



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 27, 2026

Nicholas Burnett
Flatrock Manor, Inc.
310 W. Oakley
Flint, MI 48503

RE: License #: AS630419190
Investigation #: 2026A0612024
Whistle Stop

Dear Mr. Burnett:

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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Johnna Cade". The signature is written in black ink and is positioned below the word "Sincerely,".

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630419190
Investigation #:	2026A0612024
Complaint Receipt Date:	05/13/2026
Investigation Initiation Date:	05/13/2026
Report Due Date:	07/12/2026
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	310 W. Oakley St. Flint, MI 48503
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldrich
Licensee Designee:	Nicholas Burnett
Name of Facility:	Whistle Stop
Facility Address:	2400 Whistle Stop Ln Holly, MI 48442
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	07/09/2025
License Status:	REGULAR
Effective Date:	01/09/2026
Expiration Date:	01/08/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
<ul style="list-style-type: none"> • Resident A cannot leave the home until she completes unknown tasks. • On an unknown date, Resident A cut herself. Resident A should not have access to sharp objects. 	No
Resident A's PRN medication is not being administered as prescribed.	No
Whistle Stop does not have a working telephone.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/13/2026	Special Investigation Intake 2026A0612024
05/13/2026	APS Referral Referral received from Adult Protective Services (APS). APS denied the referral for investigation.
05/13/2026	Special Investigation Initiated - Letter Email sent to Oakland Community Health Network - Office of Recipient Rights.
05/18/2026	Inspection Completed On-site I completed an unscheduled onsite inspection. I interviewed Resident A, office administrator Sierra Weatherspoon, direct care staff Dearea Holmes, and direct care staff Dearea Holmes and 1st shift manager Mackenzy Hosey.
05/18/2026	Contact - Document Received I received and reviewed a copy of Resident A's treatment plan from Flatrock sent via email from office administrator Sierra Weatherspoon.
05/18/2026	Contact - Document Received I reviewed a photo of a cut on the top of Resident A's head provided by direct care staff Dearea Holmes.

05/21/2026	Contact - Document Received Resident A's May 2026 inclusion logs and May 2026 Incident Reports received via email from home manager Gavin Sukup.
05/22/2026	Contact – Telephone call made Telephone interview completed with Health Care Manager Tiffany Ellis.
05/22/2026	Exit Conference I placed a telephone call to administrator Carrie Aldrich to conduct an exit conference. There was no answer. I left a voicemail requesting a return call.
05/26/2026	Exit Conference I placed a telephone call to administrator Carrie Aldrich to conduct an exit conference. There was no answer. I left a voicemail requesting a return call.
05/27/2026	Exit Conference I completed a telephone interview with licensee designee Nicholas Burnett and administrator Carrie Aldrich to conduct an exit conference and review my findings.

ALLEGATION:

- **Resident A cannot leave the home until she completes unknown tasks.**
- **On an unknown date, Resident A cut herself. Resident A should not have access to sharp objects.**

INVESTIGATION:

On 05/13/26, I received a referral for Adult Protective Services (APS). APS denied the referral for investigation. In summary, the referral indicates Resident A resides at Whistle Stop. For unknown reasons, there is no phone at Whistle Stop that Resident A can use to contact family members. The only time Resident A can use a phone to contact anyone outside of Whistle Stop is when a staff member allows her to use their personal cell phones. The staff at Whistle Stop refuse to allow Resident A to leave the home until she completes unknown tasks. Recently, on an unknown date, Resident A cut herself. It is unknown what she cut herself with, where on her body she cut herself, and/or if it was intentional or unintentional. Resident A is reported to have issues with swallowing foreign objects and should not have access to any sharp objects. It is unknown if Resident A required any medical treatment after she was cut. Resident A is supposed to receive PRN medication but the staff at Whistle Stop do not ensure she

receives it as prescribed. The name of the medication is unknown. Why the medication is prescribed is also unknown.

On 05/13/26, I initiated my investigation by contacting Oakland Community Health Network – Office of Recipient Rights to determine if Resident A receives services within their network. It was determined that Resident A receives community mental health services from Health West – Muskegon.

On 05/18/26, I completed an unscheduled onsite investigation. I interviewed Resident A, office administrator Sierra Weatherspoon, direct care staff Dearea Holmes, and direct care staff Deshawn Douglas. While onsite I also interviewed 1st shift manager Mackenzy Hosey via telephone.

On 05/18/26, I interviewed Resident A. Resident A stated last week she carved the letter “J” in her arm using a piece of a broken CD that she had in her bedroom. Resident A stated she received first aid for the cut. Resident A stated she used the same object to cut the top of her head. Resident A stated she took the CD from the sensory room. It belonged to another resident. Resident A stated although the door on the sensory room has a lock with keypad entry, she knows how to unlock the door which she did to obtain the CD that she used to cut herself.

While onsite Resident A showed this licensing consultant how she gained access into the sensory room despite the door having an automatic self-closing device and a keypad entry. Resident A demonstrated that if the door is unlocked from the inside of the room when the door is closed if you pull up on the door handle (as opposed to pulling down as it is intended to function) the door will unlock.

Resident A stated on an unknown date a staff told her that she could not go into the community unless she showered and behaved. Resident A was unable to provide a name of the staff or when this occurred.

On 05/18/26, I interviewed office administrator Sierra Weatherspoon. Ms. Weatherspoon chose to call 1st shift manager Mackenzy Hosey and have her present via telephone. Ms. Weatherspoon indicated that Ms. Hosey is more aware of the day-to-day happenings of this home. As such, I interviewed Ms. Weatherspoon and Ms. Hosey together. Ms. Weatherspoon and Ms. Hosey consistently stated Resident A consistently displays hospital seeking behaviors including self-injurious behaviors and swallowing foreign objects. Resident A has been hospitalized several times recently due to self-harm. Resident A enjoys going to the hospital and sometimes she will make false allegations about swallowing objects to get to the hospital. Resident A does not have access to sharps however she will use her fingernails to self-harm. If the cut requires first aid, she will refuse first aid in the home in an effort to be sent to the hospital.

Ms. Weatherspoon and Ms. Hosey consistently stated Whistle Stop is a locked facility. Resident A does not have independent community access, and she must be accompanied by staff while in the community. Whistle Stop has eight staff on first shift,

eight staff on second shift, and seven staff on the midnight shift. If Resident A requests to go outside staff will accompany her. Resident A has the opportunity to attend daily group outings and a personal outing once a week. Additionally, the residents can attend Oakley Monday – Saturday where the provider, Flatrock, offers activities for all residents in a club house type setting. Prior to outings in the community Resident A is prompted by staff to shower, put on clean clothes, and if necessary, clean up her room. Ms. Weatherspoon and Ms. Hosey consistently stated if Resident A refuses to do any of these tasks she is still able to go into the community. Flatrock also offers a token program where residents can earn up to 12 tokens a day for completing tasks such as activities of daily living (ADL's) or household chores such as washing dishes or cleaning their bedrooms. Residents are encouraged to participate in these activities however their community access is not restricted/ denied if they choose not to.

On 05/18/26, I interviewed direct care staff Dearea Holmes. Mr. Holmes stated on 05/09/26 he worked the morning shift. When he arrived at 7:00 am he was informed that Resident A was cutting her arm during the midnight shift. She used a plastic wrapper from a piece of nicotine gum that she found to cut herself. Then during the morning shift Resident A cut her head. Her bedroom was searched and it was discovered that Resident A was cutting herself using a piece of a broken CD belonging to another resident. Mr. Holmes stated he took pictures of the cut on Resident A's head and informed the weekend manager, Nadia Clark. Resident A was taken to the hospital. An incident report was completed.

Mr. Holmes stated Resident A has the option to attend group outings in the community daily and a one-on-one outing weekly. Prior to going into the community staff prompt Resident A to shower and get dressed. Mr. Holmes stated if Resident A chooses not to shower or put on clothes, she is not denied the ability to go into the community.

On 05/18/26, I interviewed direct care staff Deshawn Douglas. Mr. Douglas stated Resident A has self-injurious behavior. Resident A does not have access to sharps, sometimes she will use her fingernails to scratch her arms. Mr. Douglas stated, when he arrived at work on 05/14/26, he observed that the day before, Resident A scratched the letter "J" into her arm. Mr. Douglas does not know what Resident A used to do this. Mr. Douglas stated he believes Resident A was sent to the hospital because of this.

Mr. Douglas stated Resident A has the option to attend group outings in the community daily and a one-on-one outing weekly. Prior to going into the community staff prompt Resident A to shower and get dressed. Mr. Douglas stated if Resident A chooses not to shower or put on clothes, she is not denied the ability to go into the community. Mr. Douglas stated there have been times Resident A refuses to shower and she has still gone into the community.

On 05/18/26, I reviewed a photo of a cut on the top of Resident A's head. The picture was taken on 05/09/26 by direct care staff Dearea Holmes.

On 05/18/26, I received and reviewed a copy of Resident A's Behavioral Treatment Plan from Flatrock, dated 11/07/2025. The plan notes Resident A frequently engages in self-injurious and crisis behaviors, including inserting (vagina; belly button; under eyelids; and ear), cutting, wound picking, and banging head against hard objects, and swallowing foreign objects. Historically, Resident A's self-injurious behaviors are often attention-seeking and linked to manipulating home visits, especially with her mother. Behavior typically subsides once visits are scheduled. Because of the frequency and severity of Resident A's self-injurious behavior, physical aggression, and crisis generating behavior, the following restrictions are in place: locked/alarmed windows and delayed egress on exit doors, community supervision, locked laundry, restriction of personal property (self-harm items) with scheduled search and seizures, restricted access to peer's personal rooms, and PRN medication. Because of the strong potential for harm to herself and others, these restrictions are needed to maximize safety.

On 05/24/26, I received and reviewed Resident A's May 2026 inclusion logs which summarizes Resident A's community outings. The logs note that from 05/01/26 - 05/18/26, Resident A went into the community on the following dates: 05/01/26, 05/02/26, 05/04/26, and 05/05/26. The log notes on several days that Resident A refused the activity or she was asleep in bed.

On 05/24/26, I received and reviewed Resident A's Incident Reports (IR's) from 05/01/26 – 05/18/26. The following was noted:

- On 05/06/26, Resident A reportedly swallowed a piece of metal. Resident A was taken to the hospital. X-ray showed no findings of a foreign body.
- On 05/09/26 Resident A was taken to the hospital due to eye pain. She was diagnosed with a cornea abrasion.
- On 05/09/26 Resident A put a bead and toilet paper in her ear. She was taken to the hospital and the bead was removed.
- On 05/11/26, Resident A reportedly swallowed a pen cap. Resident A was taken to the hospital. X-ray showed no findings of a foreign body. Resident A was admitted for observation.
- On 05/12/26, Resident A made verbal threats to go into her bedroom and "swallow" a search and seizure of her bedroom was completed.
- On 05/13/26, Resident A swallowed a battery. Resident A was taken to the hospital. X ray showed an object in her stomach, not a battery. Resident A was admitted.
- On 05/13/26, Resident A refused to attend her telehealth appointment.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	<p>Based upon the information gathered during this investigation there is insufficient information to conclude that Resident A is not receiving supervision, protection, and personal care as specified in her behavioral treatment plan.</p> <p>Although Resident A reported that on an unknown date an unknown staff told her that she could not go into the community unless she showered and behaved all staff interviewed consistently reported that Resident A is prompted to shower and put on clothes to go into the community however, if she chooses not to her community access is not restricted/denied.</p> <p>Resident A engages in self-injurious behavior; this is thoroughly documented in her Behavioral Treatment Plan and in Incident Reports. Because of the strong potential for harm to herself and others, there are restrictions in place to maximize Resident A's safety. Although these restrictions significantly reduce instances of self-harm, they do not fully eliminate such behavior. Resident A has a history of using everyday household items and/or her fingernails to self-harm however, there were no reports of Resident A having access to sharps in which she used to harm herself.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A's PRN medication is not being administered as prescribed.

INVESTIGATION:

The referral also alleged that Resident A is supposed to receive PRN medication but the staff at Whistle Stop do not ensure she receives it as prescribed. The name of the medication is unknown. Why the medication is prescribed is also unknown.

On 05/18/26, I completed an unscheduled onsite investigation. I interviewed Resident A, office administrator Sierra Weatherspoon, direct care staff Dearea Holmes, and direct care staff Deshawn Douglas. While onsite I also interviewed 1st shift manager Mackenzy Hosey via telephone.

While onsite I observed the facilities medication room. The residents' medications are kept in a locked medication cart. The facility uses an electronic medication record. I observed direct care staff Dearea Holmes complete a medication pass. Mr. Holmes administered 4mg nicotine gum to Resident A. Mr. Holmes conducted the medication pass sufficiently. I observed Resident A's physical medications on hand and Resident A's medication administration record. Resident A is prescribed three PRN medications:

1. *Nicotine gum 4 mg* – chew one piece of gum every 4 hours as needed
2. *Olanzapine 10 mg* – take 1 tablet by mouth daily as needed
3. *Epinephrine inj 0.3 mg* – inject 0/3 mg intramuscular as needed for bee stings

Per the May 2026 medication administration record Resident A uses nicotine gum regularly. There is no documented use of the Epinephrine injection. Olanzapine 10 mg was administered to Resident A on 05/09/26.

On 05/19/26, I interviewed Resident A. Resident A stated she is not getting her PRN medication that helps her calm down. Resident A cannot recall the name of this medication but described it as a small round yellow pill (later determined to be Olanzapine.) Resident A stated a few weeks ago she asked a staff for this medication because she felt like hurting herself and they said no because they were busy on the floor or on their phone. Resident A could not recall the name of this staff person or provide a description of what they look like. Resident A stated she asked for this medication again "the other day" and it was given to her.

On 05/18/26, I interviewed office administrator Sierra Weatherspoon and 1st shift manager Mackenzy Hosey together. Ms. Weatherspoon and Ms. Hosey consistently stated Resident A's PRN medications are administered as they are prescribed. The home recently obtained a new medication coordinator who oversees resident medications.

On 05/18/26, I interviewed direct care staff Dearea Holmes. Mr. Holmes stated Resident A's PRN medications are administered as they are prescribed. Mr. Holmes stated Resident A typically only asks for nicotine gum. Mr. Holmes stated Resident A has not asked him for any of her other PRN medications. Mr. Holmes has no concerns that any other staff are not administering Resident A's PRN medications as they are prescribed.

On 05/18/26, I interviewed direct care staff Deshawn Douglas. Mr. Douglas stated Resident A's PRN medications are always administered to her as they are prescribed. Mr. Douglas stated Resident A usually only request nicotine gum. Mr. Douglas stated Resident A has a PRN medication to calm her down (Olanzapine) however, she has never requested this medication from him. Mr. Douglas has no concerns that any other staff are not administering Resident A's PRN medications as they are prescribed

I received and reviewed a copy of Resident A's Behavior Treatment Plan from Flatrock, dated 11/07/2025. The plan notes at times Resident A experiences anxiety or has agitation that requires PRN medication. Utilization of PRN is determined as a last resort after all medical reasons have been ruled out and other strategies and interventions have been deemed unsuccessful (such as utilization of proactive and reactive strategies and coping skills); or Resident A requests her PRN medication due to self-reported agitation, depression, anxiety, psychiatric symptoms, or behavioral concerns. PRN medication shall be administered per doctor's written order. Prescribing doctor will monitor medication(s) for optimum functioning, being prescribed to address specific diagnosis consistent with DSM 5 and will address titration of medication.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	<p>Based upon the information gathered during this investigation there is insufficient information to conclude that Resident A's medications are not being given to her as they are prescribed.</p> <p>Resident A is prescribed three PRN medications: Nicotine gum 4 mg, Olanzapine 10 mg and Epinephrine inj 0.3 mg. Per the May 2026 medication administration record Resident A uses nicotine gum regularly. There is no documented use of the Epinephrine injection. Olanzapine 10 mg was administered to Resident A on 05/09/26. Although Resident A reported an incident of a staff not giving her Olanzapine as she requested, she was unable to provide any additional details such as the date of the alleged incident and/or a staff person's name. Direct care staff Deshawn Douglas and Dearea Holmes consistently reported Resident A does not request Olanzapine. Furthermore, Resident A's Behavior Treatment Plan indicates PRN medication should be used as a last resort or if Resident A requests her PRN medication.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Whistle Stop does not have a working telephone.

INVESTIGATION:

The referral also alleged for unknown reasons, there is no phone at Whistle Stop that Resident A can use to contact family members. The only time Resident A can use a phone to contact anyone outside of Whistle Stop is when a staff member allows her to use their personal cell phones.

On 05/18/26, I completed an unscheduled onsite investigation. I interviewed Resident A, office administrator Sierra Weatherspoon, direct care staff Dearea Holmes, and direct care staff Deshawn Douglas. While onsite I also interviewed 1st shift manager Mackenzy Hosey via telephone. While onsite I observed that the homes' telephones were broken/ inoperable. There were two telephones locked in the medication room. One was in a closet unable to be accessed. The staff on shift Dearea Holmes was unable to open the closet door to get to the phone. The other telephone was on a shelf; it appeared to be missing wires in the back of the phone. Although the telephone rings when receiving a call you cannot answer/ accept the incoming call. You cannot make outgoing calls on the telephone.

On 05/19/26, I interviewed Resident A. Resident A stated she tore the cord out of the telephone that was in the living room about a month ago. Since then, the home has not had a telephone. Resident A stated the only way that she can talk on the phone is if a staff lets her use their cell phone.

On 05/18/26, I interviewed direct care staff Deshawn Douglas. Mr. Douglas stated on or around 05/09/26, Resident A swallowed the batteries from the telephone. He was not on shift when this occurred, however, he did hear about the incident. Mr. Douglas stated Resident A was taken to the hospital following this incident. Mr. Douglas stated the home has not had a telephone since. Mr. Douglas stated he does not allow residents to use his cell phone for personal calls.

On 05/18/26, I interviewed direct care staff Dearea Holmes. Mr. Holmes stated the home phone is usually on the charger in the kitchen. Mr. Holmes stated he does not allow residents to use his cell phone for personal calls. At the time of the onsite inspection Mr. Holmes observed and acknowledged that the home phone was locked in the medication room and inoperable. Mr. Holmes was not aware of why the phone was locked away/not working.

On 05/18/26, I interviewed office administrator Sierra Weatherspoon and 1st shift manager Mackenzy Hosey together. Ms. Weatherspoon and Ms. Hosey consistently stated the home has a telephone for resident use. There is no need for Resident A to use a staff's personal cell phone. Ms. Hosey stated Resident A likes to talk to her mom on the phone. The home does not document resident phone calls unless the need is specified in their assessment plan.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.

	<p>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</p> <p>(e) Have reasonable access to a telephone for private communications, but a licensee may charge a resident for the cost of long-distance telephone calls.</p>
ANALYSIS:	<p>Based upon the information gathered during this investigation there is sufficient information to conclude that Resident A does not have reasonable access to a telephone. During the unscheduled onsite inspection completed on 05/18/26, I observed that the home telephone was broken/ inoperable. There were two telephones locked in the medication room. One was in a closet unable to be accessed. The staff on shift was unable to open the closet door to get to the phone. The other telephone was on a shelf; it appeared to be missing wires in the back of the phone. Although the telephone rings when receiving a call you cannot answer/ accept the incoming call. You cannot make outgoing calls on the telephone. Resident A and direct care staff Deshawn Douglas stated that Resident A broke the telephone, and the home has not had a telephone since.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/18/26, I completed an unscheduled onsite investigation. I observed that Resident A is prescribed Olanzapine 10 mg – take 1 tablet by mouth daily as needed. The bubble pack on hand was delivered on 05/01/26. There were two tablets missing/gone. One tablet was administered on 05/09/26. The bubble pack is dated and the staff that administered the medication initialed the bubble pack. The medication administration record reflects that this medication was administered to Resident A on 05/09/26. The second pill popped out/gone from the bubble pack has no date or signature written on the bubble pack for when it was administered or who it was administered by. Additionally, there is no documentation on the medication administration record indicating when this medication was administered to Resident A or what staff administered the medication.

On 05/22/26, I interviewed Health Care Manager Tiffany Ellis via telephone. Ms. Ellis stated direct care staff Greg Davis administered Olanzapine 10 mg to Resident A on 05/12/26, at 1:47 pm. The medication was administered per Resident A’s request. Mr. Davis documented the medication pass on the medication communication log which is a log that summarizes what occurred during his shift. However, Mr. David did not document on Resident A’s medication administration record. Ms. Ellis stated Mr. Davis will be re-trained in medications.

On 05/22/26 and 05/26/26, I placed a telephone call to administrator Carrie Aldrich to conduct an exit conference and review my findings. On 02/11/26, Flatrock licensee designee Nicholas Burnett indicated in writing that Ms. Aldrich is authorized to conduct exit conferences on behalf of Flatrock. At the time of both calls there was no answer. I left a voicemail requesting a return call. I informed Ms. Aldrich of the rule violations and indicated that a corrective action plan is required. On 05/27/26, I had a conference call with licensee designee Nicholas Burnett and administrator Carrie Aldrich to discuss my findings. I advised that a corrective action plan is required. I provided technical assistance to Ms. Aldrich and Mr. Burnett regarding Resident A's ability to unlock the doors at the facility despite the doors having an automatic self-closing device and keypad entry. Ms. Aldrich and Mr. Burnett acknowledged and will work to address this issue immediately.

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(b) Complete an individual medication log that contains all of the following:</p> <p>(v) Initials of the individual who administered the medication at the time given.</p>
ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude that Resident A's medication administration record does not contain the initials of the individual who administered Resident A's Olanzapine 10 mg on 05/12/26.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective plan, I recommend no changes to the status of the license.



05/27/2026

Johnna Cade
Licensing Consultant

Date

Approved By:



For

05/27/2026

Denise Y. Nunn
Area Manager

Date