GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 21, 2025

Mark James
American AFC Inc.
5355 Northland Dr. C-133
Grand Rapids, MI 49525

RE: License #: AM610259339
Investigation #: 2025A0583027
Terrace Manor

Dear Mr. James:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610259339
Investigation #:	2025A0583027
Complaint Receipt Date:	03/12/2025
Investigation Initiation Date:	03/14/2025
Report Due Date:	04/11/2025
Licensee Name:	American AFC Inc.
Licensee Address:	5355 Northland Dr. C-133 Grand Rapids, MI 49525
Licensee Telephone #:	(616) 292-2837
Administrator:	Mark James
Licensee Designee:	Mark James
Name of Facility:	Terrace Manor
Facility Address:	1148 Terrace Street Muskegon, MI 49442-3449
Facility Telephone #:	(231) 722-7442
Original Issuance Date:	05/12/2004
License Status:	REGULAR
Effective Date:	12/22/2023
Expiration Date:	12/21/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
On 03/12/2025, Resident B physically assaulted Resident A.	No

III. METHODOLOGY

03/12/2025	Special Investigation Intake 2025A0583027
03/14/2025	Inspection Completed On-site
03/14/2025	APS Referral
03/14/2025	Special Investigation Initiated - On Site
03/21/2025	Exit Conference Licensee Designee Mark James

ALLEGATION: On 03/12/2025, **Resident B physically assaulted Resident A.**

INVESTIGATION: On 03/12/2025 the above complaint allegation was received from the LARA-BCHS-Complaints system. The complaint stated that on 03/12/2025, Resident A was hit in the back by Resident B and that "a verbal altercation ensued a bit later in the morning" that led to Resident B picking Resident A up and slamming him into the wall. The complaint stated that it is not believed that Resident A was injured as a result of the altercation.

On 03/14/2025 I completed an unannounced onsite investigation at the facility and privately interviewed staff Johnny Chandler, Resident A, Resident B and Resident C.

Staff Johnny Chandler stated that the incident occurred on the early morning of 03/12/2025. Mr. Chandler stated that he did not work until 9:00 AM on 03/12/2025. Mr. Chandler stated that when he arrived at the facility on 03/12/2025 at 9:00 AM, he spoke to staff Dina Johnson who was working during the incident. Mr. Chandler stated that Ms. Johnson reported that Resident A had said that Resident B punched Resident A in the arm because Resident A would not leave their shared bedroom. Mr. Chandler stated that Ms. Johnson did not observe the incident because the altercation was reported to have occurred in Resident A and Resident B's shared bedroom. Mr. Chandler stated that Resident C also shares the bedroom with Resident A and Resident B. Mr. Chandler stated that he assessed Resident A and did not observe any injuries on 03/12/2025 at 9:00 AM. Mr. Chandler stated that Resident B can be a "bully" but has never physically assaulted other residents of the

facility. Mr. Chandler stated that Resident B will be discharging from the facility on 04/01/2025.

Resident A stated that he shares a bedroom with Resident B and Resident C. Resident A stated on 03/12/2025 at approximately 7:00 AM he was in the bedroom with Resident B and Resident C. Resident A stated that Resident B would not allow Resident A to leave the bedroom. Resident A could not remember why Resident B would not allow him to leave. Resident A stated that Resident B then proceeded to hit him on the lower side of Resident A's back. Resident A stated that he was unsure if Resident C observed the incident. Resident A stated that after he was struck in the back by Resident B, Resident A was able to leave the shared bedroom. Resident A stated that he immediately informed staff Dina Johnson of the incident. Resident A stated that Ms. Johnson asked Resident A to stay in the living area of the facility while she spoke with Resident B. Resident A stated that he did not sustain any injuries from the incident, and he continues to share a bedroom with Resident B. Resident A stated that he feels safe and understands that Resident B will be moving out of the facility on 04/01/2025. Resident A stated that Resident B has never previously assaulted him or any other residents to his knowledge.

Resident B stated that on the morning of 03/12/2025, Resident A grabbed Resident B by the neck after Resident B directed Resident A to "take a shower". Resident B stated that he then "cussed" Resident A out and walked away. Resident B stated that the incident occurred in their shared bedroom. Resident B stated that at no time did Resident B put his hands on Resident A. Resident B stated that he did not assault Resident A in any manner. Resident B stated that Resident C was present during the incident.

Resident C stated that on the morning of 03/12/2025 he was playing with video games with headphones on in the bedroom he shares with Resident A and Resident B. Resident C stated that he did not hear or observe a physical altercation between Resident A and Resident B.

On 03/17/2025 I emailed Adult Protective Services staff Emily Graves and verified that the complaint allegation was assigned to Adult Protective Services staff Reid Arends to investigate.

On 03/18/2025 I interviewed staff Dina Johnson via telephone. Ms. Johnson stated that on 03/12/2025 at approximately 6:45 am, she was in the process of setting up residents' medications. Ms. Johnson stated that he heard Resident B yelling at Resident A inside their shared bedroom. Ms. Johnson stated that immediately after she heard Resident B yelling; Resident A exited the bedroom and reported that Resident B had hit Resident A in the back. Ms. Johnson stated that Resident A did not display any injuries and Resident B denied physically assaulting Resident A. Ms. Johnson stated she asked Resident A to stay in the communal area for separation. Ms. Johnson stated that Resident B has never assaulted Resident A in the past.

On 03/21/2025 I completed an exit conference via telephone with Licensee Designee Mark James. Mr. James stated that he agreed with the special investigation findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means. **(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:** **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R 400.14102(1)(m).** **(i) Any electrical shock device.**
ANALYSIS:	A preponderance of evidence was not discovered to support violation of the applicable rule. Resident A stated that he was assaulted by Resident B. Resident B denied assaulting Resident A. Resident A does not display injuries from the alleged assault. No other individuals observed the incident.

CONCLUSION:	VIOLATION NOT ESTABLISHED

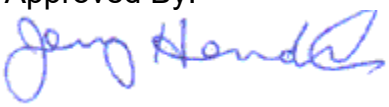
IV. RECOMMENDATION

I recommend no change to the license.

03/21/2025

Toya Zylstra — Date
Licensing Consultant

Approved By:



03/21/2025

Jerry Hendrick — Date
Area Manager