GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 1, 2026

Sylvantious Jayaraman
Sylva Villas, L.L.C.
680 Larkspur Pl
St. Joseph, MI 49085

RE: License #: AM110383672
Investigation #: 2026A0790025
Sylva Villas 2

Dear Mr. Jayaraman:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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 (616) 356-0100.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
gillr@michigan.gov
(517) 980-1433

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
"THIS REPORT CONTAINS QUOTED PROFANITY"

I. IDENTIFYING INFORMATION

License #:	AM110383672
Investigation #:	2026A0790025
Complaint Receipt Date:	03/27/2026
Investigation Initiation Date:	03/30/2026
Report Due Date:	05/26/2026
Licensee Name:	Sylva Villas, L.L.C.
Licensee Address:	680 Larkspur Pl St. Joseph, MI 49085
Licensee Telephone #:	(269) 281-0428
Licensee Designee:	Sylvantious Jayaraman
Administrator:	Mohan Jayaraman
Name of Facility:	Sylva Villas 2
Facility Address:	8934 George Avenue Berrien Springs, MI 49103
Facility Telephone #:	(269) 473-1729
Original Issuance Date:	12/08/2016
License **Status:**	REGULAR
Effective Date:	05/29/2024
Expiration Date:	05/28/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member is giving Resident A another resident's medication.	No
The residents are not receiving nutritious meals.	No
Additional Findings	Yes

III. METHODOLOGY

03/27/2026	Special Investigation Intake 2026A0790025
03/27/2026	APS Referral is not necessary because the allegations do not meet assignment criteria for Adult Protective Services (APS). The allegations pertain to licensing rule violations and not abuse or neglect of a vulnerable adult.
03/30/2026	Special Investigation Initiated - On Site I interviewed Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, and direct care staff members (DCSMs) Matthew Mamesah and Presley Prabhu.
03/30/2026	Inspection Completed On-site
03/31/2026	Exit Conference / Interview with licensee designee Sylvantious Jayaraman.
04/01/2026	Inspection Completed-BCAL Sub. Compliance
04/01/2026	Corrective Action Plan Requested and Due on 04/16/2026

ALLEGATION:

Direct care staff member is giving Resident A another resident's medication.

INVESTIGATION:

On 3/27/26, I reviewed a Michigan Department of Licensing and Regulatory Affairs (LARA) – Bureau of Community and Health Systems (BCHS) Online Complaint

Form dated 3/27/26. The complaint indicated that the Office of Recipient Rights received the following complaint. The complaint indicated that Resident A disclosed sometimes one of the direct care staff members (DCSMs) Name Unknown gives him another resident's medication. Resident A had no additional information regarding this allegation and stated it was okay that he received another resident's medication. Resident A disclosed that only the one DCSM gives him the wrong medication.

The complaint indicated that case manager Isabella Pinto from Riverwood Center was visiting Resident A at the facility and witnessed a DCSM Name Unknown bring Resident A's medication box up and ask where they can refill one of his medical supplies. The DCSM stated they called Genoa Pharmacy and they could not refill it. The medical supply was allegedly testing strips for diabetes.

On 3/30/26, I conducted an unannounced onsite investigation. I interviewed Resident A. Resident A said he was admitted to the facility in 10/24.

Resident A stated that certain DCSMs will give him the wrong medication. He said they give him another resident's medication, and it happens a lot. Resident A did not know the DCSMs' names that give him the wrong medication but said it last happened on 3/28/26. He said he believes the DCSMs that give him the wrong medication are Timothy Last Name Unknown, Mr. K, and Emmanuel Last Name Unknown. Resident A stated that one time when Emmanuel Last Name Unknown was giving him another resident's medications, he told Resident A he was giving him "shit to pop his heart".

I asked Resident A how he knows several of the DCSMs are giving him another Resident's medication and he said because DCSM Timothy Last Name Unknown told him he gave him someone else's medication. Resident A had no additional information or evidence indicating or proving he has been receiving the wrong medication.

I interviewed DCSM Matthew Mamesah. Mr. Mamesah stated that he has worked at the AFC facility for approximately six months. He said that he has been trained in medication administration and is in the process of learning how to administer medications. Mr. Mamesah stated that he does not currently administer medications when on shift. He said he is not aware of any medication errors involving Resident A. Mr. Mamesah stated he has never heard that Resident A received someone else's medications and believes he would have been told or would have found out if medical error of this magnitude occurred.

I interviewed DCSM Presley Prabhu. Mr. Prabhu said he has worked at the facility since 2019. Mr. Prabhu stated he administers the residents' medications when he is

on shift. Mr. Prabhu disclosed that he administers medications one resident at a time.

Mr. Prabhu denied he has ever made a medication error when administering Resident A's medication. He said he has no knowledge of any of the other DCSMs giving Resident A another resident's medication either on purpose or accidentally. Mr. Prabhu said it would be difficult to make an error when administering Resident A's medications given that all his oral medications are in a blister pack.

Mr. Prabhu allowed me to review Resident A's *Medication Administration Record (MAR)* and compare his prescribed medications to the medications available for him at the facility. I found that all of Resident A's oral medications are delivered in a blister pack or bubble pack. I found all of Resident A's prescribed medications to be available at the facility. I found Resident A's *MAR* to be accurate and that DCSMs had appropriately initialed when giving Resident A his prescribed medications.

I found no evidence indicating that Resident A received another resident's medication. I found that it would be difficult for a DCSM to accidentally administer another resident's medication to Resident A.

On 3/31/26, I conducted an interview / exit conference with licensee designee Sylvantious Jayaraman. Mr. Jayaraman said he is not aware of any medication errors involving Resident A.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was insufficient evidence found indicating that a direct care staff member was giving Resident A another resident's medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The residents are not receiving nutritious meals.

INVESTIGATION:

The complaint indicated that the residents at the facility complain about the food. The residents disclosed they have been eating pizza for breakfast, pizza for days in a row, and other non-nutritious meals. The residents reported there are never any vegetables or fruits, and the majority of the food is frozen and bad for them.

Resident A said they get three meals a day but the food they are served is "garbage". He said they purchase the food on Sundays and by Wednesday the milk they bought is expired.

Resident A said all they get to eat is pizza and baked chicken. He stated that the only meat they get to eat is chicken, chicken, chicken. Resident A complained that the DCSMs always boil the chicken and it is disgusting. Resident A said they get fruits and vegetables, but they are all spoiled.

I interviewed Resident B, Resident C, Resident D, Resident E, and Resident F. Resident B, Resident C, Resident D, Resident E, and Resident F all complained about the meals they are served. They all explained that the quality of the food they receive has gone downhill. Resident B, Resident C, Resident D, Resident E, and Resident F all indicated that they get fruits and vegetables but that the fruits and vegetables are often expired and/or rotten.

Resident B, Resident C, Resident D, Resident E, and Resident F also complained that the majority of the time the only protein they receive is chicken and indicated the DCSMs always are boiling the chicken and indicated it is disgusting.

Mr. Mamesah said he does not believe that the food at the facility is not good or not healthy for the residents. He stated he often prepares meals when he is working and follows the menu. Ms. Mamesah said he will negotiate with the residents if they do not want to eat what is on the menu. He stated if he deviates from the regular

menu and fixes something for a meal other than what is listed on the weekly menu that he will write in what he substituted for the regular meal on the menu.

Mr. Mamesah stated that he has never witnessed any expired or spoiled food served to the residents.

Mr. Mamesah said when he works the residents do not only get chicken for their protein. He stated that he has cooked beef, sausage, bacon, and other meats for the residents as well as chicken.

Mr. Prabhu said he does not believe that the food served to the residents is not good. Mr. Prabhu stated that he has never witnessed any expired or spoiled food served to the residents.

Mr. Prabhu said when he works the residents do not only get chicken for their protein. He stated that he has witnessed the residents eating beef, sausage, bacon, and other meats for their protein as well as chicken.

On 3/30/26, I inspected all of the refrigerators, freezers, and food pantries. The refrigerators, freezers, and food pantries were observed to be clean and well organized. There was a sizable amount of beef, chicken, sausage, pizzas, fruits, vegetables, eggs, milk, and other various foods.

I checked the expiration dates on much of the food. I specifically checked the expiration dates on all of the fresh fruit and vegetable labels. I also checked the expiration dates on the plastic milk jugs. I found nothing to be expired. The fresh fruits and vegetables looked crisp, healthy, and appropriate to consume.

The amount and variation of food in the home was adequate to meet the nutritional allowances recommended by the United States Department of Agriculture and the United States Department of Health and Human Services in the Dietary Guidelines for Americans (DGA), 2020-2025.

I reviewed a weekly menu posted on the refrigerator located in the kitchen and found that the meals prepared by the DCSMs meet the nutritional allowances recommended by the United States Department of Agriculture and the United States Department of Health and Human Services in the Dietary Guidelines for Americans (DGA), 2020-2025.

Mr. Jayaraman said they pride themselves on serving better food to their residents than other AFC facilities. He stated that he is not aware of residents ever receiving expired or spoiled food or milk. Mr. Jayaraman said he could assure me that the residents receive a variety of proteins and not just chicken.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was insufficient evidence found indicating that the residents are not receiving a minimum of three nutritious meals a day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(4) Meals must meet the nutritional allowances recommended by the United States Department of Agriculture and the United States Department of Health and Human Services in the Dietary Guidelines for Americans (DGA), 2020-2025. The Dietary Guidelines for Americans 2020-2025 are adopted by reference and available to be viewed or downloaded from the U.S. Department of Agriculture and the U.S. Department of Health and Human Services at https://www.dietaryguidelines.gov at no cost at the time of adoption of these rules. A copy of these guidelines is available for inspection and distribution from the Bureau of Community and Health Services, Department of Licensing and Regulatory Affairs, at 611 West Ottawa Street, P.O. Box 30664, Lansing, Michigan 48909 at a cost of 15 cents per page as of the time of the adoption of these rules.

ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was insufficient evidence found indicating that the meals served at Sylva Villas 2 do not meet the nutritional allowances recommended by the United States Department of Agriculture and the United States Department of Health and Human Services in the Dietary Guidelines for Americans (DGA), 2020-2025.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A showed me trash and debris stored in a dilapidated shed located in the backyard and some furniture including a mattress laden with mold and mildew piled up in the back and on the left side of the AFC facility. Resident A said he sees raccoons in and around the shed often.

On 3/30/26, I observed a dilapidated shed in the backyard full of trash and debris. There was drywall and other contents in the shed covered in mold and mildew.

There was trash and debris piled up on the left side of the home as you are looking at the facility. The trash and debris included filthy mattresses, a bathroom sink, pieces of drywall, plywood, wood trim, a broken folding chair, etc. The trash and debris was covered with mold and mildew.

Mr. Jayaraman did not explain the reason for the trash and debris located in the dilapidated shed in the backyard and on the left side of the facility as you face it from the street.

I informed Mr. Jayaraman of the additional concerns. I informed him of the health and safety concerns on the exterior of the facility including the trash and debris in the dilapidated shed in the backyard and left side of the facility.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(16) Yard areas must be kept reasonably free from hazards, nuisances, refuse, and litter.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was sufficient evidence found indicating that yard areas were not kept reasonably free from hazards, nuisances, refuse, and litter.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A disclosed that the sewer is backed up. Resident A showed me a large puddle in the front yard on the left side of the AFC facility that looked and smelled like it could have been the result of a sewer back up.

Resident A showed me a second fairly large puddle in the backyard of the AFC facility that was undeniably filled with septic waste.

Resident B, Resident C, Resident D, Resident E, and Resident F all disclosed that there has been a sewer leak, and the toilets have backed up. They indicated that the sewer had been backing up causing the toilets to clog and a pooling of raw sewage in both the front and back yards.

Mr. Mamesah said they have had issues with the septic system and the toilets backing up. He stated he believes it is a result of the cold winter and things possibly freezing up.

Mr. Prabhu said they have had issues with the septic system and the toilets backing up at the facility. He stated he believes it is a result of the cold winter and things possibly freezing up.

On 3/30/36, I inspected the outside of the AFC facility. I observed a puddle on the left side of the property as you are looking at the facility that appeared to contain septic waste and observed the contents of the puddle running down and pooling at

the edge of the driveway. I observed a second puddle in the backyard of the facility that was clearly full of septic waste.

Mr. Jayaraman admitted that they have been having issues with their septic system since the weather has gotten warmer. He said he has had a septic specialist come out to complete an inspection to find out what was going on. Mr. Jayaraman said the specialist found a couple of issues one of which was that a resident had inadvertently unplugged the septic pump which was located in the outside patio area where the residents smoke.

Mr. Jayaraman stated that they have two septic tanks for the facility and have them pumped out every six months.

I informed Mr. Jayaraman of the additional concerns. I informed him of the health and safety concerns on the exterior of the facility including the pooling of raw sewage in both the front and back yards.

On 3/31/26, I reviewed an Environmental Health Inspection (EHI) Report for Sylva Vilas 2 from the Berrien County Health Department dated 1/21/26. The report indicated that on 1/21/26, the facility was determined to be in substantial compliance with applicable rules.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(6) Plumbing fixtures and water and waste pipes must be properly installed and maintained in good working condition.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was sufficient evidence found indicating that water and waste pipes were not maintained in good working condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A led me into an outdoor patio area where the residents smoke and pointed out exposed wires on the ceiling.

Resident B, Resident C, Resident D, Resident E, and Resident F all complained about there being exposed wires in the outdoor patio area located in the back of the AFC facility where they smoke.

On 3/30/26, I observed exposed wires on the ceiling of an attached outdoor patio area located in the back of the facility where the residents sit and smoke.

Mr. Jayaraman said he was not aware of any exposed wires in the outdoor patio area located in the back of the facility where the residents smoke.

I informed Mr. Jayaraman of the additional concerns. I informed him of the health and safety concerns on the exterior of the facility including the exposed wires on the ceiling of the outdoor patio area where the residents smoke.

APPLICABLE RULE	
R 400.649	**Electrical service.**
	Electrical service must be maintained in a safe condition. Where conditions indicate a need for inspection, and on all new or remodeled projects, the electrical service must be inspected by a qualified electrical inspection service, and a copy of the inspection report must be maintained for 2 years.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was sufficient evidence found indicating that electric service was not maintained in a safe condition as exposed wires were observed in the outdoor patio area located in the back of the facility where the residents smoke.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A indicated that the AFC facility is filthy. Resident A said the DCSMs never clean and when they do they use a dirty mop and water that have been sitting in the mop bucket forever. Resident A said there is also a foul odor in the AFC facility.

Resident A said there is a mattress in the dining room currently that may have bedbugs on it. He stated that they recently had bedbugs in the home and the home was professionally treated by a pest control specialist.

Resident B, Resident C, Resident D, Resident E, and Resident F indicated that the AFC facility is filthy. Resident B, Resident C, Resident D, Resident E, and Resident F all stated that the DCSMs seldom clean and when they do they use the same mop and bucket of water for weeks at a time and the mop and water are black and filthy.

Resident B, Resident C, Resident D, Resident E, and Resident F all indicated that they recently had a bedbug infestation and that the licensee had the home professionally treated.

Mr. Mamesah stated that he cleans when he is working at the facility.

Mr. Mamesah stated that they did recently have bedbugs at the facility. He said the licensee had the facility professionally treated to ensure they indeed got rid of the bedbugs.

Mr. Prabhu stated that he cleans when he is working at the facility.

Mr. Prabhu stated that they did recently have bedbugs at the facility. He said the licensee had the facility professionally treated to ensure they indeed got rid of the bedbugs.

On 3/30/26, I inspected the inside of the facility. Mr. Mamesah accompanied and assisted me while I completed the inspection. I noticed a foul odor upon entering the

facility. The odor appeared to be coming from an electric sweeper located behind a closet door in the front room.

I observed the floors throughout the facility to be dirty but in good condition.

I observed what appeared to be a layer of filth and scum in the facility's two showers. I also observed what appeared to be mold and mildew in the showers and on the walls and ceiling above both showers.

I observed the residents' rooms and found them to be adequately clean and organized.

I observed a mattress in the front dining area. I was informed by Mr. Mamesah that it was Resident G's mattress, and he was cleaning his room.

I observed Resident G in his room, and he said he was willing to speak with me. I interviewed Resident G. Resident G explained that his bedframe was broken and he needed a new one. He said he was removing the old bed frame and cleaning and organizing his room in the process. Resident G denied there were any bedbugs on his mattress or in his room. Resident G's room appeared clean and relatively organized even as he was removing the bed frame.

I observed the toilets in both of the facility bathrooms to be clean and in good working order.

I observed a mop sitting in a mop bucket located by a rear entrance into the facility. The mop itself was filthy, black in color, and full of all type of trash and debris. The water in the mop bucket was also black, filled with all type of trash and debris, and appeared not to have been changed or cleaned out in quite some time.

I observed the kitchen counters and cabinets to be clean and well organized.

I inspected all of the refrigerators, freezers, and food pantries. The refrigerators, freezers, and food pantries were observed to be clean and well organized.

I informed Mr. Jayaraman of the health and safety concerns inside the facility. I informed him that the floors were found to be filthy and that a layer of filth and scum was found in both of the facility's showers, and also what appeared to be mold and mildew in both showers and on the walls and ceiling above the showers.

I informed Mr. Jayaraman of the filthy cleaning equipment I observed and the foul odors.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was sufficient evidence found indicating that the housekeeping standards did not present a clean appearance.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(5) Floors, walls, and ceilings must be cleanable, maintained clean, and in good repair.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was sufficient evidence found indicating that the floors were not maintained clean, nor were the walls and ceilings above the two facility showers.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F all complained that they only get one towel and can only wash their clothing once a week. They indicated that their one towel gets very dirty before they are allowed to

wash it. They complained there are never clean towels, washcloths, or paper towels for their use at the facility.

During my inspection on 3/30/26, Mr. Prabhu showed me where they store the towels, wash clothes, and linens. I could only find two clean wash clothes in the entire facility. I did not find any clean towels or paper towels during the inspection.

I observed a laundry schedule posted on a cabinet located in the living room. The schedule indicated that the residents in each room are able to wash their clothes one time per week on their specified day of the week.

I informed Mr. Jayaraman of no clean towels, washcloths, or paper towels observed in either of the two bathrooms and only two clean wash clothes found when I had conducted the unannounced onsite investigation.

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following: **(c) Bath towels and washcloths.**
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was sufficient evidence found indicating that the licensee did not provide an adequate amount of clean bath towels or washcloths.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.669	**Linens.**
	(2) Bed linens must be changed and laundered at least once a week and towels and washcloths changed and laundered not less than twice weekly or more often if soiled.

ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G, DCSMs Mr. Mamesah, Mr. Prabhu, and licensee designee Mr. Jayaraman there was sufficient evidence found indicating that towels and washcloths were not being changed and laundered not less than twice weekly or more often if soiled.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/31/26, I conducted an exit conference via phone with licensee designee Sylvantious Jayaraman. Mr. Jayaraman was informed of the outcome of this special investigation and did not dispute the findings. Mr. Jayaraman agreed to complete an acceptable Corrective Action Plan (CAP) within the required timeframe.

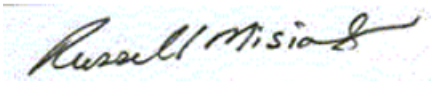
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

4/1/26

Rodney Gill Date
Licensing Consultant

Approved By:



4/2/26

Russell B. Misiak Date
Area Manager