GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 13, 2026

Rose Ogolla
Precious Care Assisted Living, LLC
720 W. Walnut Street
Kalamazoo, MI 49007

RE: License #: AS390390449
Investigation #: 2026A1024037
Precious Care Assisted Living

Dear Ms. Ogolla:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the quality of care violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390390449
Investigation #:	2026A1024037
Complaint Receipt Date:	06/10/2026
Investigation Initiation Date:	06/11/2026
Report Due Date:	08/09/2026
Licensee Name:	Precious Care Assisted Living, LLC
Licensee Address:	720 W. Walnut Street Kalamazoo, MI 49007
Licensee Telephone #:	(269) 414-8013
Administrator:	Rose Ogolla
Licensee Designee:	Rose Ogolla,
Name of Facility:	Precious Care Assisted Living
Facility Address:	720 W. Walnut Street Kalamazoo, MI 49007
Facility Telephone #:	(269) 414-8013
Original Issuance Date:	02/27/2018
License Status:	REGULAR
Effective Date:	08/27/2024
Expiration Date:	08/26/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide safety and protection to Resident A who was found deceased after he was left unsupervised while eating.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/10/2026	Special Investigation Intake 2026A1024037
06/11/2026	Special Investigation Initiated – Letter email correspondence with Recipient Rights Officer (RRO) Suzie Suchyta
06/11/2026	Contact - Document Received-Resident A's *Individualized Plan of Service* (IPOS)
06/12/2026	Contact - Document Received-*AFC Licensing Division Incident/Accident Report* (report), *Assessment Plan for AFC Residents* (plan)
06/12/2026	Inspection Completed On-site with direct care staff member Caren Ogola
06/12/2026	Contact - Telephone call made with direct care staff member Tatenda Zindoga
06/12/2026	Contact - Telephone call made with administrator/licensee designee Rose Ogolla
06/12/2026	Contact - Document Received-*KDPS Police Report* #26-007243
06/12/2026	APS Referral-not warranted- Resident is deceased.
06/15/2026	Contact - Document Received-Medical Examiner *Investigative Report*-Case W26-0729
06/15/2026	Contact - Document Received Caren Ogola's trainings and Tatenda Zindoga's trainings
06/15/2026	Contact - Document Received-*911 Dispatch Call Recording*
06/16/2026	Contact-Document Received-*Medical Visit Sheet*

06/22/2026	Contact- Face to Face-with case managers Emily Welch and Rachel Harrison from Milestone Senior Services.
07/06/2026	Exit Conference with administrator/licensee designee Rose Ogolla
07/06/2026	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION: Staff failed to provide safety and protection to Resident A who was found deceased after he was left unsupervised while eating.

INVESTIGATION:

On 8/10/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged direct care staff failed to provide safety and protection to Resident A who was found deceased after he was left unsupervised while eating.

On 6/11/2026, I reviewed email correspondence from RRO Suzie Suchyta who stated that she is also investigating this allegation and had interviewed AFC staff members Caren Ogola and Tatenda Zindoga. Suzie Suchyta stated both reported to her that Resident A was given a peanut butter sandwich cut in quarter size pieces, however according to his *Individualized Plan of Service* (IPOS), he requires his food to be cut up in bite-size pieces. Suzie Suchta stated that based on her investigation she believes staff member statements regarding this incident “are not adding up.” Suzie Suchyta stated direct care staff member Caren Ogola reported she came in to the facility at 10:30pm and found Resident A on the kitchen floor while staff member Tatenda Zindoga was on the phone talking to the 911 operator. However, staff member Tatenda Zindoga stated Resident A fell and was found on the dining room floor. Suzie Suchta stated that she is unsure if staff members cut Resident A’s sandwich as required according to his treatment plan, which is her biggest concern.

On 6/11/2026, I reviewed Resident A’s *Individualized Plan of Service* (IPOS) dated 4/10/2026 which documented that Resident A is followed by a Pulmonologist. The IPOS documented that direct care staff members must cut Resident A’s food into “small pieces” to reduce choking hazards and that direct care staff must prepare all meals for Resident A. It should be noted that this IPOS does not document what medical provider recommended for Resident A’s food to be cut into small pieces.

On 6/12/2026, I reviewed the *AFC Licensing Division-Incident/Accident Report* (report) dated 6/7/2026 and written by direct care staff member Tatenda Zindoga. According to this report, at 10:35pm Resident A asked for a snack so direct care staff member Tatenda Zindoga prepared a sandwich for him. The report stated that while Resident A was eating, Tatenda Zindoga left to respond to the facility doorbell and when Tatenda Zindoga returned Resident A was on the floor and not breathing. The report stated that staff immediately called 911 and continued to perform CPR until the ambulance arrived to take over the process.

I reviewed Resident A's *Assessment Plan for AFC Residents* (plan) dated 1/5/2026, which documented that all meals will be prepared by staff. It should be noted that this plan did not document any special instructions such as supervising Resident A while eating or cutting his food into bite sized pieces for Resident A. Although these special instructions were not documented in Resident A's plan, according to licensee designee Rose Ogolla all direct care staff knew that Resident A is required to have 1:1 supervision while eating and his food must be cut in small pieces to prevent incidents of choking as recommended by his medical provider.

On 6/12/2026, I conducted an onsite investigation at the facility and interviewed direct care staff member Caren Ogola who stated that that when she arrived to the home on 6/7/2026 on her off day, she knocked on the side door attached to the kitchen area and Tatenda Zindoga opened the door while on the phone with 911. Caren Ogola stated she immediately noticed Resident A lying non-responsive on the kitchen floor. Caren Ogola stated that Tatenda Zindoga was talking to the 911 operator upon her arrival and told the 911 operator that Resident A was eating a peanut butter sandwich and when he returned to the kitchen from getting something, Resident A was found on the floor not breathing. Caren Ogola stated that Tatenda Zindoga performed CPR until EMS arrived and while waiting for EMS, she observed a jar of peanut butter next to an opened half full loaf of bread on the counter. Caren Ogola stated that she has worked at the facility for several years and is very familiar with Resident A who requires 1:1 supervision when eating because he has a history of choking. Caren Ogola stated Resident A's experiences choking episodes at least twice a month while eating due to swallowing issues. Caren Ogola stated that Resident A likes to eat peanut butter and jelly sandwiches, however, usually eats around 5pm, so she was unsure why Resident A was given a peanut sandwich for a snack as late as 10pm. Caren Ogola further stated that she has no knowledge that Resident A required his food to be cut in bite-size pieces and stated she has never cut up his food in bite-size pieces as recommended by his medical provider. Caren Ogola did not report that any special equipment like a food processor was needed when preparing Resident A's meals. Caren Ogola stated that all other residents were sleeping during this incident and did not witness Resident A on the floor in the kitchen when EMS arrived.

On 6/12/2026, I conducted an interview with direct care staff member Tatenda Zindoga who stated that on 6/7/2026 Resident A asked if he could have a peanut butter sandwich for a late night snack at which time he prepared a peanut butter sandwich for Resident A and cut the sandwich into four pieces. Tatenda Zindoga stated he did not cut the peanut butter sandwich into bite-size pieces as instructed by Resident A's medical professional. After cutting the sandwich into quarters or four pieces, he gave Resident A the sandwich to eat. Tatenda Zindoga stated he observed Resident A take one small bite of the sandwich before leaving the kitchen area. Tatenda Zindoga stated Resident A was sitting on a stool at the kitchen counter, when he left the kitchen area to answer the front door after he heard the doorbell ring. Tatenda Zindoga stated that when he returned to the kitchen area after being gone for less than 60 seconds to open the front door for Caren Ogola, he found Resident A on the kitchen floor not breathing. Tatenda Zindoga stated that after he and Caren Ogola found Resident A on the floor, he

immediately called 911 and performed CPR until EMS arrived. Tatenda Zindoga stated he usually only works once per week (on Sundays) at this AFC facility but was aware that Resident A required 1:1 supervision while eating and that his food needs to be cut in smaller pieces to prevent choking as recommended by his medical provider. Tatenda Zindoga stated that when he left to answer the doorbell, he did not hear any indication that Resident A was choking such as coughing or crying for help. I asked Tatenda Zindoga about inconsistent statements he reported to law enforcement and the medical examiner regarding this incident like how long he was away from the kitchen area, the reason for leaving the kitchen area, and if Resident A prepared his food on his own, at which time Tatenda Zindoga changed his statement and stated that he really does not know what happened because he has “been in shock” and has no recollection of the incident since “everything happened so fast.”

On 6/12/2206, I conducted an interview with administrator/licensee designee Rose Ogolla who stated on 6/7/2026, she was contacted by staff member Caren Ogola who reported that Resident A was unresponsive on the kitchen floor due to choking on a peanut butter sandwich and Tatenda Zindoga was attempting to do CPR however was unsuccessful because peanut butter was blocking his airway. Rose Ogolla stated when she arrived at the facility, EMS was performing CPR and she was immediately interviewed by law enforcement. Rose Ogolla stated Resident A was still on the kitchen floor in the facility. Rose Ogolla stated she observed a jar of peanut butter and a loaf of bread on the counter, however she did not see any evidence of a prepared peanut butter sandwich. Rose Ogolla stated that Resident A requires 1:1 staff supervision while eating and his food must be cut up in small pieces due to issues with swallowing which cause him to choke easily. Rose Ogolla stated that both Caren Ogola and Tatenda Zindoga were trained on and familiar with Resident A’s eating accommodations as instructed by his medical provider and to her knowledge all staff members were adhering to these accommodations regularly. Rose Ogolla did not report that any special equipment like a food processor was needed when preparing Resident A’s meals.

On 6/12/2206, I reviewed the Kalamazoo Department of Public Safety (KDPS) *Police Report* #26-007243 written by Public Safety Officer (PSO) David Karel #16661 which documented that KDPS police, Fire and LIFE EMS units were dispatched to the facility for a 62-year-old male that was not breathing and later identified as Resident A. This *Police Report* documented that arriving units began CPR and attempted all life-saving measures to resuscitate Resident A however after exhausting all measures, Resident A was pronounced deceased at the scene at 2315 or 11:15PM. The *Police Report* documented interviews were conducted with direct care staff member Caren Ogola who stated that when she arrived to the facility she knocked on the front door and direct care staff member Tatenda Zindoga answered the door in a frantic manner and was already on the phone with 911. Caren Ogola stated Tatenda Zindoga informed her that he had found Resident A unresponsive on the floor in the kitchen.

The *Police Report* documented an interview with Tatenda Zindoga who explained that he was in the kitchen making a peanut butter and jelly sandwich for Resident A and

briefly left the kitchen to check on something within the office at the AFC home. Tatenda Zindoga explained to the officer that Resident A continued making his peanut butter and jelly sandwich and approximately five minutes lapsed before Tatenda Zindoga returned to the kitchen and found Resident A unresponsive on the floor. Medical Examiner Deann Green responded to the scene to complete a death investigation and placed a hold on the body for autopsy and post-mortem examination.

Sergeant Michael O'Strander Badge #14596 provided additional information to this *Police Report* which documented that he also responded to the facility to find LIFE EMS already on the scene. Sergeant Michael O'Strander's report documented that LIFE EMS advised that they had to suction a large amount of peanut butter from Resident A's mouth and throat while they were attempting to establish an airway for ventilation which indicated the possibility of Resident A choking prior to going into cardiac arrest.

On 6/15/2026, I reviewed the Medical Examiner's *Investigative Report* dated 6/7/2026 and written by Deann Green. According to this *Investigative Report,* Resident A was found unresponsive on the floor of the AFC home where he resides after it is suspected that he choked on a peanut butter sandwich. The suspected manner of death in this case is accidental, and the decedent was transported for further examination. This *Investigative Report* documented that Resident A has a known history of dysphagia and according to Tatenda Zindoga, Resident A was in the kitchen while he was helping him make a peanut butter sandwich. Tatenda Zindoga then reported that he left Resident A unattended in the kitchen for approximately five minutes when he heard a noise and returned to kitchen finding Resident A on the floor on his right side. Tatenda Zindoga called 911 and KDPS, LIFE EMS and MSU-2 arrived to the scene and attempted resuscitation, which was unsuccessful. Seargent O'Strander from KDPS reported that LIFE EMS confirmed to him that they pulled food from Resident A's airway during resuscitation attempts.

This *Investigative Report* provided medical history which documented that according to *Bronson Hospital Epic Records*, which is a database that holds a person's medical history, Resident A was diagnosed with dysphagia. The medical records also documented multiple completed *Speech and Language Evaluations* with the last discharge note dated 1/8/2025 which recommended that sandwiches be cut into smaller pieces to minimize overstuffing and that his supervision level when eating be 1:1 supervision. The *Investigative Report* documented that Resident A's sister also reported that Resident A is considered to be a choking hazard as he tends to put a lot of food in his mouth and eats very fast.

This *Investigative Report* provided a scene description which documented that Resident A was located on the kitchen floor with a jar of smooth peanut butter and partial loaf of white bread on the kitchen counter as well as what appears to be chewed up bread with peanut butter on it in the kitchen sink and small pieces of what appears to be bread on the floor to the right of Resident A's body.

On 6/15/2025, I listened to the *911 Dispatch Call Recording* and heard a direct care staff member, who sounds like Tatenda Zindoga, request EMS assistance because the resident ate peanut butter and was not breathing. While talking to the 911 operator, another staff member, who sounds like Caren Ogola, can be heard asking the staff member on the phone “what happened” at which time the staff member talking to the operator replied, “I don’t know, he had peanut butter.”

On 6/16/2026, I reviewed the facility’s *Medical Visit Sheet* dated 12/30/24 which documented that Resident A was seen by medical provider Nicole Sobell from Bronson Rehabilitation Services for a swallow evaluation and was diagnosed with Oral Phase Dysphagia. Nicole Sobell ordered Resident A to have a mechanical soft diet, all meat should be chopped in a food processor, and all other foods should be easily chewable. Nicole Sobell also recommended Resident A take frequent pauses while eating and small volumes of thin liquid while eating. I reviewed the facility’s *Medical Visit Sheet* dated 1/8/25 which documented that Resident A was seen by medical provider Nicole Sobell from Bronson Rehabilitation Services for Oral Phase Dysphagia. Nicole Sobell recommended that Resident A continue to use a food processor to break down hard textured foods and to cut sandwiches into bite size pieces. Nicole Sobell also recommended Resident A be verbally cued by direct care staff to slow down while eating and that Resident A needs to have a smaller drink size to prevent guzzling.

On 6/22/2026, I conducted interviews with Resident A’s former case manager Emily Welch who stated that she was Resident A’s case manager for a little over a year ending in 2025 however did not know much information regarding Resident A’s swallowing issues. Emily Welch stated that she visited Resident A frequently and never saw any special modifications to Resident A’s food such as his food being cut into pieces or pureed in a food processor nor did she notice any enhanced supervision when Resident A ate his food although staff were always nearby in the area. Emily Welch stated that staff never expressed any concern regarding Resident A having issues with choking while eating.

I also interviewed Resident A’s current case manager Rachel Harrison who stated that she has been Resident A’s case manager for a short period of time and was working on getting more familiar with Resident A and his needs. Consequently, she stated she had no knowledge of Resident A having issues with swallowing when eating. Rachel Harrison stated direct care staff never mentioned this concern to her. Rachel Harrison stated that she visited Resident A monthly at the facility and does not recall seeing Resident A having his food cut nor has she seen staff members provide enhanced staff supervision while Resident A was eating.

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:	Based on my investigation which included interviews with direct care staff members Caren Ogola, Tatenda Zindoga, administrator/licensee Rose Ogolla, ORR Suzie Suchyta, case managers Emily Welch and Rachel Harrison, along with my review of Resident A's *Individualized Plan of Service* (IPOS) *AFC Licensing Division Incident/Accident Report* (report), *Assessment Plan for AFC Residents* (plan), *KDPS Police Report, 911 Dispatch Call Recording,* and Medical Examiner *Investigative Report* there is evidence direct care staff Tatenda Zindoga did not provide safety and protection to Resident A who was found deceased after being left unsupervised while eating. According to licensee designee and administrator Rose Ogolla, Resident A's medical provider ordered 1:1 supervision while eating and for Resident A's food to be cut up in small pieces to prevent him from choking while eating. Resident A's IPOS also documented that staff members must cut Resident A's food into small pieces to reduce choking hazards and staff must prepare all meals for Resident A. The Medical Examiner's *Investigative Report* provided medical history which confirmed these special dietary instructions including providing 1:1 supervising while eating, cutting sandwiches into small pieces, using a food processor for hard textured foods, and offering small amounts of thin liquids to assist with not choking. Tatenda Zindoga stated that the peanut butter sandwich he made for Resident A on 06/07/2026 at approximately 1030PM was cut int four pieces. Tatenda Zindoga denied cutting the peanut butter sandwich into small bite sized pieces as instructed by Resident A's medical provider. Tatenda Zindoga also confirmed that he left Resident A unattended while he was eating for at least one minute and up to five minutes, which was also contrary to Resident A's medical instruction of 1:1 supervision while eating. According to the *Police Report* LIFE EMS a large amount of peanut butter was suctioned from Resident A's mouth and throat while attempting to establish an airway for ventilation which indicated the possibility of Resident A choking prior to going into cardiac arrest. This also indicates that direct care staff member Tatenda Zindoga did not do a mouth sweep to remove any food obstruction prior to calling 911 even though he suspected Resident A was choking. Despite having known special dietary instructions in place to ensure safety and protection to Resident A while eating, direct

	care staff member Tatenda Zindoga left Resident A unattended while he was eating and failed to cut up Resident A's peanut butter sandwich in smaller pieces which subsequently contributed to Resident A having a blocked airway caused by peanut butter and bread leading to Resident A choking and passing away.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference**
	(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.
ANALYSIS:	Resident A has two medical visit records from 2024 and 2025 that documented special dietary recommendations by his health care provider, Nicole Sobell from Bronson Rehabilitation Services for his condition Oral Phase Dysphagia. These special dietary instructions required recommendations advised Resident A continue to use a food processor to break down hard textures and to cut sandwiches into bite size pieces. It was also advised that Resident A take frequent pauses with small volumes of thin liquid. Licensee designee Rose Ogolla and direct care staff members Caren Ogola and Tatenda Zindoga never mentioned that Resident A was required to use a food processor for some food therefore this recommendation was not followed by staff members. In addition, Resident A's case managers Emily Welch and Rachel Harrison made routine visits with Resident A during 2024 and 2025 and have never seen Resident A's food put in a food processor or cut in small pieces during his mealtimes. Therefore, Resident A was not provided his prescribed special diet as instructed by his health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Licensee designee and administrator Rose Ogolla stated that direct care staff member Caren Ogola have been living in the facility since 2018, and she did not know that this information was supposed to be reported to the department. It should be noted that Rose Ogolla and Caren Ogola have a different spelling in their last name.

APPLICABLE RULE	
R 400.611	**Required information; fee; posting of license; change of information.**
	(4) An applicant or licensee shall give written notice to the department within 10 business days after a change occurs in information that was previously submitted in or with an application for a license.
ANALYSIS:	Licensee designee and administrator Rose Ogolla stated that direct care staff member Caren Ogola have been living in the facility since 2018, yet Rose Ogolla did not report this information to the department as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On the *911 Dispatch Call Recording,* Tatenda Zindoga can be heard informing the operator that Resident A was found on the floor not breathing and asking the 911 operator throughout the call, "what should I do and should I be doing CPR". Tatenda Zindoga can be heard saying that he “did not know what to do.”

According to employee records, Tatenda Zindoga was trained in First Aid/CPR/AED on 3/21/2026 by the American Heart Association.

According to the American Heart Association, First Aid fully covers what to do if a person becomes unconscious and stops breathing which includes immediately beginning CPR and opening the mouth to look for obstructing objects after 30 compressions.

According to the *Police Report,* LIFE EMS advised that they had to suction a large amount of peanut butter from Resident A’s mouth and throat while they were attempting to establish an airway for ventilation which indicated the possibility of Resident A choking prior to going into cardiac arrest and indicates that no previous mouth swipes were done to remove any food.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	On the *911 Dispatch Call Recording,* Tatenda Zindoga can be heard telling the 911 operator that he did not know what to do and asking if he should be performing CPR. Despite Tatenda Zindoga being trained in First Aid and CPR in March 2026, Tatenda Zindoga demonstrated that he was not capable of handling an emergency situation by not immediately beginning CPR and following First Aid guidelines aligned with his training from the American Heart Association. This is evident by statements Tatenda Zindoga made to the 911 operator during this resident emergency.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed employee trainings for Caren Ogola and Tatenda Zindoga and could not verify completed required training for reporting requirements, personal care, supervision and protection, food safety and special diets.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: **(a) Reporting requirements.** **(d) Personal care, supervision, and protection.** **(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.** **(i) Nutrition and special diets.**

ANALYSIS:	I reviewed employee training for Caren Ogola and Tatenda Zindoga and could not verify completed required training for reporting requirements, personal care, supervision and protection, food safety and special diets. There was no written verification that Tatenda Zindoga was trained on Resident A's special dietary instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

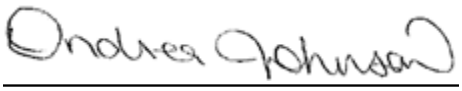
According to licensee designee/administrator Rose Ogolla, direct care staff members Tatenda Zindoga and Caren Ogola, Resident A's medical visit logs and medical records mentioned in the medical examiner's investigative report, Resident A required 1:1 supervision while eating and must have his food cut up in smaller pieces to reduce choking however these special accommodations are not included in his written assessment plan.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: **(b) The services, skills, and physical accommodations required by the resident that are available at the facility.**
ANALYSIS:	According to licensee designee/administrator Rose Ogolla, direct care staff members Tatenda Zindoga and Caren Ogola, Resident A's medical visit logs and medical records mentioned in the medical examiner's investigative report, Resident A requires 1:1 supervision while eating and must have his food cut up in smaller pieces to reduce choking however these special accommodations were not included in Resident A's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/6/2026, I conducted an exit conference with licensee designee Rose Ogolla. I informed Rose Ogolla of my findings and allowed her an opportunity to ask questions and make comments.

IV. RECOMMENDATION

Due to the severity of the quality of care violations, revocation against your license is recommended.



Ondrea Johnson
Licensing Consultant

7/7/2026
Date

Approved By:

07/13/2026

Dawn N. Timm
Area Manager

Date