GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2026

Teresa Wendt
HGA Non-Profit Homes Inc.
917 West Norton
Muskegon, MI 49441

RE: License #:	AS610091644
Investigation #:	2026A0356017
	Virginia's House

Dear Ms. Wendt:

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.

A six-month provisional license is recommended. 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610091644
Investigation #:	2026A0356017
Complaint Receipt Date:	01/12/2026
Investigation Initiation Date:	01/12/2026
Report Due Date:	03/13/2026
Licensee Name:	HGA Non-Profit Homes Inc.
Licensee Address:	917 West Norton Muskegon, MI 49441
Licensee Telephone #:	(231) 728-3501
Administrator:	Jessica Carter, Administrator
Licensee Designee:	Teresa Wendt, Designee
Name of Facility:	Virginia's House
Facility Address:	391 Whispering Oaks Drive Muskegon, MI 49442-1853
Facility Telephone #:	(231) 788-5156
Original Issuance Date:	05/23/2000
License Status:	REGULAR
Effective Date:	11/23/2024
Expiration Date:	11/22/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A died unexpectedly at the facility.	Yes

III. METHODOLOGY

01/12/2026	Special Investigation Intake 2026A0356017
01/12/2026	Special Investigation Initiated - Telephone Sandy Kotecki, Health West, supports coordinator supervisor.
01/12/2026	Contact - Telephone call made Teresa Wendt, LD, Jessica Carter, Admin.
01/12/2026	Contact - Document Received Resident A documents.
01/12/2026	Contact-Telephone call received Anonymous voicemail message.
01/12/2026	Contact - Telephone call made Tasha Kuklewski, ORR, health west, CMH.
01/12/2026	APS Referral
01/20/2026	Contact - Telephone call made Ka'Tonica Hairston, DCW.
02/16/2026	Contact - Document Received Tasha Kuklewski-ORR info.
02/17/2026	Inspection Completed On-site
02/17/2026	Contact - Face to Face DCW's Ja'Tea Patterson, Tiffany Priest, DCW.
03/09/2026	Contact-Telephone call made Teresa Wendt, re: resident documents.
03/10/2026	Contact-Telephone call made Jessica Sobers, RN supervisor at Health West Ruth Burkert, legal guardian.

03/11/2026	Contact-Telephone call received Ruth Burkert-legal guardian re: cause of death.
03/11/2026	Exit conference-Teresa Wendt, Licensee Designee.

ALLEGATION: Resident A died unexpectedly at the facility.

INVESTIGATION: On 01/12/2026, I received a telephone call from Sandy Kotecki, Health West (Community Mental Health) supports coordinator supervisor. Ms. Kotecki reported that Resident A died unexpectedly in the facility on 01/05/2026. Ms. Kotecki reported there was concern regarding Resident A being sick and the lack of timely care.

On 01/12/2026, I interviewed Teresa Wendt, Licensee Designee and Jessica Carter, Administrator via telephone. Ms. Wendt stated she is in the process of reviewing this incident, Ms. Wendt and Ms. Carter confirmed the death of Resident A, a non-hospice resident, in the facility on 01/05/2026. Ms. Wendt and Ms. Carter stated they would send facility documentation for review.

On 01/12/2026, I received an anonymous voicemail message that reported Ja'Tea Patterson and Ka'Tonica Hairston were the staff on duty during 3rd shift when Resident A was discovered deceased. The anonymous caller stated that Resident A had been sick for days prior to his death. He was vomiting and should have been taken to the doctor.

On 01/12/2026, I interviewed Tasha Kuklewski, Health West, Office of Recipient Rights, Recipient Rights Advisor. Ms. Kuklewski stated she is already investigating Resident A's death. Ms. Kuklewski stated that former staff, Tamea Williams, went to the facility on 01/04/2026, to deliver Christmas gift cards and asked DCW (direct care worker) Diana Hannah how Resident A was doing. Ms. Kuklewski stated that Ms. D. Hannah reported to Ms. Williams that Resident A had been sick and vomiting for the past two days and was in his bedroom with the door closed. Ms. Kuklewski stated Ms. Williams reported she did not enter Resident A's room because the door was closed and his roommate was in the living room watching tv. Ms. Kuklewski documented that Ms. Williams asked Ms. D. Hannah if Resident A had Covid-19 and Ms. D. Hannah responded no, but that Resident A's vital signs were being taken regularly. Ms. Kuklewski stated Ms. Williams was concerned about the care Resident A received in this facility. Ms. Kuklewski stated the investigation is ongoing.

On 01/12/2026, I reviewed Resident A's assessment plan, resident care agreement and health care appraisal. Resident A's date of birth was 03/31/1954. Resident A's diagnosis is as follows: Mild IDD (intellectual developmental disability), Bipolar Disorder, Hypothyroidism, High Cholesterol, Legally blind, hypertension, seasonal allergies, non-alcohol fatty liver disease, chronic kidney disease, kyphosis, osteopenia, dysphagia, elevated PSA, calculus of the kidney, degenerative disease

of the nervous system, GERD, Urinary Retention, overweight, constipation, incontinence, atrial fibrillation, urinary urgency, iron deficiency, hearing loss, borderline diabetic and Vitamin D deficiency.

The assessment plan dated 06/04/2025, documented Resident A's need for staff assistance with almost all aspects of daily living such as toileting, bathing, grooming, dressing, eating and personal hygiene. Resident A used a wheelchair for mobility, and a Hoyer lift for transfers. Resident A could verbally communicate his needs and understands verbal communication. It was noted that the facility does not keep bed check logs that document times that bed checks of the residents are completed.

On 01/12/2026, I reviewed two IR's (Incident Reports). The first IR was dated 01/02/2026, 8:30p.m., written by DCW Diana Hannah, staff on duty listed Ms. D. Hannah and Ja'Tea Patterson, signed by Melissa Skuse, home manager. The IR documented the following information, '*Staff came in around 3:00p.m., noticed (Resident A) had a cough and mucus in his throat. Staff gave (Resident A) tea and meds for his congestion, continued to monitor (Resident A) every 2 hours, 5p.m., staff asked (Resident A) if he wanted dinner, said no, staff gave more fluids, continued to monitor him. (Resident A) got his meds at 7p.m., gave more fluids. At 8:30p.m. staff seen and heard (Resident A) coughing. Diana went in to assist him then called Ja'Tea to help sit him up in bed. (Resident A) began to throw up for 5 minutes. After staff got (Resident A) cleaned off, and sitting up more in the bed to help him with his cough and throwing up. (Resident A) threw up again, staff cleaned him up. Ja'Tea called home manager (Melissa) and med lead (Tiffany) and on call nurse, no one answered but Melissa. Staff asked if we should take (Resident A) to ER, Melissa said no, continue to monitor. Diana sat outside room until 11:00p.m. when third shift arrived.' At the bottom of the IR, the supervisor, Melissa Skuse documented, 'I asked staff to continue to monitor and call on call nurse for further instruction. I had no more calls about his condition. Spoke to staff about calling the nurse anytime and reminded them they didn't need my permission.'*

The second IR was dated 01/05/2026, 2:30a.m., written by Ka'Tonica Hairston, staff on duty listed Ms. Hairston and Lijesha Hannah, signed by Ms. Skuse. The IR documented the following information, *'Regular bed checks were made from 11p.m. at the start of my shift (Resident A) had been sick for the past 3-4 days, when bed checks were made we could see (Resident A) breathing but not moving. At about 1/1:30a.m. a bed check was done by Jay (Lijesha Hannah) while I (Ka'tonica) finished cooking and he seemed fine and breathing by the next bed check I was done with all kitchen duties and housework so I did my bed check about 2:30a.m., that's when I discovered (Resident A) deceased, he had been unresponsive, starting to discolor by mouth and skin and could visible see he was not breathing and green drainage started to come out when letting the head of his bed down. When I discovered he had been unresponsive, I went to go get Jay from living room so we could figure out our next steps, in which it was to call 911 asap. Over the phone they had us start chest compressions; he still felt slightly warm to the touch. We resumed chest compressions until EMS arrived in which they then pronounced him deceased,*

I then called my manager Melissa Skuse afterwards.' At the bottom of the IR, Ms. Skuse documented, *'Staff completed all steps necessary. They called 911 then myself, I reported to my supervisor, Incident Report completed, guardian, supervisor and case manager was notified.'*

On 01/20/2026, I interviewed DCW Ka'Tonica Hairston via telephone. Ms. Hairston stated she arrived at 11:15p.m. for 3rd shift on 01/04/2026. Ms. Hairston stated she was late and when she arrived, Resident A's bedroom door was closed. Ms. Hairston stated that was "odd" because Resident A had been sick and staff left the door open the previous nights to monitor him, when usually they keep resident doors shut when they are sleeping. Ms. Hairston stated she asked her co-worker, Lijesha Hannah if Resident A was ok and Ms. Hannah responded "yes." Ms. Hairston stated Ms. L. Hannah had been at work since 9:00p.m. on 01/04/2026 and she was unsure if Ms. L. Hannah had checked on Resident A between 9:00p.m.-11:15p.m. when she (Ms. Hairston) got to work. Ms. Hairston stated at 1:30a.m., Ms. L. Hannah conducted a bed check on Resident A and reported that he was ok but the room had a "sickly smell." Ms. Hairston stated from 11:15p.m., upon her arrival to work until 2:30a.m., she did not check on Resident A, but that Ms. L. Hannah had at 1:30a.m. Ms. Hairston stated another DCW, Da'Niya Bates gave Resident A water earlier in the evening on 01/04/2026. Ms. Hairston stated it was not until 2:30a.m. when she checked him, that is when she found him unresponsive. Ms. Hairston stated Resident A had a "common cold," and was not vomiting the night of his death but had been ill 2-3 days prior and vomited in the days preceding his death. Ms. Hairston stated she found Resident A at 2:30a.m., she turned the light on in his room and noticed his coloring was not right, so she called for Ms. L. Hannah who was in the living room. They called 9-1-1, started chest compressions with Resident A in his bed and EMS (emergency medical services) responded. Ms. Hairston stated Resident A, to her knowledge, did not see a medical professional prior to his death while he was ill. Ms. Hairston stated she expressed her opinion to the manager, Ms. Skuse, that Resident A should go to ER (emergency room) for evaluation and treatment. Ms. Hairston stated Resident A said he wanted to go to the ER in the morning before his death on 01/04/2026. Ms. Hairston stated DCW Tiffany Priest said she would take him but that Ms. Skuse said if Resident A's vitals were stable, he did not need to go in to ER. Ms. Hairston stated again, Resident A was sick in the days preceding his death, but he was not complaining and reiterated that Resident A had said the day prior to his death that he wanted to go to ER.

On 02/17/2026, I conducted an unannounced inspection at the facility and interviewed DCW Tiffany Priest, 1st shift, medication lead worker and Ja'Tea Patterson, 2nd shift DCW. Ms. Priest stated on 01/02/2026, Resident A was sick, did not feel well, vomited and had diarrhea. Ms. Priest reported later in her shift Resident A threw up. She (Ms. Priest) sat Resident A up in his bed. He had a bowel movement in his brief, and she called Ms. Skuse who instructed her to monitor Resident A and to inform the following shift to monitor him. Ms. Priest stated Resident A vomited two more times during her shift. Ms. Priest reported 2nd shift DCW, Ja'Tea Patterson reported to her that Resident A took his medications,

refused snacks, (which was unusual for Resident A because he enjoyed snacks), drank fluids and did not throw up during her shift. Ms. Patterson stated she gave Resident A a cup of tea. He was doing fine. He coughed but seemed better during her shift. Ms. Patterson concurred with the information that Ms. Priest provided.

Ms. Patterson added that she called Ms. Priest, Ms. Skuse and DCW Catrina Bankhead on 01/02/2026 about Resident A's illness. Ms. Patterson stated she was able to reach Ms. Skuse who instructed her if Resident A's vitals are good and he seemed like he was doing fine, he does not need to be sent into the ER. Ms. Patterson stated Resident A's bedroom door was left open, his bed tipped up so his head was elevated in case he vomited.

Ms. Priest stated on 01/03/2026, Resident a vomited once, he did not want to eat, he took his medications and they stayed down. Resident A was vocal and stated that his stomach hurt. Ms. Priest stated Resident A's vitals were taken and his O2 (oxygen) was between 96-99, his temperature was 97.6 and his blood pressure checked out normal, although she (Ms. Priest) could not remember exactly what it was. Ms. Priest described Resident A's illness as a "normal sickness", that Resident A was not so sick that they felt like they had to call 9-1-1 or that he required hospitalization, but that Resident A did seem "weak."

Ms. Priest stated on 01/04/2026, she and DCW Da'Niya Bates worked 1st shift and left Resident A's door open and checked on him every 15-20 minutes. Ms. Priest stated Resident A had diarrhea, which was not unusual. He did not vomit, drank a lot of fluids, took his medications and things seemed to be "ok." Ms. Priest stated she asked Resident A if he wanted to go to the doctor and he did not respond. Ms. Priest stated Resident A ignored staff when he did not feel like doing what they are asking.

Ms. Priest and Ms. Patterson stated they did not call the Health West on call nurse, or any on call nurse. They stated that Ms. D. Hannah may have done so, but neither of them called a nurse for instructions.

On 02/17/2026, I reviewed Tasha Kuklewski's ORR Report of Investigative findings dated 02/13/2026. Ms. Kuklewski's report documented a phone interview with Ms. L. Hannah, on 01/28/2026. Ms. L. Hannah reported (referenced as Jay Hannah in this interview) the following information, '*she reported to work at approximately 9:00 PM on January 04, 2026. She stated that when a resident is sick, staff typically monitor and check on them frequently, either every other hour or every hour. Jay Hannah stated she did a quick glance check on (Resident A) when she arrived and then began completing her usual duties. Jay Hannah stated that second shift informed third shift that (Resident A) was not feeling well and that he had been watched closely. Jay Hannah stated she did not believe anyone understood how sick (Resident A) was, but third shift continued monitoring him as well. Jay Hannah stated she was sitting in the living room when Ka'Tonica Hairston approached her, Jay Hannah stated she didn't know what time that was as so much was happening, but Ka'Tonica Hairston stated she thought (Resident A) was dead and that he had*

“brown stuff” coming out of his mouth. Jay Hannah stated she went to check (Resident A) *and attempted to lift his arm, but he did not respond. Jay Hannah stated Ka’Tonica Hairston called 911, and 911 instructed them to begin chest compressions. Jay Hannah stated she and Ka’Tonica Hairston took turns providing chest compressions until EMS arrived. Jay Hannah stated that when EMS arrived, EMS checked (Resident A’s) pulse and instructed staff to stop compressions, advising that (Resident A) had passed away. Jay Hannah stated Diana Hannah reported she had been checking on (Resident A) every hour*.’

Ms. Kuklewski’s report documented an in-person interview on 01/26/2026 with DCW Diana Hannah. Ms. D. Hannah reported the following information to Ms. Kuklewski, **‘***Diana Hannah stated that when she arrived for second shift on January 2, 2026, (Resident A) was still ill, coughing with mucus, and positioned propped up in bed. Regarding the evening of January 2, 2026, Diana Hannah stated she heard (Resident A) coughing and vomiting while they were in the dining room. Diana Hannah stated she and Jate’a Patterson waited until he finished vomiting around 9:00 PM, then provided water to rinse his mouth, cleaned him, and changed bedding, which took about 30 minutes. She reported that (Resident A) began dry heaving afterward and she remained outside his bedroom door until third shift arrived at 11:00 PM. Diana Hannah stated staff attempted to contact the medication lead and the HealthWest on-call nurse but did not receive an answer. She reported that Melissa Skuse, Home Manager, instructed all staff that had been working with (Resident A) over the past few days, that if his vital signs were fine, EMS did not need to be called. Diana Hannah stated Jate’a Patterson placed the calls to Melissa Skuse, Tiffany Priest, and the on-call nurse, and she indicated Jate’a Patterson handled voicemail/return-call issues. Diana Hannah stated that at shift handoff at approximately 11:00 PM on January 2, 2026, staff advised the oncoming shift that (Resident A) had been monitored throughout the night and needed continued close monitoring; she also stated staff felt he should have been taken to the hospital. Diana Hannah confirmed she told Tamea Williams that (Resident A) had been vomiting for two days and that staff had been taking vitals regularly*.’

Ms. Kuklewski’s report documented a phone interview on 01/28/2026 with Melissa Skuse, former home manager. The report documented the following information, *‘Melissa Skuse stated she was at Virginia’s home on January 2, 2026, between approximately 6:00 PM and 7:00 PM and stated she checked on (Resident A) briefly at that time and he appeared fine, and she stated she was ill and did not want to expose him. Melissa Skuse stated Ka’Tonica Hairston called her at approximately 8:00 PM and reported (Resident A) was throwing up. Melissa Skuse stated she instructed staff to elevate the head of (Resident A’s) bed, sit him up, take his vital signs, and call the HealthWest on-call nurse. Melissa Skuse stated she did not instruct staff to call 911 as she was told his vitals were fine and later sent a group message advising that any employee may call the on-call Nurse phone number before contacting her. Melissa Skuse stated she later learned the HealthWest on-call nurse did not answer the phone. Melissa Skuse stated Tiffany Priest, DCW contacted her on January 3, 2026, and reported third shift said (Resident A) needed*

to be monitored; however, Melissa Skuse stated Tiffany Priest told her (Resident A) was not sick and that his vital signs were "all OK." Melissa Skuse stated she was not present at the home on January 4, 2026, and was notified at approximately 3:00 AM on January 5, 2026, by Ka'Tonica Hairston that (Resident A) had passed away.'

Ms. Kuklewski's report documented an in-person interview on 01/29/2026 with Detective Sergeant, Pete Kutches, Muskegon Police Department**.** Ms. Kuklewski documented, **'***Detective Sergeant Pete Kutches stated that Detective Robert Kanaar was the detective who responded to Virginia's Home on January 05, 2026. Detective Sergeant Pete Kutches stated Detective Robert Kanaar spoke with the employee(s) on shift and the home manager at the time of the response. Based on Virginia's Home staffing documentation for January 05, 2026, the employee(s) on shift were Ka'Tonica Hairston and Lijehsha "Jay" Hannah, and the home manager was Melissa Skuse. Detective Sergeant Pete Kutches stated Detective Robert Kanaar did not believe foul play was involved. Detective Sergeant Pete Kutches stated Detective Robert Kanaar expressed concern that the staff's reported bed-check timeline was not consistent with when (Resident A) was found deceased and stated Detective Robert Kanaar believed (Resident A) may have been deceased for a longer period of time than staff reported. Detective Sergeant Pete Kutches stated the official time and cause of death had not yet been determined by the medical examiner.'*

Ms. Kuklewski's report documented email correspondence on 02/05/2026 with Angela Pouch, RN at Health West and a phone interview with Jessica Sobers, RN, clinical services supervisor, Health West. Ms. Pouch reported, *'I did not receive any calls on call, and I also looked through my voicemails on my regular work cell as I was in office Friday and don't have any voicemails on that phone.*' Ms. Sobers reported, *'she is part of the nursing on-call coverage and stated she did not receive any calls from Virginia's Home regarding (*Resident A) *during the overnight shift in the early morning hours of January 05, 2026.'*

On 03/10/2026, I interviewed Ms. Sobers, RN and she confirmed that no calls went through call logs from 01/02/2026-01/05/2026 while Resident A was reportedly ill. Ms. Sobers stated there has been no on-call nursing communication with this facility since January 2025. Ms. Sobers confirmed that Ms. Couch said she received no calls or missed calls from 01/02/2026 through 01/05/2026 from staff at this facility. Ms. Sobers stated Resident A's primary care physician was at the Integrated Health Clinic located at the Health West building. They have no after-hour nursing services and any communication they would have had with staff would have been input into the electronic charting system called EHR (electronic health record) and Ms. Sobers would be able to see it.

On 03/10/2026, I interviewed Resident A's court appointed guardian Ruth Burkert via telephone. Ms. Burkert stated she is no relation to Resident A and she has been his guardian for just under a year. Ms. Burkert stated she was not feeling well herself and saw Resident A via zoom on Friday, 01/02/2026 for his IPOS meeting. He seemed fine and greeted her in a cheerful manner. Ms. Burkert stated no one informed her that Resident A was ill and he did not appear to be ill during the zoom

meeting. Ms. Burkert stated she was “shocked” when the police knocked on her door. Ms. Burkert stated the police notified her of Resident A’s passing and did not provide any further information about his death. Ms. Burkert is still waiting to receive Resident A’s death certificate.

On 03/11/2026, I received a telephone call from Ms. Burkert. Ms. Burkert stated she contacted the funeral home and asked what Resident A’s death certificate documented as his cause of death. Ms. Burkert stated Resident A’s death certificate documented Resident A’s cause of death as hypertension, cardiovascular disease and possible secondary cause, bowel obstruction.

On 03/11/2026, I conducted an exit conference with Teresa Wendt, Licensee Designee via telephone. Ms. Wendt stated she understood the information, analysis, and conclusion of this rule. Ms. Wendt stated she understood and accepted the recommendation of a provisional license and will submit a corrective action plan.

APPLICABLE RULE	
R 400.689(3)	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	The complainant reported that Resident A died unexpectedly in the facility on 01/05/2026 and expressed concern regarding Resident A’s illness and lack of timely care. DCW’s Ms. Hairston, Ms. Priest and Ms. Patterson indicated that they were aware that Resident A was ill as early as 01/02/2026. They reportedly contacted the home manager, Ms. Skuse but did not contact on-call nursing. Ms. Kuklewski interviewed Ms. L. Hannah, Ms. D. Hannah and Ms. Skuse along with staff I interviewed, and all were aware that Resident A was ill on 01/02/2026 but no one called professional medical providers to seek assistance regarding Resident A’s continued illness. Ms. D. Hannah reported she attempted to contact on-call nursing on 01/02/2026 but got no answer. Ms. Sobers and Ms. Pouch reported they went back and reviewed all on-call telephone call logs received from 01/02/2026 through 01/05/2026 and did not receive any calls from facility staff regarding Resident A’s illness.

	Ms. Burkert stated she saw Resident A via zoom on 01/02/2026 and did not know Resident A was ill. Resident A did not act like he was ill, he did not say he was ill nor did anyone in the meeting report that he was ill. Muskegon Police Detective Kanaar expressed concern that staff's reported bed-check timeline was not consistent with when Resident A was found deceased and stated Resident A may have been deceased for a longer period of time than staff reported. Based on the investigative findings, there is a preponderance of evidence to show that on 01/02/2026, staff knew Resident A was ill and continued to be ill for days prior to his death on 01/05/2026. Over the course of those days no one sought professional health care services for Resident A. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

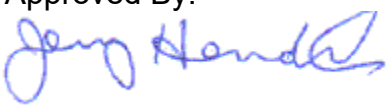
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license be changed to a six-month provisional license.

03/11/2026

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



03/11/2026

Jerry Hendrick — Date
Area Manager