GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 6, 2025

Katie Edwards
Symphony of Linden Health Care Center, LLC
30150 Telegraph Rd
Suite 167
Bingham Farms, MI 48025

RE: License #:	AL250331306
Investigation #:	2025A0872029
	Degas House Inn

Dear Katie Edwards:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250331306
Investigation #:	2025A0872029
Complaint Receipt Date:	03/11/2025
Investigation Initiation Date:	03/12/2025
Report Due Date:	05/10/2025
Licensee Name:	Symphony of Linden Health Care Center, LLC
Licensee Address:	7257 N. Lincoln Lincolnwood, IL 60712
Licensee Telephone #:	(810) 735-9400
Administrator:	Katie Edwards
Licensee Designee:	Katie Edwards
Name of Facility:	Degas House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	1ST PROVISIONAL
Effective Date:	04/28/2025
Expiration Date:	10/27/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility neglected Resident B while she was in their care.	Yes
Resident B was prescribed narcotics, but the facility failed to have the narcotics available for administration.	Yes

III. METHODOLOGY

03/11/2025	Special Investigation Intake 2025A0872029
03/12/2025	Special Investigation Initiated - Letter I contacted the referral source to find out which Inn this complaint is against
03/13/2025	Inspection Completed On-site Unannounced
03/17/2025	Contact - Document Received I received photographs from Relative B1 via email
04/01/2025	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
04/03/2025	Contact - Document Received I received documentation from the licensee designee
04/15/2025	Contact - Document Received I received a copy of Resident B's death certificate
05/02/2025	Contact - Telephone call made I interviewed Kim Cox, regional director of The Medical Team hospice
05/05/2025	Contact - Document Received I received documentation from The Medical Team Hospice
05/05/2025	Exit Conference I conducted an exit conference with the licensee designee, Katie Edwards

05/05/2025	Inspection Completed-BCAL Sub. Non-Compliance
05/06/2025	Contact – Telephone call made I interviewed staff Destany Kelly
05/06/2025	Contact – Telephone call made I interviewed the assistant to the assisted living director, Kesha Harris
05/06/2025	Contact – Telephone call made I interviewed customer service representative, Richard from MedWiz pharmacy
05/06/2025	Contact – Telephone call made I interviewed staff Felicia Taylor

ALLEGATION: The facility neglected Resident B while she was in their care.

INVESTIGATION: On 03/12/2025, I received numerous photographs from Relative B1 which she stated were regarding Resident B and the condition of her room at times. The photographs showed a pair of jeans and a pair of black sweatpants which appeared to be soiled with dried feces, several soiled briefs full of urine and feces that had dates, times, and staff names and/or initials, a swept-up pile of debris on the floor, a pair of soiled underwear, dried feces on a bathroom floor, two unidentified pills on the resident room counter, and photographs of Resident B's bottom with what appeared to be wounds and/or pressure sores. The photographs do not contain information that allows me to determine if the photographs are of Resident B, her room, or her briefs.

On 03/13/2025, I conducted an unannounced onsite inspection of Degas House Inn. I interviewed the facility administrator (FA), Bowe Davey and the director of assisted living, (DAL) Jessica Butler. FA Davey said that Resident B was admitted to this facility on 01/07/2025. FA Davey and DAL Butler confirmed that Resident B received hospice services while a resident of this facility. FA Davey and DAL Butler also confirmed that relatives of Resident B had expressed concerns about her care while she resided at Degas House Inn. FA Davey told me that he investigated the concerns and found out from staff that Resident B was often refusing care. FA Davey said that he and DAL Butler spoke to Resident B's hospice nurses, and they never reported any concerns about Resident B's care. Resident B passed away on 03/03/25 so I was unable to interview her. Resident B was 93-years old at the time of her death.

On 03/17/2025, I received copies of Resident B's brief change records from February and March 2025 from Relative B1. Relative B1 stated that although staff documented that they were changing Resident B's briefs as required, they were not doing so.

Relative B1 said that if Resident B's briefs were being changed regularly, she would not have had so many photographs of Resident B's soiled briefs.

According to this documentation, during the evening, staff were responsible for checking and/or changing Resident B's briefs at 6pm and 8pm. This order was implemented on 08/30/2024. Staff initialed the log each day and time indicating that this task was completed for February and March 2025.

Another order was implemented on 08/30/2024 for a "4-hour check and change and room/bathroom check for bowel movement three times a day" at 2am, 6am, and 8:20pm. Staff initialed the log each day and time indicating that this task was completed for February and March 2025.

The last order was implemented on 08/30/2024 for a "2-hour check and change five times a day" at 8am, 10am, 12pm, 2pm, and 6pm. Staff initialed the log each day and time indicating that this task was completed for February and March 2025.

On 04/03/2025, I received AFC documentation related to this complaint. Resident B was admitted to Degas House Inn on 04/19/2024. According to Resident B's Assessment Plan, Resident B requires supervision with transfers, toileting and dressing and requires staff assistance with bathing. Resident B uses a wheelchair and walker for mobility and wears pull-ups for occasional incontinence. Resident B has a history of falls without significant injury. Resident B has an unstable gait and loss of balance while standing. Resident B receives hospice services from Medical Team Hospice. Resident B is diagnosed with Type II diabetes, hyperlipidemia, unspecified dementia, major depressive disorder, anxiety disorder, adjustment disorder, restless leg syndrome, vision problems, hypertension, chronic kidney disease, chronic atrial fibrillation, polyarthritis, osteoarthritis, weakness, difficulty walking, and acute kidney failure.

I reviewed progress notes from Kristen Dziadula, Physician's Assistant (PA-C) from January and February 2025. The first progress note dated 01/03/2025 stated that Resident B was seen for a follow up to chest congestion. Resident B appeared fatigued and weak. PA-C Dziadula noted that Resident B had a productive cough, negative COVID-19 swab, and a negative x-ray. PA-C Dziadula suggested that Resident B continue with Robitussin for her cough as needed.

The progress note dated 01/07/2025 stated that Resident B was seen regarding debility and acceptance into hospice care. Resident B was observed to be "quite fatigued" and weak. PA-C Dziadula recommended that Resident B proceed with hospice services.

According to the progress note dated 01/28/2025, Resident B was seen regarding edema concerns. Resident B was observed to be fatigued and weak. PA-C noted that the edema was minimal, there was no evidence of lower extremity edema, and she recommended that staff continue to monitor.

Resident B was seen by PA-C Dziadula on 02/13/2025 regarding nausea and vomiting. Resident B was observed to be fatigued and weak. PA-C Dziadula recommended that Resident B begin Zofran for nausea and staff to monitor for efficacy. Also, PA-C Dziadula recommended that Resident B continue with hospice services.

I reviewed a Facility Staff Incident Report dated 02/27/2025 completed by staff Chazielle Cochran. According to this document, “Another resident came to get me, went to scene. She’s on the floor on her left side, took vitals. (Resident B) said she hit her head, went to get her up, she’s in a lot of pain on (the) left side. Didn’t really tell me how she had fallen.” Staff Cochran contacted her supervisor, Resident B’s hospice team, and Relative B1. Staff also contacted Kristen Dziadula, Physician’s Assistant (PA-C) who examined Resident B.

According to PA-C Dziadula’s progress note dated 02/27/2025, Resident B was seen regarding a fall. When PA-C Dziadula arrived, Resident B was on the floor, holding her left upper leg and it was obvious Resident B was in pain. Staff lifted Resident B to her feet and Resident B was able to bear weight on her leg although she was in pain. PA-C Dziadula assisted Resident B to her walker and continued her exam. PA-C Dziadula’s treatment plan stated that she notified hospice, and to proceed with fall precautions, and continue to monitor closely. According to the note, “Resident unable to bear weight, per hospice services, no x-ray, no hospitalization. Treat pain and proceed with conservative treatment.”

I reviewed Resident B’s hospice visit log and noted that she was seen by a member of Resident B’s hospice team on the following dates: 01/06/2025, 01/07/2025, 01/10/2025, 01/14/2025, 01/30/2025, 02/04/2025, 02/25/2025, 02/27/2025, and 02/28/2025. Resident B had a DNR in place.

On 04/15/2025, I received a copy of Resident B’s death certificate. According to this document, Resident B’s death was pronounced on 03/03/2025 at 6:21pm by Kristin Nikolakeas, DO. Resident B was 93-years old. Resident B’s manner of death was listed as “natural”, and an autopsy was not performed. Resident B’s causes of death were “cerebral atherosclerosis, hypertension, and atrial fibrillation.”

On 05/02/2025, I interviewed Kim Cox, regional director (RD) of The Medical Team, hospice. I reviewed the allegations with RD Cox, and she stated that she is aware that members of Resident B’s hospice team did have concerns about the care of Resident B while she resided at Degas House Inn. RD Cox agreed to send me documentation about the concerns.

On 05/05/2025, I received an email from RD Cox. On 01/27/2025, Resident B’s hospice aide (HA), Emily Rivard, sent a message to the hospice team stating that she visited Resident B on 01/25/2025. At that time, she changed, initialed, and dated Resident B’s brief. When HA Rivard returned on 01/27/2025, she found Resident B in the same brief, which was completely soiled and soaked.

According to Resident B's hospice nurse, (HN), Jolene Stepanski, on 02/11/2025, she arrived at the facility and found Resident B sitting up in bed, eating lunch. HN Stepanski took Resident B to the bathroom and discovered that she had soiled herself and she did not have on a brief. No facility staff was present so HN Stepanski and Relative B1 cleaned Resident B up and changed her clothes.

On 05/06/2025, I interviewed staff Destany Kelly via telephone. Staff Kelly said that she has worked at Degas House Inn since December 2024. Staff Kelly typically works from 6am-6pm and she works two days a week. I reviewed the allegations with Staff Kelly, and she stated that she never had concerns about the care Resident B received at this facility. Staff Kelly told me that when she worked, she made sure that Resident B was checked and changed every two hours. Staff Kelly stated that she never found Resident B in an excessively soiled brief.

On 05/06/2025, I interviewed the assistant to the assisted living director (AALD), Kesha Harris. AALD Harris said that she has worked at this facility for approximately two years, and she typically works from 8am-4:30pm. According to AALD Harris she is aware of the concerns regarding Resident B while she resided at Degas House Inn. AALD Harris told me that day shift staff told her that night shift staff were not checking and changing Resident B's briefs as required. AALD Harris stated that because of these concerns, staff made a brief change log which staff then began completing and initialing when Resident B's brief was changed.

On 05/06/2025, I interviewed staff Felicia Taylor via telephone. Staff Taylor said that she has worked at Degas House Inn for almost a year, and she typically works from 6pm-6am. According to Staff Taylor, she never found Resident B in an excessively soiled brief. Staff Taylor stated that she would check on Resident B every two hours during the night but would only change her brief if Resident B needed it. Staff Taylor said that prior to Resident B's fall on 02/27/2025, she was able to toilet herself independently although she still wore briefs. I asked Staff Taylor if she ever found Resident B to have soiled clothing and she said no.

On 11/09/2022, I completed investigation #2022A0872058 regarding two residents receiving improper care. I concluded that on one occasion, it took over five hours for staff to respond to one resident's call light and during that time, another resident was sitting in a wet brief. Both residents stated that staff often neglected their personal care. The family reported that they spent 8-12 hours a day caring for both residents, because staff were failing to do so. Staff Melissa White and Trinidy Tomlin stated that on occasion, staff were unable to respond to resident needs timely. The licensee designee, Kimberly Gee, submitted a corrective action plan dated 11/21/2022 stating that the licensee and director will review staff schedules and assignments sheets to ensure proper levels of staff are provided.

On 03/15/2023, I completed investigation #2023A0872020 regarding inappropriate resident care of a resident. I concluded that a resident fell in December 2022 and lay on the floor for a significant period of time without staff assistance. Numerous staff reported that staff is required to check on the residents every two hours or more often if needed. On

05/25/2023, a settlement agreement was reached, and the facility agreed not to admit residents to this facility for 6 months. Once the 6-months was up, a 6-month provisional license was issued during which the facility was allowed to admit residents back into the facility. The licensee designee agreed to conduct weekly audits of the staffing at this facility and produce those audits to the licensing consultant. This facility remained on a provisional license until 05/24/2024 at which time they were given a regular license.

On 05/05/2025, I conducted an exit conference with the licensee designee (LD), Katie Edwards. I discussed the results of my investigation and explained which rule violations I am substantiating. I told LD Edwards that I am recommending continuation of the provisional license which was issued on 04/28/2025. LD Edwards said that she is working closely with staff and the director of assisted living, (DAL) Jessica Butler, to ensure compliance with these rules is achieved. LD Edwards agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
ANALYSIS:	**(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.**
	I reviewed numerous photographs of soiled clothing and soiled briefs which Relative B1 said are from Resident B but there was no identifying information on the photographs. Relative B1 said that facility staff neglected Resident B while she was in their care. The facility administrator (FA) Bowe Davy and director of assisted living (DAL) Jessica Butler stated that Resident B's family expressed concerns about the care Resident B received while at Degas House Inn. I reviewed Resident B's brief change records for February and March 2025 and noted that staff initialed the record indicating that Resident B's briefs were checked and changed according to the schedule. Kim Cox, regional director (RD) of The Medical Team Hospice stated that Resident B's hospice team had concerns about the care Resident B received while residing at Degas House Inn. According to Resident B's hospice aide (HA), Emily Rivard, she met with Resident B on 01/25/2025. At that time, she changed, initialed, and dated Resident B's brief. When HA Rivard returned on 01/27/2025, she found Resident B in the same brief, which was completely soiled and soaked.

	On 02/11/2025, Resident B's hospice nurse (HN), Jolene Stepanski found Resident B sitting up in bed eating her lunch. HN Stepanski took Resident B to the bathroom and discovered that she had soiled herself and she did not have on a brief. No facility staff was present so HN Stepanski and Relative B1 cleaned Resident B up and changed her clothes. Staff Destany Kelly said that she checked and changed Resident B every two hours. Staff Kelly stated that she never found Resident B in an excessively soiled brief. The assistant to the assisted living director (AALD), Kesha Harris, said that on several occasions, day staff told her that night shift staff were not changing Resident B's briefs often. AALD Harris told me that because of these concerns, staff began initialing a brief change log indicating that Resident B's brief was being changed as required. Staff Felicia Taylor said that she checked on Resident B every two hours and would change her brief if necessary. Staff Taylor said that she never found Resident B in a soiled brief or soiled clothing. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref. SIR #20222A0872058, dated 11/21/22.** **SIR #2023A0872020 dated 3/25/2023.**

ALLEGATION: Resident B was prescribed narcotics, but the facility failed to have the narcotics available for administration.

INVESTIGATION: On 05/02/2025, I reviewed Resident B's medication administration records (MARs) for February and March 2025. According to these records, she was prescribed the following medications:

- Ativan 0.5mg, 1 tablet daily for anxiety, prescribed 01/08/25
- Hydrocodone-Acetaminophen 7.5-325mg, 1 tablet every 6 hours for pain, prescribed 02/27/25
- Ativan 0.5mg, 1 tablet every 4 hours as needed for anxiety, prescribed 01/08/25
- Morphine Sulfate, oral solution, 0.25ml by mouth every 4 hours as needed for pain, prescribed 02/27/25 and discharged 03/01/25
- Morphine Sulfate, oral solution 0.25ml by mouth every 2 hours as needed for pain, prescribed 03/01/25

- Haloperidol 0.5mg, 1 tablet every 4 hours as needed for agitation, prescribed 01/08/25
- Atropine Sulfate 1%, 2 drops sublingually every 2 hours as needed for secretions, prescribed 03/02/25
- Aspirin 81mg, 1 capsule daily for heart health, prescribed 01/08/25
- Trazodone 100mg, 1 tablet at bedtime for depression insomnia, prescribed on 07/15/24
- Voltaren 1% gel, apply to back topically 1 time per day due to back pain, prescribed 04/20/24
- Tylenol 325mg, 2 tablets twice a day for pain, prescribed on 01/11/25
- Xanax 0.5mg, 1 tablet every 4 hours as needed for anxiety, prescribed 03/03/25
- Zofran 8mg, 1 tablet every 8 hours as needed for nausea and vomiting, prescribed 02/13/25

Resident B's February MARs showed that she was administered these medications each day as prescribed except for the following:

- Ativan not administered on 02/06/25 and 02/26/25 due to "drug refused"
- Hydrocodone-Acetaminophen not administered on 02/27/25 or 02/28/25 due to "hold/see nurse notes" and/or "other/see nurse notes"

Resident B's March MARs showed that she was administered these medications each day as prescribed except for the following:

- Aspirin not administered 03/01/25 – 03/03/25 due to "other/see nurse notes"
- Ativan not administered 03/01/25 – 03/03/25 due to "other/see nurse notes"
- Trazodone not administered on 03/01/25 due to "other/see nurse notes" and 03/02/25 due to "drug refused"
- Voltaren not administered on 03/01/25 and 03/03/25 due to "other/see nurse notes" and 03/02/25 due to "drug refused"
- Tylenol not administered 03/01/25 – 03/03/25 due to "other/see nurse notes"
- Hydrocodone-Acetaminophen not administered on 03/01/25 – 03/03/25 due to "other/see nurse notes" or "drug refused."

I reviewed the medication order for Hydrocodone-Acetaminophen dated 02/27/2025 prescribed by PA-C Dziadula at 1:26pm. According to the licensee designee (LD), Katie Edwards, this medication was on order for a couple of days following the original start date. LD Edwards said that she reached out to the pharmacy to determine why there was a delay in receiving the medication and she was told that the pharmacy was waiting for a script from the physician.

I reviewed the progress notes from staff explaining that the medication Hydrocodone-Acetaminophen was not administered because it was still on order from the pharmacy. The progress notes dated 03/02/2025 gave the following reasons for Resident B not taking this medication:

- Not taking any meds except morphine
- Unable to take

- Family refused

On 05/02/2025, I interviewed Kim Cox, regional director (RD) of The Medical Team, hospice. I reviewed the allegations with RD Cox, and she stated that she is aware that members of Resident B's hospice team did have concerns about the care of Resident B while she resided at Degas House Inn. RD Cox agreed to send me documentation about the concerns.

On 05/05/2025, I received an email from RD Cox. She stated that on 02/27/25, Resident B's hospice nurse (HN), Jolene Stepanski, ordered Norco. On 03/01/2025, HN Stepanski noted that Norco was not yet available at the facility.

On 05/06/2025, I interviewed AALD Harris via telephone. According to AALD Harris, Resident B's hospice team ordered Norco for her. However, the hospice team doctor did not sign the order and therefore, the pharmacy, Medwiz, would not fill the prescription. AALD Harris told me that she contacted Medwiz and was told that they could not fill the prescription without a doctor's signature. AALD Harris told me that she told Resident B's hospice nurse that the prescription was not available because the doctor had not signed the order, and the hospice nurse agreed to investigate the matter. However, by the time of Resident B's death, the Norco was not filled and administered because it was not signed by a doctor.

On 05/06/2025, I interviewed customer service representative (CSR), Richard Jones, from MedWiz pharmacy. CSR Jones looked up Resident B's medication list and said that there is no order for Norco in their system. CSR Jones told me that if Norco was ordered but the doctor had not signed the script, it would still show up in their system. Therefore, CSR Jones said that there was no order received for Norco for Resident B.

On 11/09/2022, I completed investigation#2022A0872058 regarding staff making medication errors regarding two residents. I determined that on numerous occasions, staff failed to administer and/or remove one resident's medicated patch as instructed by his doctor. Staff also failed to follow doctor's orders regarding another resident's Ativan and Zyprexa on more than one occasion. I also determined that in July, August, and September 2022 staff failed to initial a resident's medication log and/or failed to administer her medication. The licensee designee, Kimberly Gee submitted a corrective action plan dated 11/21/22 stating that the director of assisted living will continue to audit and review medication records for accuracy and timelessness.

On 02/01/2023, AFC Licensing Consultant Sabrina McGowan completed Special Investigation Report #2023A0580013 regarding residents not receiving their medications during an internet outage on 12/19/2022 and 12/20/2022. The licensee designee, Melissa Sevegney submitted a corrective action plan dated 02/14/2023 stating that staff will undergo reeducation on proper documentation and medication administration policies and procedures and the licensee designee will review the medication administration records at least weekly for three months to ensure compliance.

On 04/03/2023, I completed Special Investigation Report #2023A0872026 alleging that a resident was not administered her medications as prescribed. I determined that on

numerous occasions in January 2023, a resident was not administered several medications as prescribed by her doctor. On 05/25/2023, a settlement agreement was reached, and the facility agreed not to admit residents to this facility for 6 months. Once the 6-months was up, a 6-month provisional license was issued during which the facility was allowed to admit residents back into the facility. The licensee designee agreed to conduct weekly audits of the staffing at this facility and produce those audits to the licensing consultant. This facility remained on a provisional license until 05/24/2024 at which time they were given a regular license.

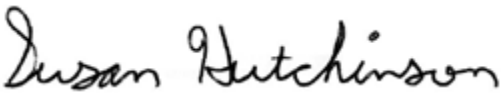
On 05/05/2025, I conducted an exit conference with the licensee designee (LD), Katie Edwards. I discussed the results of my investigation and explained which rule violations I am substantiating. I told LD Edwards that I am recommending continuation of the provisional license which was issued on 04/28/2025. LD Edwards said that she is working closely with staff and the director of assisted living, (DAL) Jessica Butler to ensure compliance with these rules is achieved. LD Edwards agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 02/27/25, Resident B was prescribed Norco for pain. According to Resident B's medication administration records (MARs), staff did not administer this medication as prescribed. I reviewed the medication order for Hydrocodone-Acetaminophen dated 02/27/2025 prescribed by PA-C Dziadula at 1:26pm. According to Kim Cox, regional director of The Medical Team Hospice, Resident B's hospice nurse (HN), Jolene Stepanski prescribed Resident B Norco on 02/27/25. On 03/01/25, HN Stepanski noted that Norco was not yet available at the facility. AALD Harris said that Resident B's hospice team prescribed her Norco on 02/27/25. It was not delivered by 03/01/25 so AALD investigated and was told that the pharmacy was unable to fill the prescription because the script was not signed by a doctor.

	CSR Jones from MedWiz pharmacy said that there is no record of their pharmacy receiving an order for Norco for Resident B. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Ref. SIR #20222A0872058, dated 11/09/2022.** **SIR #2023A0580013, dated 02/01/2023.** **SIR #2023A0872026, dated 04/03/2023.**

IV. RECOMMENDATION

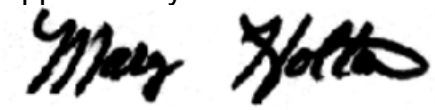
Upon the receipt of an acceptable corrective action plan, I recommend continuation of the provisional license.



May 6, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 6, 2025

Mary E. Holton Area Manager	Date