



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 9, 2025

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

RE: License #: AM610259339
Investigation #: 2025A0583055
Terrace Manor

Dear Mr. James:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script, appearing to read "Toya Zylstra".

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 #:	2025A0583055
Complaint Receipt Date:	08/25/2025
Investigation Initiation Date:	08/25/2025
Report Due Date:	09/24/2025
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, AGED, DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is denied reasonable access to the facility's telephone.	Yes
Resident A has not received any of her prescribed medications.	Yes
Resident A is a fall risk and her bedroom is located on the second floor of the facility.	Yes
The electrical outlets in Resident A's bedroom do not work.	No
Additional Findings	Yes

III. METHODOLOGY

08/25/2025	Special Investigation Intake 2025A0583055
08/25/2025	Special Investigation Initiated - Telephone LARA Staff Elizabeth Elliott
08/29/2025	Inspection Completed On-site Staff Stephanie Gregory, Resident A, Resident B, Resident C
08/29/2025	Contact - Document Sent Licensee Designee Mark James
09/03/2025	Contact - Telephone call made Licensee Designee Mark James
09/03/2025	Contact - Telephone call made Staff Johnnie Chandler
09/04/2025	Contact - Telephone call made Staff Johnnie Chandler
09/04/2025	Contact - Document Sent Licensee Designee Mark James
09/04/2025	Contact - Telephone call made Licensee Designee Mark James
09/05/2025	Contact - Telephone call made Bryce Welsh, Pharm D., Guardian Pharmacy
09/05/2025	Contact - Telephone call received Staff Johnnie Chandler
09/08/2025	Contact - Document Sent Licensee Designee Mark James

09/08/2025	Contact - Document Sent Licensee Designee Mark James
09/23/2025	Exit Conference Licensee Designee Mark James

ALLEGATION: Resident A is denied reasonable access to the facility's telephone.

INVESTIGATION: On 08/21/2025 complaint allegations were received from Adult Protective Services centralized intake. The allegations were screened out for Adult Protective Services investigation. The complaint alleged that Resident A is not allowed to use the telephone at the home until after 5:00 PM.

On 08/29/2025 I completed an unannounced onsite investigation at the facility and privately interviewed staff Stephanie Gregory, Resident A, Resident B, and Resident C.

Staff Stephanie Gregory stated that Resident A was recently admitted to the facility. Ms. Gregory stated that she allows all residents unfettered access to the facility's communal telephone. She stated that she has heard from residents that other staff restrict their access.

Resident A, Resident B, and Resident C each stated that staff Johnnie Chandler does not allow residents to use the communal telephone between the hours of 9:00 AM and 5:00 PM.

On 09/04/2025 I interviewed staff Johnnie Chandler via telephone. Mr. Chandler confirmed that he does not allow residents to use the facility's communal telephone between the hours of 9:00 AM and 5:00 PM. He stated that staff need to keep the telephone free during those hours to receive phone calls from professionals such as physicians and case managers.

On 09/23/2025 I completed an exit conference with licensee designee Mark James via telephone. Mr. James stated that staff are instructed to allow residents to use the facility telephone without restrictions. Mr. James stated that he does not believe that staff are restricting residents from using the facility's telephone. Mr. James stated that he will read the Special Investigation report before deciding on his next course of action.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated

	representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes. (2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	Resident A, Resident B, and Resident C each stated that staff Johnnie Chandler does not allow residents to use the communal telephone between the hours of 9:00 AM and 5:00 PM. Staff Johnnie Chandler acknowledged that he does not allow residents to use the facility's communal telephone between the hours of 9:00 AM and 5:00 PM. Based on my investigative findings, which included interviews with staff and residents, a preponderance of evidence was discovered to substantiate a violation of the applicable rule. Residents are prohibited from using the communal telephone between 9:00 AM and 5:00 PM by facility staff Johnnie Chandler.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A has not received any of her prescribed medications.

INVESTIGATION: On 08/21/2025 complaint allegations were received from Adult Protective Services centralized intake. The complaint alleged that Resident A was admitted to the home a week ago and has not received any of her prescribed medications.

On 08/29/2025 I completed an unannounced onsite investigation at the facility and privately interviewed staff Stephanie Gregory and Resident A.

Staff Stephanie Gregory stated that Resident A was admitted to the facility for approximately a week without receiving her medications. She stated that she could not recall the exact date Resident A was admitted to the facility. She stated that

staff ordered Resident A's medications and administered them once they were received approximately a week later. She stated that since Resident A's medications have arrived at the facility, she has received her medications according to physician's instructions.

Resident A stated that she does not know the names of all her prescribed medications and is unsure if she is receiving all her prescribed medications. She stated that she was admitted to the facility without her prescribed medications and after "7-10 days" the facility received her medications from the pharmacy and began administering them.

While onsite I observed that Resident A's medications, packaged in blister packs by Guardian pharmacy, included the following: Aspirin 81 MG, Vitamin D3 1000U, Pantoprazole 40MG, POT Chloride 20 MEQ, Gabapentin 100 MG, Hydrochlorot 25 MG, Metformin 500 MG, and Atorvastatin 40 MG, Quetiapine 400 MG.

While onsite I attempted to review Resident A's Medication Administration Record (MAR), however Ms. Gregory stated that she was not trained and does not know how to print a monthly MAR.

On 09/04/2025 I interviewed staff Johnnie Chandler via telephone. Mr. Chandler stated that Resident A was admitted to the facility without her prescribed medications and he could not recall Resident A's date of admission. Mr. Chandler stated that he ordered Resident A's medications from Guardian Pharmacy and immediately after the medications were delivered, staff administered her medications as prescribed. Mr. Chandler stated that staff marked in Resident A's MAR that the medications were "on hold" during the time she was residing at the facility but not receiving her medications because the pharmacy had not delivered them. Mr. Chandler stated that it took approximately a week before Resident A's medications were received from the pharmacy.

On 09/05/2025 I interviewed Bryce Welsh, Pharm D. He stated that he is the Director of Operations for Guardian Pharmacy of West Michigan. Mr. West stated that on 08/13/2025 Guardian Pharmacy received an electronic alert that a request was made to refill Resident A's medications. The electronic alert does not identify who made the request for medications. He stated that on 08/14/2025 he requested Resident A's identifying information from the facility because that information is required before sending Resident A's medications to the facility. He stated that on 08/21/2025 he received "enough" information from facility staff to send Resident A's medications to the facility. He stated that on 08/21/2025 at 8:17 PM staff Dina Johnson signed that the facility had received Resident A's prescribed medications. He stated that all of Resident A's medications, except Naproxen BID, were sent to the facility from Guardian Pharmacy. He stated that Resident A's Naproxen BID is "supplied by the VA".

On 09/05/2025 I received Resident A's MAR from 08/01/2025 until 08/31/2025. This documentation indicates that staff administered all Resident A's prescribed medication from 08/22/2025 until 08/31/2025. The MAR indicates from 08/14/2025 until 08/21/2025 staff noted that Resident A's medications were "on hold", consequently indicating she was residing in the home, but not receiving the medications.

On 09/15/2025 I completed a LARA file review and observed that the facility was found to be in violation of R 400.14312 (1) on 03/21/2025. Per Special Investigation 2025A0356019, staff failed to administer resident medications as prescribed. A Corrective Action Plan was received and approved on 04/23/2025. Additionally, the facility was found to be violation of R 400.14312 (1) on 07/30/2025. Per Special Investigation 2025A0356042, staff failed to administer resident medications as prescribed, which resulted in a recommendation of changing the licensing status to a first provisional license. This matter is still pending.

On 09/23/2025 I completed an exit conference with licensee designee Mark James via telephone. Mr. James stated that the facility attempted to fill Resident A's medications upon her admission, however the Veterans' Administration would not fill Resident A's medications at a civilian pharmacy. He stated that he disputes the finding and will read the Special Investigation report before deciding on his next course of action.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A stated that she was admitted to the facility without her prescribed medications and it took "7-10 days" after her admission before she began receiving her medications. Staff Stephanie Gregory and Johnnie Chandler both stated that Resident A was admitted to the facility for approximately a week before she began receiving her medications.

	Bryce Welsh, Pharm D., Director of Operations for Guardian Pharmacy of West Michigan stated that on 08/14/2025 he requested Resident A's identifying information to send her medications to the facility. He stated that on 08/21/2025 he received "enough" information from facility staff to send Resident A's medications to the facility. He stated that on 08/21/2025 8:17 PM staff Dina Johnson signed that the facility received Resident A's prescribed medications. Repeated attempts were made to contact and speak with licensee designee Mark James requesting the date Resident A was admitted to the facility. As of the date of this report, Mr. James has failed to respond and failed to provide the date of Resident A's admittance to the facility. Based on my investigative findings, which included interviews with staff, residents, pharmacy staff, and a review of pertinent documents, a preponderance of evidence was discovered to substantiate a violation of the applicable rule. Resident A was admitted to the facility for approximately a week before Resident A received her prescribed medications.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A is a fall risk and her bedroom is located on the second floor of the facility.

INVESTIGATION: On 08/21/2025 complaint allegations were received from Adult Protective Services centralized intake. The complaint stated that Resident A "recently had a stroke and has limited use of the right side of her body" and that her bedroom is on the 2nd floor of the home and she cannot use the stairs.

On 08/29/2025 I completed an unannounced onsite investigation at the facility and privately interviewed staff Stephanie Gregory and Resident A.

Staff Stephanie Gregory stated that she has not reviewed Resident A's Assessment Plan or Health Care Appraisal and is therefore unsure if Resident A is a fall risk or displays impaired mobility. She stated that she could not locate the requested documents at the facility and therefore could not supply them for my review. She confirmed that Resident A's bedroom is located on the second floor of the facility. She stated that she has not observed Resident A display an inability to navigate the stairs up to the second floor. Ms. Gregory stated that Resident A has never complained regarding navigating the stairs.

Resident A stated that she suffered a stroke just prior to being admitted to the facility. Resident A stated that the stroke affected the right side of her body and has limited her mobility. She stated that she cannot raise her right arm above her shoulder and her right leg “drags”. She stated that her bedroom is located on the second floor of the facility which is unsafe. She stated that she can navigate the stairs, but it is difficult and unsafe. She stated that she is a fall risk and recently fell down the facility’s front porch stairs causing her to sustain a “skinned knee”.

I observed that Resident A cannot raise her right arm above her right shoulder. I also observed that Resident A can walk but drags her right leg. She exhibits impaired mobility due to her right-side deficits.

On 09/04/2025 I interviewed staff Johnnie Chandler via telephone. Mr. Chandler stated that he has observed Resident A “has a problem with her arm” but has not observed ambulation deficits. He stated that Resident A has not reported to him that she recently fell down the stairs from the front porch.

On 09/23/2025 I completed an exit conference with licensee designee Mark James via telephone. Mr. James stated that Resident A was previously residing at Pine Rest just before being admitted to the facility. Mr. James stated that the social worker from Pine Rest assured Mr. James that Resident A could successfully navigate the facility’s stairs with a railing. He stated that he was initially informed that Resident A had a legal guardian and thus sent Resident A’s Assessment Plan to the guardian for completion. Mr. James stated that he was subsequently informed that Resident A does not have a guardian and Resident A currently refuses to sign her Assessment Plan. Mr. James stated that there are no rooms available at the facility on the main floor and he will be issuing Resident A a 30-day discharge notice.

APPLICABLE RULE	
R 400.14408	Bedrooms generally.
	(9) A resident who has impaired mobility shall not sleep in or be assigned a bedroom that is located above the street floor of the home.
ANALYSIS:	Resident A stated that she suffered a stroke just prior to being admitted to the facility which has limited her mobility. I observed that Resident A cannot raise her right arm above her right shoulder and drags her right leg while ambulating. I observed that Resident A’s bedroom is located on the second floor of the facility. While onsite, staff Stephanie Gregory stated that she has not reviewed Resident A’s Assessment Plan or Health Care Appraisal. She stated that she could not locate these

	documents at the facility and therefore could not supply them for my review. Repeated attempts were made to contact and speak with licensee designee Mark James to request a copy of Resident A's Assessment Plan. As of the date of this report, Mr. James has failed to respond to my attempts to reach him. Based on my investigative findings, which included interviews with staff, and residents, a preponderance of evidence was discovered to substantiate a violation of the applicable rule. Resident A demonstrates impaired mobility, and her bedroom is located on the second floor of the facility.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: The electrical outlets in Resident A's bedroom do not work.

INVESTIGATION: While onsite on 08/29/2025, I observed an electrical outlet located in Resident A's private bedroom lacks a wall plate cover, leaving the outlet exposed. I observed that the electrical outlet does have power.

On 09/23/2025 I completed an exit conference with licensee designee Mark James via telephone. Mr. James stated that he agreed with the finding.

APPLICABLE RULE	
R 400.14512	Electrical service.
	(1) The electrical service of a home shall be maintained in a safe condition.
ANALYSIS:	While onsite on 08/29/2025, I observed an electrical outlet located in Resident A's private bedroom lacks a wall plate cover, leaving the outlet exposed. I observed that the electrical outlet does have power. Based on my investigative findings, a preponderance of evidence was not discovered to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: Licensee Designee Mark James failed to cooperate with the current Special Investigation.

INVESTIGATION: On 08/29/2025 I emailed licensee designee Mark James. The email contained the complaint allegations and requested Mr. James email me a copy of Resident A's Medication Administration Records (MAR), Resident A's Assessment Plan, and staff contact information.

On 09/03/2025 I telephoned licensee designee Mark James. Mr. James did not answer the telephone call, and I left a message requesting a return call to discuss the complaint allegations and Resident A's required documents.

On 09/04/2025 I telephoned licensee designee Mark James. Mr. James did not answer the telephone call, and I left a message requesting a return call to discuss the complaint allegations and Resident A's required documents.

On 09/04/2025 I emailed licensee designee Mark James and requested Mr. James email Resident A's MAR and Assessment Plan. I also requested that Mr. James call me to complete an interview regarding the complaint allegations.

On 09/08/2025 I emailed and text messaged licensee designee Mark James. The email requested Mr. James email me a copy of Resident A's MAR and Assessment Plan. The email provided a deadline of 5:00pm on 09/11/2025 for the delivery of these documents and stated that should the documents not be received by this date, I would assume Mr. James did not have them and would include that finding in the special investigation report.

On 09/15/2025 I completed a LARA file review and observed that the facility was found to be violation of R 400.14103 (3) on 07/30/2025. Per Special Investigation 2025A0356042, facility staff failed to cooperate with the special investigation and refused to provide a Corrective Action Plan. As a result, a recommendation for changing the licensing status to a first provisional license was entered. This matter is still pending.

On 09/23/2025, I completed an Exit Conference with licensee designee Mark James via telephone. Mr. James stated that he has been "out of town" the past three weeks on a cruise which led to his lack of communication. He elaborated that he was not technically on a ship for three weeks but stated that he "had to get out town" after dealing with "personal matters". Mr. James stated that he would read the Special investigation report before deciding upon his next course of action.

APPLICABLE RULE	
R 400.14103	Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.
	(3) The failure of an applicant or licensee to cooperate with the department in connection with an inspection or

	investigation shall be grounds for denying, suspending, revoking, or refusing to renew a license.
ANALYSIS:	Despite multiple email, telephone, and text message requests, licensee designee Mark James failed to cooperate with the department regarding this Special Investigation. Mr. James, by virtue of his failure to respond, failed to supply required documents including Resident A's Medication Administration Records and Assessment Plan and failed to provide an interview regarding the complaint allegations. Based on my investigative findings, a preponderance of evidence was discovered to substantiate a violation of the applicable rule. Licensee designee Mark James failed to cooperate with the department in connection with this Special Investigation.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING: Resident A's bedroom contains an electrical outlet without a wall plate cover.

INVESTIGATION: While onsite on 08/29/2025, I observed an electrical outlet located in Resident A's private bedroom lacks a wall plate cover, leaving the outlet exposed.

Resident A stated that the electrical outlet has lacked the wall plate cover for as long as she has resided at the facility.

Staff Stephanie Gregory stated that she was unaware that the electrical outlet was in disrepair.

On 09/05/2025 I interviewed staff Johnnie Chandler via telephone. Mr. Chandler stated that he was on his way to a store to secure supplies to fix Resident A's wall plate cover. He stated that Mr. James informed him that Resident A's outlet was in disrepair and required remediation.

On 09/23/2025 I completed an exit conference with licensee designee Mark James via telephone. Mr. James stated his staff informed him that the wall plate was broken and staff have corrected the issue. He stated that he did not dispute this violation.

APPLICABLE RULE	
R 400.14512	Electrical service.

	(1) The electrical service of a home shall be maintained in a safe condition.
ANALYSIS:	While onsite on 08/29/2025, I observed an electrical outlet located in Resident A's private bedroom lacks a wall plate cover, leaving the outlet exposed. Resident A stated that the electrical outlet has lacked the wall plate cover for as long as she has resided at the facility. Based on my investigative findings, a preponderance of evidence was discovered to substantiate a violation of the applicable rule. Resident A's private bedroom contains an electrical outlet that lacks a wall plate cover.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Licensing Consultant Elizabeth Elliott completed Special Investigation 2025A0356042 which found the facility to be in violation of R 400.14312 (1) and R 400.14103 (3) on 07/30/2025. Per Ms. Elliott's investigation, the facility failed to administer resident medications as prescribed and licensee designee Mark James failed to cooperate with that investigation which resulted in a recommendation of a first provisional license. As a result of the findings of Ms. Elliott's investigation in addition to the findings of this investigation, I recommend the license be modified to first provisional status.



10/06/2025

Toya Zylstra
Licensing Consultant

Date

Approved By:



10/09/2025

Jerry Hendrick
Area Manager

Date