GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 2, 2026

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

RE: License #:	AM610259339
Investigation #:	2026A0356021
	Terrace Manor

Dear Mr. James:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the 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. 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610259339
Investigation #:	2026A0356021
Complaint Receipt Date:	02/13/2026
Investigation Initiation Date:	02/13/2026
Report Due Date:	04/14/2026
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:	1ST PROVISIONAL
Effective Date:	10/20/2025
Expiration Date:	04/19/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
The licensee failed to move Resident A to a room she can access due to her physical impairment.	No
Residents at the facility stole money and personal belongings from Resident A and staff failed to protect Resident A.	No
Additional Finding	Yes

III. METHODOLOGY

02/13/2026	Special Investigation Intake 2026A0356021
02/13/2026	APS Referral Stephanie Kindle.
02/13/2026	Special Investigation Initiated - Telephone Stephanie Kindle, APS
02/17/2026	Contact-Document received LARA BCHS online complaint
02/17/2026	Contact - Telephone call made Krystal Bronnekant, RN, VA nurse case manager.
02/17/2026	Inspection Completed On-site
02/19/2026	Contact - Document Received Krystal Bronnekant.
02/19/2026	Contact - Telephone call received Licensee Designee, Mark James.
03/09/2026	Contact - Document Received Krystal Bronnekant.
03/09/2026	Contact - Telephone call received Licensee Designee, Mark James.
03/09/2026	Contact - Telephone call made LD, Mark James.

03/11/2026	Contact - Document Received Mark James, LD.
03/25/2026	Contact-Telephone call received M. James.
03/25/2026	Contact-Document received Email message from K. Bronnekant.
03/27/2026	Exit conference, Mark James, LD.

ALLEGATION: Licensee failed to move Resident A to a room she can access due to her physical impairment.

INVESTIGATION: On 02/13/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that Resident A had a stroke last summer and needs to be in a first-floor bedroom. The AFC home has denied this to Resident A so she is forced to climb a full set of stairs to her room. The complainant reported there is a bathroom on her level. The kitchen is on the first floor and laundry is in the basement. Resident A does not receive any help with laundry and needs to climb those stairs also. Resident A is a fall risk due to the stroke. The complainant reported Resident A has fallen many times since she has lived at Terrace Manor and has even been hospitalized as a result. The complainant reported that Resident A needs a safer placement but does not have the capacity to follow through with these decisions. The AFC owner, Mark James, plans to take Resident A to the emergency room and tell them he will not accept her back in the home.

Note: On 08/21/2025, SI2025A0583055 (special investigation) was investigated by Licensing Consultant, Toya Zylstra. The allegations were that Resident A is a fall risk and her bedroom is located on the second floor of the facility. Ms. Zylstra established a violation of R400.14408(9) on 10/06/2025 and a corrective action plan was received (from licensee Mark James) on 10/10/2025 stating, '*the resident insists that she can do the stairs and does not want to move. I have given her a 30-day notice. I have contacted Muskegon DHS, and they have not been helpful as I'm being told there are very few homes in Muskegon that have openings. I am in the process of getting her an Adult Services Worker. Once that process is complete, I feel I will have better luck getting her placed in a new home. It is the opinion of all the staff at the home that she isn't having a difficult time with the stairs. I sent my handyman over to the house to ensure that handrails are available and secure on both stairways.*'

Note: On 12/29/2025, while at the home on another matter, I observed Resident A climb the stairs to her room at the facility. Resident A used the rail on the way up and down the steps but was not unsteady while climbing the steps on this date and navigated the steps adequately. Resident A stated while in the community, she uses

a motorized wheelchair and a cane. I did not observe Resident A use a cane while ambulating through the home.
On 02/13/2026, I interviewed Stephanie Kindle, DHHS (Department of Health and Human Services) APS (Adult Protective Services) Worker via telephone. Ms. Kindle stated she currently has an open investigation and is following up on the reported allegations. Ms. Kindle reported that she did not observe Resident A in the facility but saw her in the hospital.

On 02/17/2026, I conducted an unannounced inspection at the home. I interviewed DCW (direct care worker) John “June” Chandler. Mr. Chandler stated on Friday, 02/06/2026, Resident A said she wanted to kill herself. The police came and then Resident A “straightened up” and remained at the home. Mr. Chandler stated Resident A’s VA (Veteran’s Administration) worker came to see her and then she went to the VA hospital and is no longer residing in the home. Mr. Chandler stated Resident A has not fallen or had trouble getting up and down the steps to her room. Mr. Chandler stated the issues with Resident A’s mobility came into play when she used substances while out of the home, then she had trouble with mobility. I observed Resident A’s belongings still in her room, but Mr. Chandler stated Resident A is currently inpatient at a VA hospital, and there is no plan for Resident A to return to the home. Mr. Chandler stated he has never issued a 30-day notice of discharge to Resident A nor does he know if one was issued by Mr. James.

On 02/17/2026, I interviewed Resident B, C, D, E, F, G, H, I, and J at the facility. All the residents reported they have not seen Resident A fall while going up or down the steps at the facility.

On 02/17/2026, I received another LARA-BCHS online complaint. The complainant reported they were visiting Resident A at the home when licensee Mark James called the complainant. The complainant reported that she missed the call and the on-duty staff yelled up to Resident A’s room to let the complainant know that she had a telephone call. The complainant reported she called Mr. James back, and he asked how Resident A was doing. The complainant reported that Resident A was “at baseline” and willing to receive her injection for the week. The complainant reported that Mr. James indicated he was planning to use Resident A’s recent mental health decline to petition the court and have her removed from the home. Mr. James reportedly stated he was going to have his driver bring Resident A to the hospital and tell them she cannot come back to his home. The complainant stated Mr. James was told months ago that Resident A needs to be moved to a first-floor room, and this has not happened. Mr. James was far more concerned about his license than the safety of this resident.

On 02/17/2026, I interviewed Krystal Bronnekant, RN, BSN, Mental Health Intensive Case Management, U.S. Department of Veterans Affairs (VA). Ms. Bronnekant stated she is Resident A’s case manager through the VA. She stated Resident A does not have a legal guardian although she would benefit from having one. She is currently in-patient for mental health at the Ann Arbor VA and likely will not return to

this home. Ms. Bronnekant stated Resident A remained in the second-floor bedroom and Mr. James never issued a 30-day notice. Ms. Bronnekant stated she visited Resident A in her room at the facility on Wednesday, 02/11/2026. Ms. Bronnekant stated Resident A was fine and willing to get her injection medication, yet Mr. James informed her that Resident A was refusing to get her injection medication and decompensating, which was not the truth. Ms. Bronnekant stated in the week prior to 02/11/2026, Resident A reported that she was going to refuse her injection, but she never did refuse it. Ms. Bronnekant stated Mr. James ended up having a staff, possibly Roy James, drop Resident A off at ER on 02/11/2026, to get her out of the home. Ms. Bronnekant stated Mr. James told her on 02/11/2026 that he had never issued Resident A a 30-day notice because he did not have time to issue the discharge notice.

On 02/19/2026, I exchanged text messages with Licensee, Mark James. Mr. James wrote in his text that he gave Resident A a 30-day notice that has expired already and no one ever found a new placement for Resident A. Mr. James stated he did not send the notice to Ms. Bronnekant because she is Resident A's nurse and not her case manager.

On 03/09/2026, I requested Resident A's assessment plan, health care appraisal and resident care agreement for review. Mr. James informed me that staff gave Resident A's entire file to Resident A's son when he showed up at the facility and requested it. Mr. James stated he does not have a resident file for review.

On 03/11/2026 I exchanged text messages with Mr. James. Mr. James stated DCW Dinah Johnson delivered by hand the 30-day notice to Resident A but he is unsure if the document is in Resident A's file or in a lock box located at the home. Mr. James stated Ms. Bronnekant was trying to find a new placement for Resident A and Ms. Bronnekant was trying to figure out a way to get Resident A into the hospital as she reported it would be easier to find placement into a different facility directly from the hospital. Mr. James stated he had no one to issue the 30-day notice to other than Resident A because she had no guardian, no case manager and no DHHS worker.

On 03/20/2026, Ms. Bronnekant provided notes via email detailing the police interaction with Resident A on 02/06/2026. Ms. Bronnekant stated she called the police on 02/06/2026 after speaking with Resident A and Resident A made homicidal and suicidal threats. Ms. Bronnekant stated she offered Resident A to go to ER or Battle Creek for inpatient care, both of which Resident A refused. Ms. Bronnekant documented that she spoke to staff at the facility and they reported Resident A had been "going off on tangents" frequently. Ms. Bronnekant stated law enforcement, Officer VanDyken interviewed Resident A. She (Resident A) was cooperative and reported that she did not recall making those statements and said, "sometimes when I'm mad, I just say things." Officer VanDyken could not petition Resident A for inpatient care and had the police social worker check on Resident A the following day. Ms. Bronnekant documented that she would check on Resident A via telephone

and advised home staff to call law enforcement if Resident A begins to make statements of this nature again over the weekend.

On 03/20/2026, I exchanged text messages with Mr. James about Resident A's assessment plan. Mr. James reported that on the assessment plan, he had it documented that Resident A was unstable on her feet but that she was able to walk the stairs fine and if she became unsteady in the future, she would need to move downstairs if a bed was available or move out of the home if a bed was not available.

On 03/25/2026, I interviewed Mr. James via telephone. Mr. James stated Resident A's nurse, Ms. Bronnekant contacted him (Mr. James) and stated the goal was to get Resident A into the hospital because it is easier to find different placement for her from the hospital rather than from the AFC home. Mr. James stated Ms. Bronnekant could not put Resident A in the hospital, so Mr. James stated he had Roy James (DCW) take Resident A to the hospital. Mr. James stated the hospital social worker asked him if he would take Resident A back into the AFC home once she was discharged and Mr. James stated he told the social worker that he would allow Resident A to return to the home upon discharge.

On 03/25/2026, I received an email from Ms. Bronnekant. Ms. Bronnekant reported that Resident A remains in the VA hospital and they are trying to find an appropriate level of care placement for Resident A at this time.

On 03/27/2026, I conducted an exit conference with Mr. James via telephone. Mr. James stated the information provided by the complainant and Ms. Bronnekant is not accurate. Mr. James stated Resident A did refuse her injection to his staff more than once, but Ms. Bronnekant talked Resident A into taking her injection. Mr. James stated he and Ms. Bronnekant agreed upon a plan to get Resident A hospitalized with the hope that a new placement could be found while Resident A was in the hospital. Mr. James stated the complaint information was not truthful and this complaint was unnecessary. Mr. James stated he agreed with the final findings of this applicable rule.

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:	The complainant reported Resident A is a fall risk due to a stroke. Her room is upstairs while the laundry room and kitchen are on different floors of the facility. Resident A needs a safer placement and Mark James plans to take Resident A to the emergency room and tell them he will not accept her back in the home.

	Mr. James stated he never told hospital staff that he was unwilling to take Resident A back into the home upon discharge from the VA hospital. Ms. Bronnekant stated she is not aware that Mr. James refused to take Resident A back into the home upon discharge. Resident A was no longer residing in the home at the time the complaint was filed and there is a lack of evidence to show that Resident A was a documented fall risk or that Mr. James refused to take her back into the home upon discharge from the hospital. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents at the facility stole money and personal belongings from Resident A and staff failed to protect Resident A.

INVESTIGATION: On 02/13/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that other residents in the facility have stolen money and other things from Resident A. She reportedly told staff, but nothing was done to correct it.

On 02/17/2026, I conducted an unannounced inspection at the facility and interviewed Mr. Chandler. Mr. Chandler stated he is not aware nor has he been told by Resident A that residents at the home have stolen money or other items from her.

On 02/17/2026, I interviewed Resident B, C, D, E, F, G, H, I and J at the facility. Each of the residents reported they have no knowledge about anyone stealing money or other items from Resident A.

On 03/27/2026, I conducted an exit conference with Mr. James via telephone. Mr. James stated he agreed with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported that other residents in the facility have stolen money and other things from Resident A, she told staff, but nothing was done to correct it. Based on staff and resident interviews, there is a lack of evidence to show that other residents in the facility took advantage of Resident A by stealing from her. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 03/09/2026, I requested Resident A's assessment plan, health care appraisal and resident care agreement for review. Mr. James informed me that staff gave Resident A's entire file to Resident A's son when he came to the home and requested it.

On 10/13/2025, Mr. James signed a settlement agreement with Jay Calewarts, Director, AFC Division, Bureau of Community Health Systems in settlement of all issues raised in amended Special Investigation Report #2025A0356042 and Special Investigation Report #2025A0583055. One of the items on the settlement agreement (#8), documented, *'American AFC Inc. agrees to make electronic medication logs, resident care agreements, assessment plans, health care appraisals, and any other required documentation available to licensing consultants and documentation can be printed if requested by the licensing consultant.'*

On 03/27/2026, I conducted an exit conference with Mr. James via telephone. Mr. James did not have any information to add to this additional finding. Mr. James did not dispute the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.623(5)	**Applicant, licensee and administrator qualifications; licensee, administrator and staff requirements; parole or probation or convicted of felony.**
	(5) A licensee and administrator or their designee shall possess all of the following qualifications: (a) Be capable of meeting the physical, emotional, social, and intellectual needs of each resident. (c) Be capable of ensuring program planning, development, and implementation of services to

	residents consistent with the facility's program statement and in accordance with a resident's assessment plan and care agreement.
ANALYSIS:	Stipulations documented in the Settlement Agreement dated 10/13/2026, specifically stated Mr. James as the Licensee Designee for American AFC, Inc. agrees to make electronic medication logs, resident care agreements, assessment plans, health care appraisals, and any other required documentation available to licensing consultants and documentation can be printed if requested by the licensing consultant. Mr. James stated Resident A’s file was unavailable for review because the entire file was given to Resident A’s relatives. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based on the recommendation from SI2026A0356019, I continue to recommend the revocation of this license.

03/30/2026

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

03/30/2026

Jerry Hendrick — Date
Area Manager