GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2025

Syed Shah
56565 Senior Care Solutions LLC
2498 Tranquil Dr.
Troy, MI 48098

RE: License #: AS630398556
Investigation #: 2025A0612012
Blossom Hill #1-AS

Dear Mr. Shah:

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,

Johnna Cade

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadilac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630398556
Investigation #:	2025A0612012
Complaint Receipt Date:	02/14/2025
Investigation Initiation Date:	02/18/2025
Report Due Date:	04/15/2025
Licensee Name:	56565 Senior Care Solutions LLC
Licensee Address:	56565 10 Mile Rd South Lyon, MI 48178
Licensee Telephone #:	(248) 264-6497
Administrator:	Syed Shah
Licensee Designee:	Syed Shah
Name of Facility:	Blossom Hill #1-AS
Facility Address:	56565 10 Mile Rd South Lyon, MI 48178
Facility Telephone #:	(248) 264-6497
Original Issuance Date:	12/23/2019
License Status:	1ST PROVISIONAL
Effective Date:	02/04/2025
Expiration Date:	08/03/2025
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
• The licensee designee is using an employee's food stamps to buy the groceries for all residents. • The licensee designee has recently changed the employee hourly pay without notifying the employees.	No
• Direct care staff Stephanie Harding was taking fentanyl from the medication room and was always high while working. • Direct care staff Stephanie Harding has her husband in the facility, and he yells at Stephanie in front of the residents.	No
Additional Findings	Yes

III. METHODOLOGY

02/14/2025	Special Investigation Intake 2025A0612012
02/18/2025	Special Investigation Initiated - Telephone Telephone interview completed with reporting source.
02/24/2025	Inspection Completed On-site I completed an unscheduled onsite inspection. I interviewed direct care staff Deovionna Dobine, Resident A, and Resident B.
02/26/2025	Contact - Telephone call made Telephone call to direct care staff Kim Mills, no answer. Left a voicemail requesting a return call. Telephone call to direct care staff Stephanie Harding, no answer. Unable to leave a voicemail.
02/27/2025	Contact - Telephone call made Telephone call to direct care staff Kim Mills, no answer. Left a voicemail requesting a return call. Telephone call to direct care staff Stephanie Harding, no answer. Unable to leave a voicemail. Sent a text message, message was undeliverable.
02/28/2025	Contact - Telephone call made Telephone interview with licensee designee, Syed Shah.

02/28/2025	Contact - Document Received Received proof of receipts for groceries sent via email from licensee designee Syed Shah.
03/05/2025	APS Referral Referral made to Adult Protective Services (APS) via Centralized Intake.
03/05/2025	Exit Conference I placed a telephone call to licensee designee Syed Shah to conduct an exit conference.
03/10/2025	Contact Documentation Received Received copies of Resident A and Resident B's Resident Care Agreements sent via text message from licensee designee Syed Shah.

ALLEGATION:

- **The licensee designee is using an employee's food stamps to buy the groceries for all residents.**
- **The licensee designee has recently changed the employee hourly pay without notifying the employees.**

INVESTIGATION:

On 02/18/25, I received a complaint indicating that direct care staff Stephanie Harding was taking fentanyl from the medication room and was always high while working. The reporting source went to visit the residents and believes that Ms. Harding was on drugs as she appeared lethargic and did not notice that the reporting source had entered the facility. Ms. Harding has her husband in the facility, and he yells at her in front of the residents. Ms. Harding was fired in the past. However, since the facility has been short staffed, she was hired back. The owner is using an employee's food stamps to buy groceries for the residents. The owner has recently changed the employees hourly pay without notifying them.

On 02/18/25, I interviewed the reporting sources (RS). RS stated she was previously employed at this facility. She chose to end her employment however she was unable/ unwilling to provide the date that her employment ended. RS stated she is not one hundred percent sure that the owner is using an employee's food stamps to buy the groceries for the residents, but she has heard that this is happening from a current employee. RS declined to provide the current employee's name. RS stated the owner recently decreased an employee's hourly pay without notifying the employee. RS declined to provide the employee's name but clarified that she was referring to an employee who was working on the day shift and they were transferred to the night shift

at which time their rate of pay decreased. RS stated that the owner did not inform the employee about the change in pay.

On 02/24/25, I completed an unscheduled onsite inspection. I interviewed direct care staff Deovionna Dobine, Resident A, and Resident B. During the onsite inspection I observed that the home had an adequate food supply in the refrigerator, freezer and pantry.

On 02/24/25, I interviewed direct care staff Deovionna Dobine. Ms. Dobine stated she has worked at this home for 2-3 weeks, her shift is 8:00 am – 8:00 pm. Ms. Dobine stated her rate of pay has not been changed since she was hired. Ms. Dobine stated she receives her pay checks on time, and they have all been accurate. Ms. Dobine stated the licensee designee, Syed Shah purchases food for the home. Sometimes the groceries are delivered via Instacart, and other times Dr. Shah drops them off in person. Ms. Dobine stated staff prepare the meals for residents and there is always enough food in the home. Ms. Dobine stated she is unaware of what funds are used to purchase the groceries.

On 02/24/25, I interviewed Resident A and Resident B together. Resident A and Resident B consistently stated the food in the home is purchased by Dr. Shah. They receive three meals a day and snacks. Resident A and Resident B stated there is always enough food in the home. Resident A and Resident B are unaware who contributes financially to the cost of groceries. Resident A and Resident B have no information regarding the direct care staff's hourly pay.

On 02/28/24, I interviewed licensee designee Syed Shah via telephone. Dr. Shah stated he purchases groceries up to three times a week using Instacart to shop at Sams Club and Walmart. The shopping list is made by staff, and the residents give their input on what items are purchased. Dr. Shah stated the cost for groceries is factored into the residents monthly cost of care payment. Dr. Shah denied that he has ever used an employee's food stamp card to purchase groceries. Furthermore, Dr. Shah denied changing any employee's hour wage without notifying them. Dr. Shah stated the direct care staff rate of pay is dependent upon the shift that they work. Night shift staff make $15.00 an hour and day shift staff make $17.00 an hour. Dr. Shah stated when staff are hired, they verbally agree and sign documentation of their agreement of their hourly wage. The paperwork staff sign indicates that if their shift is changed their rate of pay will change. Dr. Shah stated he currently has two residents and three direct care staff Kim Mills, Stephanie Harding, and Deovionna Dobine and there have been no changes to their rate of pay.

I made multiple attempts to interview direct care staff Kim Mills and Stephanie Harding. Dr. Shah stated he advised Ms. Mills to contact this licensing consultant, Johnna Cade, regarding this investigation and provided my contact information. Dr. Shah has not had contact with Ms. Harding since she was suspended on 02/24/25, pending this investigation. As of the date of this report no contact has been made by either staff.

On 02/28/25, I received proof of receipts for groceries sent via email from licensee designee Syed Shah. I reviewed the receipts for grocery purchased in February 2025 using Instacart. The groceries were purchased from Kroger using a PayPal account for payment. The receipts do not indicate that a food stamp card was used.

On 03/10/25, I received copies of Resident A and Resident B's Resident Care Agreements sent via text message from licensee designee Syed Shah. Both agreements consistently indicate that the monthly fee includes meals.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(2) A licensee shall have the financial and administrative capability to operate a home to provide the level of care and program stipulated in the application.
ANALYSIS:	Based on the information gathered through this investigation there is insufficient information to conclude the licensee designee, Syed Shah is using an employee's food stamps to buy groceries for the residents. The reporting source is not sure that the owner is using an employee's food stamps to buy the groceries for the residents, but she has heard that this is happening from a current employee. The reporting source declined to provide the current employee's name. Licensee designee Syed Shah denied the allegation and stated the cost for groceries is factored into the residents monthly cost of care payment. He purchases groceries via Instacart. I reviewed Resident A and Resident B's Resident Care Agreements both agreements consistently indicate that the monthly fee includes meals. I reviewed the receipts for grocery purchased in February 2025 using Instacart. The groceries were purchased from Kroger using a PayPal account for payment. The receipts do not indicate that a food stamp card was used. There is insufficient information to conclude that the licensee designee, Syed Shah has changed the employees hourly pay without notifying the employees. The reporting source declined to provide the employees name whose rate of pay was allegedly changed but clarified that she was referring to an employee who was working on the day shift and they were transferred to the night shift at which time their rate of pay decreased. Dr. Shah

	stated the direct care staff rate of pay is dependent upon the shift that they work. Night shift staff make $15.00 an hour and day shift staff make $17.00 an hour. Dr. Shah stated when staff are hired, they agree to their hourly wage, they also agree and acknowledge that if their shift is changed their rate of pay will change. There are three direct care staff who work at this facility. Direct care staff Kim Mills and Stephanie Harding did not respond to attempts to be interviewed for this investigation. Direct care staff Deovionna Dobine stated there have been no changes to her rate of pay.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Direct care staff Stephanie Harding was taking fentanyl from the medication room and was always high while working.**
- **Direct care staff Stephanie Harding has her husband in the facility, and he yells at Stephanie in front of the residents.**

INVESTIGATION:

On 02/18/25, I interviewed the reporting sources (RS). RS stated on an unknown date she went to the home to visit a resident, direct care staff, Stephanie Harding was on shift. RS knocked on the front door twice, Ms. Harding did not hear her. RS stated she could see Ms. Harding through the window. RS entered the facility; Ms. Harding did not notice. RS alleged that Ms. Harding has taken fentanyl from the medication room and was always high while working. RS stated she has no proof that Ms. Harding is on drugs or that she has taken fentanyl or any other medications from the medication room but remarked that Ms. Harding appeared lethargic. RS further stated Ms. Harding could have just been tired. RS stated she does not know if any of the residents who reside in the home are prescribed fentanyl. RS stated she has no knowledge that any medications have been taken by staff or are missing from the home. RS stated she has never witnessed Ms. Harding take medications. RS stated she has never worked with Ms. Harding. RS stated Ms. Harding worked at the home previously, but she was terminated due to poor work ethic. She has since been rehired. When asked about the allegation regarding Ms. Harding having her husband in the facility, and her husband yelling at her in front of the residents RS stated this has never happened, but she is concerned that it could happen because she has heard that Ms. Harding's husband yells.

On 02/24/25, I completed an unscheduled onsite inspection. I interviewed direct care staff Deovionna Dobine, Resident A, and Resident B. I reviewed Resident A and Resident B's physical medications and the associated documentation. Resident B is prescribed fentanyl 12 Mcg/HR DIS – apply one patch every 72 hours by transdermal route for 30 days. Resident B had an unopened box of 10 patches and a partial box of 4

patches onsite. Per Resident B's February 2025, Medication Administration Record she used 7 patches in February 2025. There was no narcotic count sheet onsite for the Fentanyl patches. The medication was stored in a lockbox. The lockbox was inside of the medication cart which was also locked.

On 02/24/25, I interviewed direct care staff Deovionna Dobine. Ms. Dobine stated she is trained to administer medications; however, she does not pass meds. Ms. Dobine stated that the residents are prescribed narcotics, and she is aware that narcotic counts are completed however, she has no additional information regarding resident medication as she does not administer medication. Ms. Dobine stated she has never observed any staff including Ms. Harding appear to be high while at work. Ms. Dobine stated to her knowledge none of the residents' medications have been missing and/or taken by staff. Ms. Dobine stated she has never observed direct care staff Stephanie Harding's husband in the home.

On 02/24/25, I interviewed Resident A and Resident B together. Resident A and Resident B stated they receive their medications as they are prescribed. The medications are locked in a med cart and staff administer the medication to them. Resident A and Resident B stated their medications have never been missing or unavailable. Resident A and Resident B denied that any staff has ever taken their medications. Resident A stated she has seen Ms. Harding's husband inside of the home on two occasions. He came to cook hamburgers and another time to make sloppy joes. Resident A stated she did not witness Ms. Harding's husband yelling at her while he was at the home. Resident A stated on another occasion, while she was in bed, she seen a tall man wearing a cap in the hallway she is not sure who it was, but the person was talking to Ms. Harding.

On 02/28/24, I interviewed licensee designee Syed Shah via telephone. Dr. Shah stated Ms. Harding was employed by the previous licensee designee who was operating this facility. She was terminated. When the previous licensee designee left, Ms. Harding came in to be interviewed. Initially, Resident A voiced concerns about hiring her because she said two years ago Ms. Harding passed out due to a diabetic condition. Additionally, families of another resident who lived in the home at that time voiced concerns about Ms. Harding and said that they would move their family member out of the home if Ms. Harding was hired. As such, Dr. Shah did not hire Ms. Harding because he did not want the family to remove the resident. After that resident died, Ms. Harding came back, and Dr. Shah hired her. Ms. Harding has been working as a direct care staff in the home for three months. Dr. Shah stated when he interviewed Ms. Harding, she appeared high. Dr. Shah asked her if she was on any medications and inquired if she would be willing to complete a urine drug test. She agreed, but Dr. Shah did not move forward with his request to drug test her. Dr. Shah remarked that is just her appearance, she is a wonderful worker.

Dr. Shah stated the facility has cameras that monitor the living spaces. Dr. Shah said that he monitored Ms. Harding; she cleans and does good work with the residents. The cameras are a live feed, they do not record, Dr. Shah can access the audio on the

cameras however, he stated that he does not do that. Dr. Shah stated he has no concerns that Ms. Harding took any medication from the medication cart and/or that she was working while high. Dr. Shah stated the facility is under video monitoring, direct care staff's family members are not allowed inside of the home. Dr. Shah has never witnessed Ms. Harding's husband inside of the facility. He has observed him bringing in the garbage cans from the street when he dropped her off at work. Dr. Shah stated he suspended Ms. Harding on 02/24/25, pending this investigation.

I made multiple attempts to interview direct care staff Kim Mills and Stephanie Harding. Dr. Shah stated he advised Ms. Mills to contact this licensing consultant Johnna Cade, regarding this investigation and provided contact information. Dr. Shah has not had contact with Ms. Harding since she was suspended on 02/24/25, pending this investigation. As of the date of this report no contact has been made by either staff.

APPLICABLE RULE	
R 400.14204	**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 the information gathered through this investigation there is insufficient information to conclude that direct care staff Stephanie Harding was taking fentanyl from the medication room and was high while working. The reporting source provided no information that suggests Ms. Harding is on drugs or that she has taken fentanyl from the medication cart. Resident A and Resident B stated they receive their medications as they are prescribed, their medications have never been missing or unavailable. Direct care staff Deovionna Dobine denied the allegation stating she has never observed any staff including Ms. Harding appear to be high while at work. Ms. Dobine stated to her knowledge none of the residents' medications have been missing and/or taken by staff. Licensee designee Syed Shah stated when he interviewed Ms. Harding, she appeared high, but he remarked that is just her appearance. Dr. Shah has no concerns that Ms. Harding took any medication from the medication cart and/or that she was working while high. Direct care staff Stephanie Harding did not respond to attempts to be interviewed for this investigation. During the onsite inspection completed on 02/24/25, Resident B had an unopened box of 10 Fentanyl patches and a partial box

	of 4 patches onsite. There was no narcotic count sheet onsite for the Fentanyl patches. There is insufficient information to conclude that direct care staff Stephanie Harding has had her husband in the facility, and he yells at her in front of the residents. When interviewed the reporting source stated this has never occurred, but she is concerned that it could happen because she has heard that Ms. Harding's husband yells. Although Resident A stated that she has seen Ms. Harding's husband in the facility she has not witnessed him yelling at her. Dr. Shah stated the facility is under video monitoring, direct care staff's family members are not allowed inside of the home. Dr. Shah has never witnessed Ms. Harding's husband inside of the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During an unscheduled onsite inspection completed on 02/24/25, I observed medications being stored in clear baggies that were locked in the medication cart. Direct care staff Deovionna Dobine stated that these medications were taken out of the bubble packs and left out for her to administer to Resident A and Resident B on 02/24/25. There were three bags. They were labeled as follows:

"(Resident A's) pain pill PRN" – there was one pill in the bag
"(Resident B's) 2pm meds - there were 4 pills in the bag
"(Resident B's) 6pm meds – there was 1 pill in this bag

On 02/28/24, I interviewed licensee designee Syed Shah via telephone. Dr. Shah stated putting medications into baggies was a practice that was done under the previous leadership. He has completed staff in-services every other Friday and trained the staff not to do this. Direct Care staff Kim Mills is the only staff who should be passing medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the

	requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude Resident A and Resident B's prescribed medications were not being kept in the original pharmacy supplied container. The medications were locked in the medications cart however, they were being stored in clear baggies that were hand labeled and did not include the medication name, dosage and/or administration instructions.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report dated 03/23/23; CAP dated 04/01/23** **Special Investigation Report #2025A0991005; CAP dated 02/04/25**

INVESTIGATION:

I completed an unscheduled onsite inspection on 02/24/25, at 12:30 pm. At 6:00 am Resident B is prescribed hydrocodone/acetaminophen (hydroco /Apap) 7.5 - 325 tab. The label instructions read: *take two tablets at six in the morning, then take one tablet at two in the evening, then take two tablets at 10 in the evening.* The bubble pack was started on 02/01/25. The pills were popped out/gone from bubbles 1-25. Three dosages (6 tablets) remained in the bubble pack. The last entry on the narcotic count sheet was dated 02/25/25, indicating that there are 6 tablets left. Staff were following the dates on the bubble pack when passing the medications. The pills for 02/25/25, were popped out at the time of the onsite inspection on 02/24/25. Three dosages (6 tablets) remained in the bubble pack when there should have been four dosages (8 tablets).

On 02/28/24, I interviewed licensee designee Syed Shah via telephone. Dr. Shah stated this must have been a human error by staff.

During an unscheduled onsite inspection completed on 02/24/25, I observed that Resident B is prescribed fentanyl 12 Mcg/ HR DIS – apply one patch every 72 hours by transdermal route for 30 days. Per Resident B's Medication Administration Record (MAR) her last patch was applied at 12:30 pm on 02/21/25. Her next patch is due at 12:30 pm on 02/24/25. I completed an unscheduled onsite inspection between approximately 12:30 pm - 1:00 pm. Resident B's fentanyl patch was not replaced; the MAR was not signed indicating that a new patch had been applied on 02/24/25. Direct care staff Deovionna Dobine was scheduled alone on shift from 8:00 am – 8:00 pm, Ms. Dobine stated that she does not administered medications.

On 02/28/24, I interviewed licensee designee Syed Shah via telephone. Dr. Shah stated direct care staff Kim Mills is the only staff who should be passing medications and signing the medication administration record.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude Resident B's 6:00 am hydrocodone/acetaminophen (hydroco /Apap) 7.5 - 325 tab was not being administered per label instructions. Staff were following the dates on the bubble pack when passing the medication. The pills for 02/25/25, were popped out at the time of the onsite inspection completed on 02/24/25. Three dosages (6 tablets) remained in the bubble pack when there should have been four dosages (8 tablets). Further, Resident B is prescribed fentanyl 12 Mcg/ HR DIS – apply one patch every 72 hours by transdermal route for 30 days. Per Resident B's Medication Administration Record (MAR) her last patch was applied at 12:30 pm on 02/21/25. Her next patch was due at 12:30 pm on 02/24/25. At the time of the onsite inspection completed on 02/24/25, between 12:30 pm - 1:00 pm Resident B's fentanyl patch was not replaced the MAR was not signed indicating that a new patch had been applied.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report # 2025A0991005; CAP dated 02/04/25**

INVESTIGATION:

During an unscheduled onsite inspection completed on 02/24/25, at 12:30 pm I observed that the following medications were popped out/gone from the physical bubble packs on site, but not signed for as administered on Resident B's medication administrator record:

- 8:00 am Eye multivitamin tab sodium – take one tablet twice a day by oral route for 90 days
- 8:00 am Ferosul 325 mg – take one ablet oral every day
- 6:00 am Furosemide 20 mg – take one tablet every day by oral route

- 6:00 am Gabapentin 300 mg – take three capsules three times a day by oral route
- 6:00 am hydrocodone/acetaminophen (hydroco /Apap) 7.5 – 325 tab – take two tablets at six in the morning, then take one tablet at two in the evening, then take two tablets at 10 in the evening
- 8:00 am Loratadine 10 mg – take one tablet every day by oral route

On 02/28/24, I interviewed licensee designee Syed Shah via telephone. Dr. Shah stated direct care staff Kim Mills is the only staff who should be passing medications and signing the medication administration record. Dr. Shah stated that he completed staff in-services every other Friday and trained the staff on medication administration and documentation.

On 03/05/25, I placed a telephone call to licensee designee Syed Shah to conduct an exit conference and review my findings. Dr. Shah acknowledged the rule violations and the recommendation of revocation of the license. Dr. Shah stated that he plans to voluntarily close the facility. Resident A and Resident B are currently seeking alternative placements.

APPLICABLE RULE	
R 400.14312	**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:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that Resident B was administered the following medications on 02/24/25: Eye multivitamin tab sodium, Ferosul 325 mg, Furosemide 20 mg, Gabapentin 300 mg, hydrocodone/acetaminophen (hydroco /Apap 7.5 – 325, and Loratadine 10 mg. However, the medication administration record was not signed by the staff who administered the medications.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

	Reference Renewal Licensing Study Report dated 03/23/23; CAP dated 04/01/23 **Renewal Licensing Study Report dated 07/28/2020; CAP dated 08/13/2020** **Special Investigation Report # 2025A0991005; CAP dated 02/04/2025**

IV. RECOMMENDATION

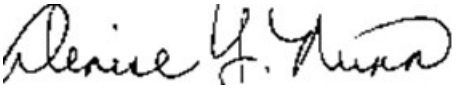
I recommend revocation of the license.

03/06/2025

_____

Johnna Cade — Date
Licensing Consultant

Approved By:



03/06/2025

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Denise Y. Nunn — Date
Area Manager