Care regarding the Resident F's food. Resident F's food must be pureed and so far, the private duty caregivers have not reported any concerns when they feed Resident F.

On 09/03/2024, I left a message for licensee designee Gagan Mann, and I also followed up with an email advising her of my findings and recommendation of revocation of the license. Ms. Mann emailed back stating because Sun Valley Senior Living was sold to Lijo Antony, she is not responsible for license. I emailed Ms. Mann informing her that our records show she is the licensee designee; therefore, responsible for the license.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my investigation and information gathered, the consistency of the food is not proper according to Resident A and Resident I. Both residents reported that the food is "hard to chew."
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0605007 dated 01/25/2024, CAP dated 02/14/2024** **Reference SIR #2024A0605015 dated 03/29/2024, CAP dated 04/22/2024**

APPLICABLE RULE	
R 400.15402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	During the on-site investigation on 07/30/2024, I observed fruits and vegetables sitting in a bag on the counter with flies flying inside. The food was not kept safe and clean.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0605007 dated 01/25/2024, CAP dated 02/14/2024**

APPLICABLE RULE	
R 400.15402	**Food service.**
	(2) All food shall be protected from contamination while being stored, prepared, or served and during transportation to a facility.
ANALYSIS:	During the on-site investigation on 07/30/2024, I observed fruits and vegetables sitting in a bag on the counter with flies flying inside. The food was not stored properly and/or kept free from contamination.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15402	**Food service.**
	(6) Household and cooking appliances shall be properly installed according to the manufacturer's recommended safety practices. Where metal hoods or canopies are provided, they shall be equipped with filters. The filters shall be maintained in an efficient condition and kept clean at all times. All food preparation surfaces and areas shall be kept clean and in good repair.
ANALYSIS:	During the on-site investigation on 07/30/2024, the refrigerator and stove in the kitchen were not working. All the food had to be thrown out.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 07/30/2024, this facility was under construction by the new owner Lijo Antony. There were mattresses leaning against the walls, construction crews going in and out of the facility. Loud construction noise can be heard in Resident A’s bedroom during her interview.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1)A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	During the on-site investigation on 07/30/2024, this facility was under construction. There were mattresses leaning against the walls in the hallway near Resident H and Resident I's bedroom. The construction crews were going in and out of the facility making it inadequate for the health, safety, and well-being of the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0605007 dated 01/25/2024, CAP dated 02/14/2024**

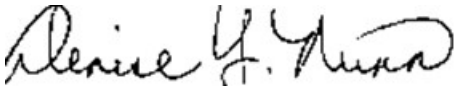
IV. RECOMMENDATION

I recommend revocation of the license.

09/03/2024

Frodet Dawisha Date
Licensing Consultant

Approved By:



09/19/2024

Denise Y. Nunn Date
Area Manager