STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

January 7, 2020

Kelly Stone
Lakeside
3921 Oakland Dr
Kalamazoo, MI 49008

RE: License #: CI390201235
Investigation #: 2020C0214009
Lakeside

Dear Ms. Stone:

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.

FOR CWL ONLY
Please note that violations of any licensing rules are also violations of the MSA and your contract.

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 Claudia Triestram, the area manager at (616) 552-3662.

Sincerely,

Paul Fatato, Licensing Consultant
MDHHS\Division of Child Welfare Licensing
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-2471

enclosure

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	CI390201235
Investigation #:	2020C0214009
Complaint Receipt Date:	11/26/2019
Investigation Initiation Date:	12/03/2019
Report Due Date:	01/25/2020
Licensee Name:	Lakeside
Licensee Address:	3921 Oakland Dr Kalamazoo, MI 49008
Licensee Telephone #:	Unknown
Administrator:	Sandra Lealofi, Designee
Licensee Designee:	Sandra Lealofi, Designee
Name of Facility:	Lakeside
Facility Address:	3921 Oakland Drive Kalamazoo, MI 49008
Facility Telephone #:	(269) 381-4760
Original Issuance Date:	04/01/1990
License Status:	REGULAR
Effective Date:	09/18/2019
Expiration Date:	09/17/2021
Capacity:	126
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

	Violation Established?
ALLEGATION 1: A staff punched a resident in the ribs during a restraint.	No
ALLEGATION 2: A staff pinned a resident to the wall and punched him.	No
ALLEGATION 3: A staff pressed his elbow into a resident's thigh during a restraint.	Yes
ALLEGATION 4: During the investigation of Allegations 1, it was reported to the DHHS worker that Administrator 5 had informed the parents of Resident A that he would investigate the report that Resident A was being abused by staff and did nothing about it.	No
Additional Findings	Yes

III. METHODOLOGY

11/26/2019	Special Investigation Intake 2020C0214009
12/03/2019	Special Investigation Initiated – Telephone – Spoke with Administrator 5 to schedule interviews
12/16/2019	Contact - Face to Face interviews with Administrator 1, Administrator 2, Administrator 3, Administrator 4, Case Manager 1, Supervisor 1, Supervisor 2, Supervisor 3, Therapist 1, Staff 1, Staff 3, Staff 4, Staff 5, Resident A, Resident B, Resident C and Resident D
12/16/2019	Contact - Documents Received: Human Resources information, resident face sheets and facility policy and procedures
12/18/2019	Contact - Document Received: Human Resources information
12/19/2020	Contact – Phone interview with Staff 2
12/20/2019	Contact - Document Received: facility policy and procedures
01/03/2020	Contact - Document Received: Human Resources information
01/03/2020	Contact - Face to Face interview with Administrator 5
01/03/2020	Exit Conference with Administrator 1, Administrator 2, Administrator 3 and Administrator 5

ALLEGATION 1:

Resident A (14) is currently in placement at Lakeside Academy. Staff 1 is a staff member at the facility.

It is reported that last week Resident A was punched in the ribs during a restraint. He was punched on his right side by Staff 1 who is a staff member at the facility. It is unknown if Resident A had any marks or bruises from this. Resident A did not report experiencing any pain from the incident. Resident A reported this to another staff, and they said they would check the cameras but is unsure if they did this.

INVESTIGATION:

I interviewed Administrator 1 (Executive Director) and Administrator 2 (Director of Compliance and Quality) at the facility on 12/16/2019. I asked them about their awareness of the allegations and both report having some knowledge of the allegations. They indicated, “Resident A has run from the facility three times and we had to involve the mobile mental health crisis unit a couple of times because he was threatening self-harm”. They both report Resident A has told staff that he will “stop at nothing to get out of here” and “doesn’t want any help”. They indicated that he has made minimal progress since entering the facility and they also indicated a belief that Resident A is experiencing significant mental health issues. This belief is based on his self-harming ideation and self-reported auditory hallucinations. They ended the interview by indicating a 30-day removal notice has been placed for Resident A. They report the rational for this is based on “his mental health needs that are beyond” what the facility can provide.

I interviewed Resident A at the facility on 12/16/2019. I asked Resident A about the allegations and he first reported that Staff 1 was not involved in the restraint allegations. He also denied that Staff 1 had struck him as noted in the allegations. He did suggest that Supervisor 1, Staff 2 and Staff 3 were involved in the allegations of him being punched during a restraint. Resident A described the restraint as taking place in his room “because there are no cameras there”. He also described that he had a sheet wrapped around his neck in an effort to self-harm, so staff intervened. Resident A stated that “one guy put my hand on the floor and started to stomp on it. I had something (unable to remember what it was) in my hand and he said that I was going to self-harm with it.” Resident A recalled that once staff let go of him, he stood up and punched Supervisor 1, which resulted in him being placed in a supine restraint. He reports that during the supine restraint, staff choked him. He also reports fighting the restraint. I asked Resident A about his waiting for a couple of weeks before reporting this information and he replied, “I didn’t tell anyone at the time because I know they would get away with it”. I asked about any injuries and if he saw the nurse and he reported having no injuries. He also reported that staff did not offer him a chance to visit with the nurse. I asked Resident A if he felt safe and was being provided services at the facility and he replied, “I feel safe here because I’m going to another placement with 30-days. They put in a 30-day notice and my

worker is going to move me." Resident A also added that he doesn't like the facility because some of the staff are "rude to me".

I interviewed Staff 1 (Youth Counselor) at the facility on 12/16/2019. I asked him about the allegations that he punched Resident A and he denied ever punching Resident A or any other resident. He also denied that he was part of the resident noted in the allegations. Staff 1 suggested that he has a "smooth relationship" with Resident A.

I interviewed Supervisor 1 (Program Director) at the facility on 12/16/2019. I asked him about the restraint noted in the allegations. He reports the restraint was appropriate and that he was the only staff involved in the restraint. He described initiating the restraint because Resident A first began to run around the dorm with a bed sheet around his neck making statements that he was going to harm himself. Supervisor 1 indicated that he kept trying to deescalate Resident A and only engaged in a restraint after Resident A pulled the bed sheet tighter around his neck. Supervisor 1 stated, "I placed him in a single person upper torso and Staff 2 and Staff 3 witnessed the restraint. I asked about the allegation that staff "stomped" on Resident A's hand and Supervisor 1 denied that this could have occurred because the restraint never went to the floor. He indicated it was a standing single person upper torso restraint throughout. Supervisor 1 denied having any knowledge of Resident A's report he was punched by staff.

I interviewed Staff 3 (Youth Counselor) at the facility on 12/16/2019. I asked him about the allegations of staff punching Resident A during a restraint and stomping on his hand during the same restraint. Staff 3 indicated that he was present and only a witness to the restraint. His report was similar to the report provided by Supervisor 1 and the written Incident Report.

I interviewed Staff 2 (Youth Counselor) by phone on 12/19/2019. I asked him about his awareness of and presence during the restraint of Resident A on November 17, 2019. He indicated being witness to the events before and during the restraint. His report was similar to the reports provided by Supervisor 1 and Staff 3. His report also matched the written documentation provided in the Incident Report, Supplemental Incident Report and Debriefing Report.

I reviewed the Incident Report, Supplemental Incident Report and Debriefing Report provided by the facility on 12/16/2019. All three reports had the same information that was provided by Supervisor 1, Staff 2 and Staff 3. The incident report has documentation from the nursing staff that Resident A was observed at the medication cart the next day and had no complaints of any injuries or concerns. I reviewed the safety plan develop by the facility and the facility is providing one-on-one supervision and another clinical evaluation.

I reviewed the personnel files of the staff involved and there was no documentation of any inappropriate interaction between staff and residents in their files. The staff

interviewed supported this finding by indicating they have never been engaged in this type of inappropriate behaviors.

I reviewed the video recording and because the restraint took place in Resident A's room, there is no view of the restraint. Supervisor 1, Staff 2 and Staff 3 can be seen in the video going into Resident A's room.

ALLEGATION 3:

On 12/08/2019, Resident D went AWOL from his placement. When he returned on that same date, Staff 4 restrained Resident D and pressed his elbow down on Resident D 's thigh hard. Staff 4 called Resident D names. Resident D does not have any marks or bruises.

Multiple staff members are cussing at, physically abusing, and grabbing the children.

INVESTIGATION:

I interviewed Administrator 1 (Executive Director), Administrator 2 (Director of Compliance and Quality) and Administrator 3 (Director of Student Services) at the facility on 12/16/2019. I asked if they had knowledge of the allegations and both report knowing about the allegations. They shared awareness that staff did not use the appropriate technique during the restraint associated with the allegations and are planning on disciplinary action after this investigation. They indicated that staff can use a two-person seated position during the transition to a supine but are not allowed to use a single person seated position unless it is an emergency situation. Administrator 2 reported overhearing Resident D tell Resident B that if he told his worker about the allegations, she would remove him from the facility.

I interviewed Resident D at the facility on 12/16/2019. I asked if he remembered the allegations and what lead up to them. He reported that on the day of the allegations he had just returned from going AWOL and upon his return, staff conducted a "dirty restraint". He described the "dirty restraint" as staff using excess force when restraining a resident. He indicated that staff placed him in a "seated position that they are only allowed to use with California kids. Staff 4 also put an elbow in my knee." I asked Resident D about the report he had told another resident that he was going to make up things so he could be removed, and he denied saying anything like this.

I interviewed Supervisor 3 (Group Leader) at the facility on 12/16/2019. I asked him about the restraint of Resident D. He reports being present and involved in the restraint. He described the restraint as an approved "two-person seated position to my knowledge". He went on to describe this two-person seated position as if it was a single person seated position. He suggested the restraint was appropriate. I asked Supervisor 3 about the allegations of staff cursing and grabbing residents and he denied observing this type of behavior from staff.

I interviewed Staff 4 (Youth Counselor) at the facility on 12/16/2019. I asked him about the restraint of Resident D and the allegation that he placed his elbow in his knee during the restraint. Staff 4 indicated that he responded to a staff call on the dorm and observed “Staff 5 and Staff 6 trying to put Resident D into an upper torso restraint. They fell to the ground because Resident D was being very aggressive with them. He was calling for the other kids to help him and to fight staff.” Staff 4 also indicated that they were able to place Resident D in a supine position after Supervisor 3 had placed him in a seated position. I asked Staff 4 about the seated position and he replied, “I believe we are not supposed to use that position anymore”. I asked if he had informed a supervisor of this issue and he indicated that he has not. Staff 4 reported that other than the seated position with Supervisor 3, the purpose and techniques of the restrain were appropriate. I asked Staff 4 if he is aware of staff mistreating residents by using “dirty restraints”, cursing at or grabbing them. He indicated not observing staff doing this. He did suggest that in the past (unable to give specifics) he has heard staff swear in the presence of residents. He also suggested that he would have told them to not do that again.

I interviewed Staff 5 (Youth Counselor) at the facility on 12/16/2019. I asked him about his awareness of the allegations and his part in the restraint of Resident D. He indicated being aware and being part of the restraint. He reported that Resident D was placed in a verbal (talking to staff about behaviors) when Resident D kicked Staff 6. Staff 5 indicated “I was told that if the residents attack you, you need to put them in a restraint”. Staff 5 reported that they tried to do a multiple upper person restraint but ended up on the ground. He indicated holding the legs of Resident D when Supervisor 3 had him in the single person seated position before moving to a supine hold. He appeared puzzled about the inappropriate restraint by Supervisor 3. He reports that the supine restraint was done appropriately. I asked Staff 5 about the allegation that staff are cursing and grabbing residents and he replied not being aware of observing this type of behavior from staff. He ended the interview by suggesting that he would report any staff that were being inappropriate to residents.

I interviewed Resident B at the facility on 12/16/2019. I interviewed this resident because he was identified as the resident who Resident D was supposed to have told about wanting to get staff in trouble so he could be removed from the program. I asked Resident B if he had been approached by Resident D about making allegations against staff and he replied, “He came to me and said that I’m going to get these staff in trouble so I can get out of here”. Resident B was unable to recall when Resident D said this to him.

I reviewed the personnel files of the staff involved and there was no documentation of any inappropriate interaction between staff and residents present in their files. The staff interviewed supported this finding by indicating they have never been engaged in this type of inappropriate behaviors.

I reviewed the video recording of this restraint. The video recording shows Supervisor 3 place Resident D in a single person seated position with the other staff nearby.

I reviewed the Incident Report for this restraint and the narrative matches what the staff reported. The narrative describes a seated position but not whether it is a single staff or multiple. However, the check list of SCM physical techniques does not match what is described by staff and viewed on the video recording. There is no box to check for a single person seated position and the two-person seated position box is checked.

I reviewed the policy and procedures for restraints and the facility developed a policy and procedure that will only allow staff to use a single person seated restraint position in emergencies.

APPLICABLE RULE	
R 400.159	**Resident restraint.**
	(2) Resident restraint shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of trauma, and done in a manner consistent with the resident's treatment plan.

ANALYSIS:	**ALLEGATION 1:** Evidence provided through interviews and written documentation do not support the allegations of Staff 1 punching Resident A during a restraint or any other time at the facility. Resident A admitted that he was engaged in self-harming behavior and that he fought the restraint. A violation of allegations 1 was not established. **ALLEGATION 3:** Evidence provided through interviews, written documentation and a video recording do support the allegations of staff not using preapproved restraint techniques during the restraint of Resident D. Administrator 1 indicated that Supervisor 3 did not use the appropriate technique when he engaged in a single person seated position. The video recording supports this conclusion. A CAP for this violation is required. **Technical Assistance:** It was discussed with the Administrators the importance of having a refresher training with all staff on the importance of staff holding each other accountable. They agreed that each staff must report any inappropriate techniques regardless of their rank and that staff are fully aware of which techniques are approved and which are not.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION 2:

Resident B was pinned to a wall, had his arm twisted behind his back and was punched in the stomach/back area by Supervisor 2. This occurred on either 11/18/19 or 11/11/19. This occurred at Lakeside Academy in the entryway between the cafeteria and the classrooms.

INVESTIGATION:

I interviewed Administrator 1 (Executive Director) and Administrator 2 (Director of Compliance and Quality) at the facility on 12/16/2019. I asked them about the allegations and both report being aware of the allegations. They also report that Resident B has denied the allegations. The indicated that another resident told his therapist about the allegations. The also indicated that the resident reporting the allegations also reported that another resident (Resident C) witnessed the allegations. They ended the interview by reporting that area of the facility that the allegations are reported to have occurred in was not under camera surveillance at the time. They did report that this area is now under surveillance.

I interviewed Resident B at the facility on 12/16/2019. I asked him about the allegations, and he indicated that Supervisor 2 is his “favorite staff on campus”. He also indicated that Supervisor 2 is always looking out for him and “helping me do better”. Resident B then reported that “Supervisor 2 has never put hands on me”. I asked Resident B if he feels safe at the facility and he reported that he does.

I interviewed Supervisor 2 (Group Leader) at the facility on 12/16/2019. I asked him about the allegations, and he denied that anything like the allegations have occurred. He reports having “good accountability” with Resident B and talks with him a lot. He was asked about his relationship with the resident who reported the allegations and indicated having no contact with him since switching dorms about a month ago.

I interviewed Therapist 1 (Therapist) at the facility on 12/16/2019. I asked him about his learning about the allegations and he reported being told by another resident. He indicated that the resident shared he observed the allegations in the hallway between the school and cafeteria. He also indicated that this resident reported that this incident took place during breakfast and that he and another resident were able to observe it from where they were seated in the cafeteria. Therapist 1 ended by stating that he was not sure why this resident would take two weeks before making a report.

I interviewed Resident C at the facility on 12/16/2019. Resident C was interviewed because he was identified by the reporting resident as a witness to the allegations. I asked him about witnessing the allegations and he responded, “who said that I saw that. I never saw that, so someone is lying on me.” I asked Resident C if he felt safe at the facility and he reported that he does.

I reviewed the personnel files of the staff involved and there was no documentation of any inappropriate interaction between staff and residents present in their files. The staff interviewed supported this finding by indicating they have never been engaged in this type of inappropriate behaviors.

I was unable to review a video recording because no video recording was made of the incident.

APPLICABLE RULE	
R 400.4126	**Sufficiency of staff.**
	The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff on duty to perform the prescribed functions required by these administrative rules and in the agency's program statement and to provide for the continual needs, protection, and supervision of residents.

ANALYSIS:	Evidence provided through interviews do not support the allegation of Supervisor 2 twisting the arm of Resident B and punching him in the side. Resident B denied that this occurred, the witnessed identified by the complainant also denied that this occurred, and Supervisor 2 denied that the incident occurred.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

During the investigation of Allegations 1, it was reported to the DHHS worker that Resident A's phone contact with is family has been reduced since he reported the allegations.

INVESTIGATION:

I interviewed Resident A at the facility on 12/16/2019. I asked about the allegation of a reduction in phone calls and he indicated that "nothing changed". He indicated that several attempted phone calls were made with no contact and it appears that the phone number for his mother is the wrong number. He also indicated that his phone calls are not restricted, and that staff offer him phone call twice a week. He ended by reporting that he normally calls on Friday.

I interviewed Administrator 1 (Executive Director) and Administrator 2 (Director of Compliance and Quality) at the facility on 12/16/2019. I asked them about the phone policy for residents after informing them of the allegation of a reduction in phone calls for Resident A. They both report that each resident is provided a minimum of two phone calls per week. They also report that phone calls are provided regardless of the resident's behaviors or status in the program.

I interviewed Supervisor 1 (Program Director) at the facility on 12/16/2019. I asked Supervisor 1 about the process of phone calls in regard to Resident A. He reports similar information about phone calls as provided by Administrator 1 and Administrator 2. His report matched the facility's policy and procedure for resident phone calls. I asked about specifics with Resident A and phone calls and he reported that lately, Resident A has refused to make some phone calls to his family.

I interviewed Administrator 4 (Clinical Director) at the facility on 12/16/2019. I asked him about the phone call process. He gave the same information as Administrator 1, Administrator 2 and Supervisor 1. The information also matched the facility's policy and procedure for resident phone calls. He ended the interview by stating that Resident A has significant mental health issues which resulted in Administrator 4 taking over the therapy for Resident A.

I interviewed Case Manager 1 (Case Manager) at the facility on 12/16/2019. I asked her about the allegations of Resident A having his phone calls to family reduced and the facility's phone call policy. She reported speaking to Resident A's father last week about phone calls and assuring him that Resident A has no restrictions. She also reported that the staff have spoken to her about Resident A's parents not answering the phone when he makes calls. I asked about what she is doing to resolve this, and she reported providing an updated phone number to Resident A after he told her he can't get his mother to answer the phone. She provided a similar report about the policy and procedure.

I reviewed the policy and procedure for "Student Rights" which included a section on "External Contacts and Visitation". This policy states that "all students are afforded weekly outgoing phone calls based on contractual and placing agency agreements". This policy also states, "extra provisions will be made, if a student is unable to connect to their contact".

I reviewed the phone logs provided by the facility and there is documentation of Resident A making and attempting phone calls to family members.

APPLICABLE RULE	
R 400.4109	**Program statement.**
	(1) An institution shall have and follow a current written program statement which specifically addresses all of the following: (c) Policies and procedures pertaining to admission, care, safety, and supervision, methods for addressing residents' needs, implementation of treatment plans, and discharge of residents.
ANALYSIS:	Evidence provided through interviews and written documentation do not support the allegations of Resident A not receiving his phone calls to family as outlined in the policy and procedure. **Technical Assistance:** We discussed the importance of ensuring that the phone call log is provided to the case managers and therapist, so they are aware of any possible issues. We also discussed the need to develop a better system of documentation of phone calls made by residents and received by residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION 4:

During the investigation of Allegations 1, it was reported to the DHHS worker that Administrator 5 had informed the parents of Resident A that he would investigate the report that Resident A was being abused by staff and did nothing about it.

INVESTIGATION:

I interviewed Administrator 5 (Living Services Director) at the facility on 1/3/2020. I asked him about the allegation that he did not follow through with the allegation that Resident A was being abused. He responded, "I did talk to the mother the same day Resident A went AWOL. She told me that he said staff are hitting him, and I told the mother I would check into it." Administrator 5 reported that he spoke to several staff identified and found that the staff Resident A was reporting struck him did not even work on the day of the allegations. He also reported viewing the video tape and finding no evidence of the allegations that staff were hitting him. Administrator 5 shared a belief that nothing had occurred, so he had no reason to suspect that Resident A was being abused.

APPLICABLE RULE	
R 400.4131	**Compliance with child protection law; development of plan required.**
	The licensee shall develop and implement a written plan to assure compliance with the child protection law, 1975 PA 238, MCL 722.621 to 722.638
ANALYSIS:	Evidence provided through an interview with Administrator 5 and the video tape recording do not support the allegation that Administrator failed to follow the procedure of allegations of abuse towards a resident. He indicated investigating the allegation and finding facts that did not support any suspected child abuse.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

During the investigation of Allegations 3, it was discovered that Staff 6 did not engage in appropriate behavior management techniques when dealing with Resident D.

INVESTIGATION:

I interviewed Administrator 1 (Executive Director), Administrator 2 (Director of Compliance and Quality) and Administrator 3 (Director of Student Services) at

the facility on 12/16/19. Administrator 1 reported that Staff 6 has been terminated because he did not follow the rule for appropriate behavior management. She indicated viewing the video recording and observing Staff 6 pushing Resident D's foot off the couch while keeping his own foot on the couch. Administrator 1 believes that Staff 6 was escalating Resident D rather than trying to deescalate him.
I asked about the video tape and what action they had taken with Staff 6. They reported that he has been terminated because of his inappropriate actions. They also reported that the termination occurred on 12/27/19.

I reviewed the video tape of the restraint involving Resident D and Staff 6. The video recording shows Staff 6 pushing Resident D's foot off the couch while keeping his own foot on the couch. This occurred three times before Resident D is seen kicking Staff 6. At this point Staff 6 engaged in beginning the restraint that was taken over by Supervisor 3.

I reviewed the termination report (12/17/19) for Staff 6, and he was terminated for the following reasons:

> Staff 6 used improper de-escalation techniques with a youth that resulted in a restraint that was not of immediate and imminent concern. This was discovered after camera review of the incident during a licensing investigation that resulted in a licensing violation. Staff 6 was previously on a final written warning.

APPLICABLE RULE	
R 400.4157	**Behavior management.**
	(2) At a minimum, the behavior management system shall include all of the following: (b) Positive intervention strategies to assist residents in developing improved problem solving, self-management, and social skills.
ANALYSIS:	Evidence provided through interviews and a video recording support the citation that Staff 6 did not engage in appropriate behavior management techniques when he kept trying to physically remove Resident D's foot from the couch, thus escalating Resident D. Throughout this action by Staff 6, he continued to place his own foot on the couch.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

With an acceptable corrective action plan, it is recommended that no change be made to the license of this child caring institution

1/6/2020

Paul Fatato Date
Licensing Consultant

Approved By:

January 7, 2020

Claudia Triestram Date
Area Manager