GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 13, 2026

Wills Dixon
7320 Lansing Ave
Jackson, MI 49201

RE: License #: AF380257231
Investigation #: 2026A0007013
Pleasant Manor I AFC, LLC

Dear Wills Dixon:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care 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.

A six-month provisional license is recommended due to the severity of the quality of care violations identified in the report. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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) 284-9730.

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

I. IDENTIFYING INFORMATION

License #:	AF380257231
Investigation #:	2026A0007013
Complaint Receipt Date:	01/16/2026
Investigation Initiation Date:	01/16/2026
Report Due Date:	03/17/2026
Licensee Name:	Wills Dixon
Licensee Address:	7320 Lansing Ave Jackson, MI 49201
Licensee Telephone #:	(517) 796-1598
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Pleasant Manor I AFC, LLC
Facility Address:	7320 Lansing Ave. Jackson, MI 49201
Facility Telephone #:	(517) 796-1598
Original Issuance Date:	07/15/2003
License Status:	REGULAR
Effective Date:	05/29/2024
Expiration Date:	05/28/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was recently admitted into the facility. On 1/15/26, Resident A went to bed around 9:00p.m. Between 9:30 p.m. and 10:00 p.m., a citizen notified facility staff that Resident A was lying in the street and to contact 911. It appeared that he had been struck by a vehicle. Resident A passed away.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/16/2026	Special Investigation Intake- 2026A0007013
01/16/2026	Special Investigation Initiated - On Site- Face to face contact with Sandra Dixon, Staff, Annette Matiska, DCW, Karen Stewart, DCW, and residents.
01/16/2026	Contact - Telephone call received from Sandra Dixon, Staff.
01/16/2026	Contact - Face to Face - contact with Mark Easter, Detective, and other officials at the Jackson County Sheriff's Department.
01/16/2026	APS Referral made.
01/16/2026	Contact - Telephone call made to Sandra Dixon. Discussion and additional information gathered.
01/20/2026	Contact - Document Received - Subsequent referral received.
01/20/2026	Contact - Face to Face with Rebecca Belcher, APS Worker. She had a case regarding Resident A back in June of 2024.
01/20/2026	Contact - Telephone call received from Sandra Dixon. Discussion.
01/26/2026	Contact - Telephone call received from Relative A1 and Relative A2.
01/26/2026	Contact - Telephone call made - Interview with Citizen #1.
01/27/2026	Contact - Telephone call received from Sandra Dixon. Discussion.
01/27/2026	Contact - Telephone call received Interview with Wills Dixon.

01/28/2026	Contact - Telephone call received from Sandra Dixon. They're installing cameras outside of the home.
02/04/2026	Contact - Document Received - APS Referral was denied
02/09/2026	Contact - Telephone call received from Wills Dixon. The media has reached out to him for a comment. He was informed that licensing could not advise him regarding that matter and I encouraged him to contact his attorney.
02/27/2026	Contact - Document Sent - Email to Mark Easter, Detective, Jackson County Sheriff's Department. Status update requested.
03/10/2026	Contact - Telephone call made Interview with Fire Fighter #1/ First Responder.
03/10/2026	Contact - Document Received - Subsequent allegations (Please see SIR #2026A0007018) for additional information.
03/11/2026	Inspection Completed On-site Unannounced - Face to face contact with Wills Dixon, Annette Matiska, DCW, Nathan Kitts, Staff, Resident B, Resident E, Resident F, and Resident G.
03/11/2026	Contact – Telephone call received from Sandra Dixon.
03/13/2026	Exit Conference conducted with Wills Dixon, Licensee.

ALLEGATION: Resident A was recently admitted into the facility. On January 15, 2026, Resident A went to bed around 9:00p.m. Between 9:30 p.m. and 10:00 p.m., a citizen notified facility staff that Resident A was lying in the street and to contact 911. It appeared that he had been struck by a vehicle. Resident A passed away.

INVESTIGATION:

During this investigation, the following subsequent allegations were also received: Resident A (76) lived at Pleasant Manor (AFC home). Resident A had a history of confusion and kidney disease. Resident A was able to walk. It is unknown if Resident A has a guardian. On 01/15/2026, Resident A wandered out of Pleasant Manor and walked into the road. Resident A was struck by a vehicle. Resident A had an obvious head injury and severe bleeding. Resident A passed away while first responders were at the scene. Resident A was about 2/10 of a mile away from the facility. Resident A's patient light was on inside of the facility. The two caretakers at the home were wearing pajamas and took 3-4 minutes to respond to the knocking at the home. The caretakers appeared disoriented and confused. The caretakers were not observed to be sleeping but there is concern that they were asleep instead of watching residents. There are no staff at the door or watching the cameras. There

was a chair propping the door open to the facility. There is concern that Resident A was a resident with confusion, and no caretaker was supervising him.

On January 16, 2026, I spoke with Sandra Dixon, who is the wife of Wills Dixon, Licensee, and she also provides direct care to the residents in the home. Sandra Dixon immediately informed me that something very bad had happened. She stated that Resident A was admitted into the home a week ago (January 9, 2026), on the family home side (AF380257231). There are two adjoined facilities located on the property (Pleasant Manor I, AFC, LLC (AF380257231) and Pleasant Manor II AFC, LLC (AS380258886)). Resident A was a (76) year-old male, who had dementia and high cholesterol. Sandra Dixon informed me that she was not home when the incident occurred. She stated that on Thursday, January 15, 2026, Wills Dixon, Licensee, gave Resident A his medications at 8:00 p.m. and Resident A went to bed at 9:00 p.m. Wills Dixon went downstairs (the licensee's living quarters). Between 9:30p.m. and 10:00 p.m. Wills Dixon heard a knock on the front door. The bystander informed him there was a resident lying in the road, as there was a hit and run. Law enforcement had been contacted, responded and conducted interviews. Sandra Dixon stated that the Sheriff's Department responded to the call. Sandra Dixon was upset during the phone call, she stated that no one said Resident A was a flight risk, and if they had known, he would have been placed on the other side (Pleasant Manor II - AS380258886). During the conversation, Sandra Dixon expressed that she desperately wanted to reach out to the family, but she was instructed by law enforcement not to call them, as they would make the notification. I expressed that I understood but encouraged her to adhere to the instructions given by law enforcement.

On January 16, 2026, I conducted an unannounced on-site investigation and made face to face contact with Sandra Dixon, Staff, Annette Matiska, DCW, Karen Stewart, DCW, and the residents. Annette Matiska, who has the role of home manager, was leaving when I arrived. She stated that she could not get the image of Resident A out of her head, she had been there all evening, and she was exhausted. I informed her that I would follow up with her later. They also informed me that Wills Dixon was not there as he was out purchasing door alarms. Sandra Dixon appeared to be in a state of shock, and she had tears in her eyes while speaking about the situation. I inquired if Resident A had a designated person or representative, and Sandra Dixon informed me that it was Relative A1. Sandra Dixon stated that she did not know how she was going to face her (Relative A1). She stated there was no explanation that she could give the family, as "they left their loved one here and expected me to provide care." Sandra Dixon informed me that they had three (later corrected herself that there were four) residents admitted into the home, Resident A, Resident C, and Resident D. While the licensee did not originally list Resident B when providing the names of the residents admitted into the home, it was later discovered that Resident B shared a room with Resident A. Resident B was admitted into the home (Pleasant Manor I) from Pleasant Manor II, on January 9, 2026. She stated that it was never disclosed that Resident A would wander, because he wouldn't have been placed on that side (in the family home). She stated that they

conduct bed checks every two hours, and over the past week when they checked on Resident A, he was usually asleep. She stated that when they have new residents, they observe them to determine if there were any patterns of behavior. Sandra Dixon stated that Annette Matiska informed her that Resident A had never gone towards the door (attempting to leave). Sandra Dixon also informed me that she knew this would be an issue as a part of the investigation but a chair was placed in the hallway, in front of the front door, so if they heard the chair move, they would know something was going on. According to Sandra Dixon, Wills Dixon did not hear anything (or the chair being moved). Sandra Dixon stated that no other residents witnessed anything, as they were asleep and stayed asleep while law enforcement was at the home.

I completed a walk-through of the home and observed Resident A's shared bedroom (with Resident B). It was noted that there was a glass sliding door in the bedroom, which led to a deck on the outside of the home. Sandra Dixon informed me that they usually kept a stick in the door (it was not there at the time of the inspection).

On this same date, I inquired about what Resident A was wearing, and Sandra Dixon informed me that Resident A was wearing dark sweatpants and a tee shirt.

I also reviewed the facility file for Resident A. It was documented on the *Assessment Plan for AFC Residents* that Resident A did not move independently in the community, and it was documented that he required "standby assist - holds hands."

On January 16, 2026, I made face to face contact with Mark Easter, Detective, and other officials at the Jackson County Sheriff's Department. He provided me with an update regarding the investigation and informed me that the family had been notified. He also provided me with the incident number for the investigation, and a copy of the Press Release (which had already been sent out).

On January 20, 2026, I spoke with Sandra Dixon, who informed me that she had spoken with Resident A's family member. She also discussed the incident, her concerns, and was considering getting out of the business.

On January 26, 2026, I spoke with Relative A1 and Relative A2 (Resident A's daughters). They informed me that Relative A1 was recently placed in the home, he managed to get out of the home after being tucked into bed, and he was struck by a vehicle; the person driving the vehicle left the scene. Relative A1 informed me that she was the Power of Attorney for her father since 2021. They informed me that Resident A was residing with a lifelong friend, Friend A1, prior to being placed in the AFC home (on January 9, 2026). Resident A was placed in the home because he was falling a lot, Friend A1 had his own health issues, and he was having a difficult time caring for Resident A. They recalled that Resident A did not like an institutionalized setting and they wanted the new placement to feel like home. In the past, while Resident A was at Facility #1, he got out of the facility, he fell in the parking lot, and his rib was fractured from the fall. Resident A required rehab after

his fall. When asked if there was a concern with him leaving the new placement, Relative A1 informed me that when Friend A1 dropped Resident A off (when he was first admitted), he (Friend A1) spoke to Annette Matiska, DCW, and he told her about Resident A being confused and about him wandering out of his house and wandering away from the other facility. Relative A1 stated that when Resident A was being admitted into the home, there was a lot going on, including the home being under construction. Relative A1 stated that she completed the paperwork, while Friend A1 was telling Annette Matiska what was going on and why it was harder for him to care for Resident A.

They informed me that people in the community had posted information on-line about the home, and Citizen #1 reached out to them, as he had found their dad. They were told that it appeared that EMS had to wake the owners up. The police also saw the chair by the front door. Relative A2 stated that they were given three different stories as to what happened. They stated that Sandra Dixon called a few days later to apologize. They were told that Resident A was given his medications at 8:00 p.m. and he was in bed at 9:00 p.m. They put a chair in front of the (front) door and they went downstairs. Sandra Dixon told them that when they go downstairs, they put a chair in front of the (front) door, so they can hear if the chair moves. Sandra Dixon said that Wills Dixson went to the bathroom downstairs and that is when Resident A got outside. They also informed me that while Relative A3 was at the home helping to pick up Resident A's belongings (after the incident), Annette Matiska told him that the owner just went to the bathroom and that's when their dad got out of the home. The female owner (Sandra Dixon) said that Wills Dixon went downstairs to clean the bathroom. Sandra Dixon told them that the front door was found wide open. During the interview, I was also informed that Resident A moved very slowly, his gate was unsteady, and it would have taken time for him to walk down the hill in front of the house. Relative A1 informed me that she saw Resident A's bedroom, with the sliding door. Per Relative A2, Relative A1 said the facility staff said they would put a nail in the track or something. After the incident, Relative A2 drove by the home, and she stated there was no way that he exited through the bedroom door; she did not observe any tracks in the snow.

On January 26, 2026, I interviewed Citizen #1. He informed me that he and his wife were in their vehicle driving, when they saw an individual (Resident A) lying in the road; and 911 was immediately contacted. Resident A was wearing a tee shirt, black sweats, without shoes. There was a chief (name unknown) that lived close by who also responded. According to Citizen #1, Resident A did not have a pulse and was deceased by the time the ambulance arrived (approximately five minutes or less after the call was made). The police then went to the facility, and they had to wait a few minutes (less than five minutes) for someone to open the door. No one was awake. According to Citizen #1 there was also a chair by the door, which may have been used to (reach) and push the button, so the door alarm did not go off. Citizen #1 stated that the owner came out with a file to identify the body. Citizen #1 stated this was a really unfortunate incident.

On January 27, 2026, I spoke with Sandra Dixon. I inquired about the intake process and the completion of the *AFC Assessment Plan*, and she informed me that the daughter (Relative A1) insisted on completing the form. I asked about the chair in front of the door, and Sandra Dixon explained that they closed the front door, turn the chair around and placed it underneath the handle. She informed me that it would take effort and some pull to remove the chair. Sandra Dixon stated that Wills Dixon had put Resident A to bed and he was going downstairs to use the bathroom and then come back upstairs. So, he put the chair there. Sandra Dixon stated she was not home and returned the next morning.

On January 27, 2026, I interviewed Wills Dixon, Licensee. He informed me on January 15, 2026, between 8:00 p.m. and 8:30 p.m. he passed medications, and then Resident A went to bed around 9:00 p.m. Willis Dixon stated, “I went downstairs for a while, about 15-20 minutes.” He stated he was using the bathroom, and he heard a knock on the door. When he came out of the bathroom, he saw two young ladies (not in uniform), standing by the top of the steps in the home. They said to check and see if any of the residents were missing. He then went to look and see if any of the residents were missing. He saw that Resident A’s bed was empty. Resident B was still in bed asleep. Wills Dixon informed me that the glass sliding door in the bedroom was shut. When Wills Dixon looked outside, he expressed that he was shocked to see EMS, flashing lights, and the police. He then realized that that something serious had occurred. Then he went outside to check and see what was happening. He stated he was looking around for the missing person (Resident A) but he was surrounded by EMS. Wills Dixon stated he spoke with the Sheriff and told him he was associated with the home. I inquired about the chair being placed in front of the door, and he informed me that the dining room chair was placed there as a precaution; in case someone opened the door, they would hear. The chair was to alarm them if someone tried to leave. They had placed the chair in front of the door a few times, even before Resident A had been admitted into the home. There was no history of Resident A trying to leave before. Resident A had only been in the home for about a week. He stated that Resident A did not have any assistive devices; however, he did require standby assistance, and they had to assist him with ambulating.

On this same day, Sandra Dixon called me back and she was speaking with Annette Matiska, who was in the background. Annette Matiska stated that Friend #1 had visited the day before (on January 14, 2026), as he had taken him out into the community. When they returned, Resident A did not want Friend A1 to leave. At first, Resident A was trying to follow him (Friend A1), but Annette Matiska was able to redirect him. Resident A did not make any more moves towards the door. Annette Matiska also recalled that when Resident A tried to get up, he would fall back into the chair, and staff would assist, giving him a boost to stand up.

On March 10, 2026, I interviewed Fire Fighter #1 (First Responder). Fire Fighter #1 (FF #1) works for Fire Department #1, and this facility is in their jurisdiction. They received a 911 call regarding an individual laying in the road, from a hit and run

incident. They responded and provided the initial patient care. When they arrived on the scene they felt for a pulse, there was no spontaneous respiration. Resident A had several traumas to his body, which was laying right out front of the facility. Resident A was wearing a brief, gray sweatpants, a long-sleeved shirt, no shoes, and one sock. The other sock was found in road. Resident A did not have on a coat or hat, and he was not dressed to be outside in those conditions. She and her colleague went to the AFC home. When she got to the front door of the facility, the screen door was closed, but the main door was open. There was a dining room chair in front of the door. She had to move the chair, which was forward facing, and push it away to get into the home. She was not sure if there were locks at the top of door; however, it looked like Resident A got up on the chair, unlocked the door, and got out. There were no cameras at the facility. She and her colleague entered the facility. There was no one (staff) upstairs, they knocked on doors, there were no lights on, and they were yelling through the house, announcing that the fire department was there. For approximately five to ten minutes, there was no one responding. They looked down the hallway, and she then sent her colleague to the other door (Pleasant Manor II). FF #1 stood in dining room, announcing that the Fire Department was there and she needed a staff member. Then a man (Wills Dixon) ran upstairs, he was wearing his pajamas, and he looked like he had just awakened. She asked him if any of the residents were missing, so he went to check, and he returned, informing her that yes, a resident was missing. She told him to get the resident file and meet them outside, as there was a deceased resident in road. Wills Dixon provided them with a photo of Resident A, but facility file was incorrect. They noticed the name on the driver's license provided did not match the file (to match photo identification). The Michigan State Police were also on the scene, and they made the call. Informing, that, "Yes, that's him." It was noted in the resident file that he had a history of dementia and kidney disease. Wills Dixon started making phone calls. The officials from the fire department then turned the matter over to the police; they cleared the scene with Fire Department. According to FF #1, there have been multiple issues with this facility, and complaints made to another investigating agency were not investigated. She recalled some incidents that occurred approximately two years ago. I provided her with my contact information along with LARA website to file a complaint, should she have any concerns in the future.

On March 11, 2026, I conducted an unannounced on-site investigation. I made face to face contact with Wills Dixon, Licensee, Annette Matiska, DCW, Nathan Kitts, Staff, Resident B, Resident E, Resident F, and Resident G.

I interviewed Annette Matiska, DCW. As I arrived, I noticed that the home was equipped with an alarm system, which was loud, and identified which door was open. The alarms were on the main door (not the screen door). Annette Matiska showed me which door alarm was new, and which one was on the door on the night of the incident. Annette Matiska stated that the batteries were dead in the original door alarm, on the day in question. I inquired who was at the home on the evening of January 15, 2026, and she informed me that Wills Dixon, Licensee and Nathan Kitts, Staff, were on the premises. Wills Dixon was at Pleasant Manor I, and Nathan Kitts

was at Pleasant Manor II, in the living room watching television, supervising Resident E and Resident F. She stated that she received a call at around 10:00 p.m. to come to the home as she was the home manager and they needed to speak with her. She stated the road was blocked off so she had to park and walk past Resident A lying in the road. She stated she had many nightmares after seeing those images. She stated that the police interviewed Wills Dixon, Nathan Kitts, and her. Annette Matiska stated that Resident B shared a room with Resident A. She also stated that Resident A had difficulty getting up out of a chair, often requiring assistance, so she was surprised that he got up and left the home.

I attempted to interview Resident B. Annette Matiska informed me that Resident B had difficulty hearing and I would need to speak very loudly. I eventually ended up writing down my questions for Resident B to read and respond to. I asked Resident B about Resident A, but he reported not to know him. While in Resident B's room it was noted that there was now a stick in the glass sliding door, to prevent it from being opened.

While at the facility, I spoke with Wills Dixon, and he confirmed that the door alarm was not working at the time of the incident. He stated that they have a new alarm system installed and any time the doors open, the alarm sounds and lets them know which door is open. He also confirmed that he and Nathan Kitts were on the premises on the evening of January 15, 2026. He stated that Nathan Kitts was always there, as he was a part of the staff.

I asked to review the employee file for Nathaniel Kitts. I then interviewed Nathaniel Kitts, who was cooperative with the investigation. He stated that he started working at the facility after Thanksgiving but before Christmas. He stated he helps with the grounds, runs errands and assists when needed. He stated that he did not supervise the residents alone and did not prepare medications. Nathaniel Kitts stated that on the evening of January 15, 2026, he went out to run some errands and returned around 8:30-8:45 p.m. He laid down after he returned. He was sleeping and shortly thereafter, he got up to find something, and that is when Wills Dixon told him about Resident A getting out of the facility. He confirmed that he was there when the fire department officials arrived but did not hear them right away.

On March 11, 2026, I spoke with Sandra Dixon, who stated that the home was not equipped with patient lights in the bedroom. In addition, they conducted bed checks every two hours but since this incident, they now conduct them every hour.

On March 13, 2026, I conducted the exit conference with Wills Dixon, Licensee. We discussed the investigation and my recommendations. I also explained that he could decide if he wanted to accept the provisional license or not, but if he accepted the provisional license and additional quality-of-care violations were established, LARA would then recommend revocation of the license. Wills Dixon stated that he would accept the provisional license. I informed him that the acceptance would need to be in writing. We also discussed information that could be included in the written

corrective action plan. I also recommended providing awake staff to supervise residents with these types of diagnoses.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	While it's noted that awake staff may not be required in a family home setting, as the licensee resides in the home, in this situation, the licensee placed a chair in front of the front door, as a precaution to alert the licensee in case a resident opened the door. The chair was to alarm them if a resident tried to leave. It was also noted that the front door was equipped with a door alarm, but it was not operational at the time Resident A eloped from the home. Given the home staff's knowledge of Resident A's diagnosis with dementia, and the knowledge that the door alarm (which should not take the place of staff supervision), was not operational, it is unrealistic to assume that by blocking the exit with a chair, it would be a responsible way to provide supervision and protection; and thus, be alerted of activity by the exit, during hours of sleep. Based upon my investigation, which consisted of unannounced on-site investigations, interviews with family members, the licensee, facility staff and direct care staff, a citizen, law enforcement and a first responder, it's concluded that there is a preponderance of the evidence to support the allegations that on January 15, 2026, Resident A was not protected and kept safe by the licensee.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
During this investigation, Sandra and Wills Dixon reported placing a chair in front of the door. Sandra Dixon informed me that she knew this would be an issue, but a chair was placed in the hallway, in front of the door, so if they heard the chair move, they would know something was going on. Sandra Dixon explained that they closed the front door, turned the chair around and placed it underneath the handle. She informed me that it would take effort and some pull to remove the chair.

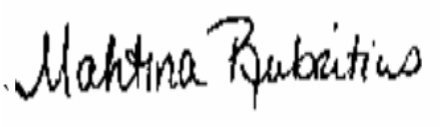
During the interview with Wills Dixon, I inquired about the chair being placed in front of the door, and he informed me that the dining room chair was placed there as a precaution; in case a resident opened the door, they would hear. The chair was to alarm them if a resident tried to leave. Wills Dixon reported the chair had been placed in front of the front door a few times, even before Resident A had been admitted into the home.

On the evening of January 15, 2026, the chair was also observed in front of the door by Fire Fighter #1 and her colleague. Fire Fighter #1 had to move the chair, which was forward facing, and push it away to get into the home.

APPLICABLE RULE	
R 400.725	**Means of egress.**
	(1) A means of egress must be considered the entire way and method of passage through the facility and out an exit door to free and safe ground outside the facility and must be arranged and maintained to provide free and unobstructed egress from all parts of the facility.
ANALYSIS:	Based upon my investigation which consisted of on-site investigations, interviews with staff, the licensee, family members, Citizen #1, and other professionals, it's concluded that there is a preponderance of the evidence to support the allegations that a chair was placed in front of the door, blocking the required means egress.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

A six-month provisional license is recommended due to the severity of the quality-of-care violations. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.



03/11/2026

Mahtina Rubritius Date

Licensing Consultant

Approved By:

03/12/2026

_____

Dawn N. Timm Date
Area Manager