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 #:	2025A0356019
	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.

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 #:	2025A0356019
Complaint Receipt Date:	01/23/2025
Investigation Initiation Date:	01/23/2025
Report Due Date:	03/24/2025
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 DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are not being administered as prescribed causing health issues.	Yes
Additional Finding	Yes

III. METHODOLOGY

01/23/2025	Special Investigation Intake 2025A0356019
01/23/2025	APS Referral
01/23/2025	Contact - Document Sent APS worker, Joe Clark, Muskegon County DHHS.
01/23/2025	Contact - Telephone call made Joe Clark, DHHS, APS worker.
01/23/2025	Special Investigation Initiated - Telephone Joe Clark, DHHS, APS worker.
02/13/2025	Inspection Completed On-site
02/13/2025	Contact - Face to Face John "June" Chandler, DCW, Resident A, Joe Clark, APS.
02/13/2025	Contact - Telephone call made Guardian Pharmacy, Holly Fetterhoff re: MARs, with June Chandler at the AFC.
03/12/2025	Contact - Telephone call made Samantha Cummins, HW supervisor re: case manager.
03/13/2025	Contact - Telephone call made Ben Borton, DNP re: medical. Left message.
03/13/2025	Contact - Telephone call made Dr. Melissa Wynsma's office, ofc mgr. Jill Venay will have the nurse call me back. No response.
03/13/2025	Contact - Telephone call made Elizabeth Anderson, HW supports coordinator.

03/18/2025	Contact-Document Sent Text messages with DCW Dinah Johnson.
03/19/2025	Contact-Telephone call made Roy James, DCW (former). Relative #1.
03/20/2025	Contact-Telephone call received. Relative #1. Ben Borton, DNP, endocrinology.
03/20/2025	Contact-Document received. Trinity Health Emergency Room notes.
03/24/2025	Exit Conference-Licensee Mark James.

ALLEGATION: Resident A's medications are not being administered as prescribed causing health issues.

INVESTIGATION: On 01/23/2025, I received a complaint emailed by Muskegon County DHHS (Department of Health and Human Services) APS (Adult Protective Services) Worker, Joseph Clark. The complainant who is kept anonymous per policy by APS reported on 10/07/2024, Resident A's seizure medication, Vimpat, was delivered but not administered and on 10/09/2024, Resident A was taken to ER for having a seizure. Resident A reported that he did not get his medication Vimpat. On 01/02/2025-01/03/2025, Resident A was hospitalized due to hyperglycemia due to a failed insulin pump. The complainant reported when Resident A saw his endocrinology doctor, the doctor stated until someone could come to an appointment with Resident A to learn about his pump and how it functions, he would not allow Resident A to try the insulin pump anymore. On 01/10/2025, Resident A was back in the ER, and reported having a seizure two days prior on 01/08/2025. The complainant reported a caregiver, Roy James called to report Resident A had a seizure on 01/07/2025. The complainant reported Mr. R. James spoke to the complainant about Resident A's insulin pump and Mr. R. James reported that it was too much for him to take on and mentioned nothing about Resident A's seizure. The complainant reported that Mr. R. James reported Resident A gets his medications and everything is fine. The complainant reported there seems to be some confusion with Mr. R. James and it is unclear if he can provide the level of care Resident A needs. In addition, there is a concern that Resident A is not getting his medication as prescribed.

On 02/13/2025, I conducted an unannounced inspection at the facility and interviewed DCW (direct care worker) John "June" Chandler. Mr. Clark was also present during this inspection. Mr. Chandler stated Resident A gets his medications as prescribed and he never goes days without either his seizure medication Vimpat or insulin, yet Resident A still gets seizures, and his blood sugar fluctuates from time to time. Mr. Chandler stated Resident A's seizure disorder throws his blood sugars

off, and that Mr. R. James takes Resident A to medical appointments, but Mr. R. James does not regularly go into the appointments as Resident A is his own guardian and does not always want staff in his medical appointments. Mr. Chandler stated medical information from doctor appointments that Resident A attends on his own often is not relayed to staff at the facility by Resident A. Mr. Chandler stated Resident A received Vimpat, in October 2024 as prescribed, and Resident A was in the hospital from 01/02/2025-01/03/2025 for hyperglycemia due to a failed insulin pump. Mr. Chandler stated he does not recall Resident A being hospitalized in October 2024 due to a seizure. Mr. Chandler stated Resident A usually has seizures in the morning when he (Mr. Chandler) is not working. Mr. Chandler stated Resident A's seizures do not make him fall and seize, he just stares and does not respond. Mr. Chandler stated Resident A could have a seizure at any time even though they administer his medications as prescribed. Mr. Chandler stated staff and residents can tell when Resident A is having a seizure because he quits responding and stares, so they make sure he is somewhere safe, sitting down and monitored. Mr. Chandler stated he had no idea how the insulin pump came about, received no training on the maintenance of the insulin pump and the pump was never on the MAR. Mr. Chandler stated he asked Resident A how they were going to know how to use the pump and Resident A told him that he knew how to use the insulin pump. Mr. Chandler stated he asked Mr. R. James about the insulin pump and Mr. R. James stated he did not know much about it. Mr. Chandler stated he requested that Resident A have the doctor call the house to explain the pump but received no feedback at all from the doctor's office. Mr. Chandler stated he called Ben Borton's office, DNP (nurse practitioner) and attempted to talk to someone at the doctor's office about the insulin pump but was told they could not talk to him due to HIPPA restrictions. Mr. Chandler stated staff at the doctor's office stated they would have to ask Resident A if Mr. Chandler could be added to his (Resident A's) chart for consultation. Mr. Chandler stated the doctor's office staff said they would call him back and he never heard from them again. Mr. Chandler stated they always test Resident A's blood sugar and administer insulin as directed by the physician, then he got this automatic insulin pump, and it did everything for him until it failed which was in the beginning of January 2025. Mr. Chandler stated now Resident A is back on the old routine of testing his blood sugar and taking Novolog and Lantus, a slow acting insulin at night. Mr. Chandler stated when Resident A's medications get low, he calls the pharmacy and the pharmacy calls the insurance company and if it isn't time to refill the medication, they will not send it until it is time. Mr. Chandler stated he administers all Resident A's medications as prescribed. Mr. Chandler stated there are no IR's (incident reports) that he is aware of that had been written regarding Resident A's hospitalizations and/or ER visits.

On 02/13/2025, Mr. Clark and I interviewed Resident A at the dining room table at the facility. Resident A stated he takes Vimpat, his seizure medication twice daily. Resident A stated he gets the medication and does not refuse to take them. Resident A stated he gets the medication at 8:00-9:00a.m. and again at 7:00-8:00p.m. Then Resident A stated he was unsure if he got his medication Vimpat twice daily, and said, "I can't remember." Resident A stated he went to the hospital

due to a seizure. Then, Resident A stated on 01/07/2025 around 9:00p.m. he had a seizure but did not go to the hospital but instead, Mr. R. James had him come downstairs to the main living area of the facility so he could monitor him. Mr. Clark stated he interviewed Resident A during an earlier visit to the facility and Resident A reported he did not have the Vimpat medication from 01/06/2025-01/08/2025. Resident A stated he does not know when his medications need refilling because they are locked up in a medication cart.

Resident A stated on 01/02/2025 he did not have insulin in the automatic insulin pump because he did not know how to refill the cartridge on the pump. Resident A stated his sugar was high and he took Novolog that was in the medication cart to bring his sugar down, but it did not help, and he had to go to the hospital. Resident A then stated the cartridge for the insulin pump did not run out until he was already in the hospital and did not run out of insulin prior to his hospital stay. Resident A still had a port on his upper arm that was the site of the automatic insulin pump. He explained the machine would automatically test his blood sugar and administer the necessary amount of insulin needed but no one at the facility knew how to maintain the pump and that his sister was assisting him with the maintenance of the pump.

On 02/13/2025, I reviewed Resident A's MAR (medication administration record) dated October 2024 per the complaint allegations. The MAR documented:

- Lacosamide (AKA Vimpat), Tab 200mg, take one tablet by mouth twice daily, at 9:00a.m. and 8:00p.m., administered as prescribed and documented by staff initials.
- The MAR does not reflect any missed seizure medications between 10/07/2024-10/09/2024, nor does it reflect Resident A missed medications on 10/09/2024 due to being hospitalized.
- In addition, there is another seizure medication on the MAR, Zonisamide Cap 100mg, take two capsules (200mg) by mouth at bedtime. This medication is documented as administered as prescribed and documented by staff initials.

On 02/13/2025, I reviewed Resident A's MARs dated October 2024 and at that time, staff were testing Resident A's blood sugar readings, administering insulin and documenting it on the MAR. The MAR documented:

- insulin ASPA INJ flex pen, NovoLog flex pen, inject up to 33 units daily per insulin instructions, 3 units before meal, plus 1 unit for every 25mg/dl greater than 150.
- Invega sust INJ 156mg/ml inject intramuscularly every month.
- Resident A's blood sugar reading, site of injection, units and time of administration are documented by staff.
- These medications are documented as administered as prescribed and documented by staff initials.

There is no insulin pump documented on the MAR.

On 02/13/2025, I reviewed Resident A's MAR dated January 2025 per the complaint allegations. The MAR documented:

- Lacosamide (AKA Vimpat), Tab 200mg, take one tablet by mouth twice daily, at 9:00a.m. and 8:00p.m., and Zonisamide Cap, 100mg, take three capsules by mouth at bedtime are documented administered as prescribed and documented by staff initials.
- The MAR does not reflect any missed seizure medications other than 01/02/2025, 01/03/2025 and 01/04/2025 as marked by an 'H' on the MAR indicating Resident A was in the hospital.

On 02/13/2025, I reviewed Resident A's MARs dated January 2025, the MAR documented:

- insulin ASPA INJ 100ML, 12/16/2024, Novolog inject up to 55 units subcutaneously once daily via insulin pump as directed.
- Insulin ASPA INJ Flex pen 1/7/2025 Novolog flex pen inject up to 45 units subcutaneously once daily per insulin instructions.
- Invega sust INJ 156mg/ml 03/01/2023 inject 156mg intramuscularly every month. This medication is documented as administered as prescribed.
- These medications are documented as administered as prescribed and documented by staff initials beginning on 01/05/2025 after Resident A's hospitalization.
- On 01/01/2025 and 01/02/2025, the MAR documented a "NR" for the site (of insulin injection) and a "0" for the 9:00a.m. administration of the insulin from the pump. "NR" is documented as meaning "not recorded." I reviewed the explanation page on the MAR and the staff initials are RJ1 (Roy James) and the explanation is the pump was the method of administering the insulin to Resident A. However, based on investigative findings, this is likely when the cartridge for the insulin pump failed causing Resident A's hospitalization.
- Based on a review of the MAR, Resident A got the insulin pump on or around 12/06/2024, he went into the hospital sometime on 01/02/2025 and upon his discharge to the facility, the insulin pump was no longer being used and the previous way of administering Resident A's insulin was restored beginning on 01/05/2025.

On 02/13/2025, I reviewed Resident A's resident care agreement signed by Resident A and Licensee Designee, Mark James. This form documented the basic fees include staff transport to 'regular local doctor and psych appointments that are considered routine.'

On 03/13/2025, I interviewed Elizabeth Anderson, Health West supports coordinator via telephone. Ms. Anderson stated she tries to go to doctor's appointments as much as possible with Resident A, both endocrinology and neurology, however, Resident A has not wanted her to go with him after she asked the doctor some questions. Ms. Anderson stated Resident A used to allow her to go to the doctor with him, but lately he has not wanted her to accompany him to learn about the insulin pump. Ms. Anderson stated that Resident A "knows his medications" and has gone through a training course on the insulin pump, but she is not aware of any staff at the facility that were trained. Ms. Anderson stated Resident A was inpatient at the hospital on

01/02/2025 for insulin reasons. A seizure hospitalization was in October and Resident A was in the ER on 01/09/2025 again for a seizure related issue. Ms. Anderson stated she did not discuss the insulin pump with staff at the facility. Ms. Anderson stated she has experienced difficulties getting a list of Resident A's medications from the facility.

On 03/18/2025, I interviewed DCW Dinah Johnson via telephone. Ms. Johnson stated Resident A gets all his medications including the seizure medication and insulin. Ms. Johnson stated Resident A has seizures when the doctors adjust his medications. Ms. Johnson stated at times they call Resident A, 3-4 times before he comes to take his medications, but staff administer all Resident A's medications as they are documented on the MARs. Ms. Johnson stated even when Resident A has his seizure medications, he sometimes still has seizures, so she is not sure what causes this. Ms. Johnson stated she was never told about Resident A's insulin pump. No one called or came to the facility to train staff on how to monitor or maintain the pump.

On 03/19/2025, I interviewed (former) DCW Roy James via telephone. Mr. R. James stated he took Resident A to his appointments but for the more critical appointments such as his neurology or endocrinology appointments, Relative #1 or case manager from Health West accompanied him. Mr. R. James stated he was aware of Resident A getting an insulin pump and Relative #1 or HW case manager took him to the appointment to get it. Mr. R. James stated Resident A had the automatic pump only for a short period of time and he (Mr. R. James) was never trained on how to work or maintain the pump. Mr. R. James stated Resident A came into the facility after getting the pump and said someone had to learn how to manage the pump, but he does not know what happened after that. Mr. R. James stated he thought it was a bit much for him to learn and monitor the pump, and acknowledged he may have told Relative #1 that he did not want to learn how to manage the pump. Mr. R. James stated eventually he did agree to learn how to work the pump and was willing to take a class to learn how to monitor and maintain it, however, immediately after that, the pump failed, and Resident A went back to the old way of getting his diabetes medication, so it was not an issue any longer. Mr. R. James stated at one time, Resident A's sugar dropped low, and he went to the ER because Resident A had not changed the cartridge on the insulin pump. Mr. R. James stated he recalls Resident A going to the hospital in October 2024 due to a seizure and the EMTs picked him up at the facility. Mr. R. James stated he does not administer resident medications but is certain Resident A was getting his medication, Vimpat, as scheduled at that time.

On 03/20/2025, I interviewed Relative #1 via telephone. Relative #1 stated Resident A did go to the hospital on 10/09/2024 due to a seizure and the hospital paperwork documented that Resident A had been off his Vimpat medication for two days prior to the hospitalization. Relative #1 stated she took Resident A in mid-December 2024 (possibly around 12/16-12/17/2024) to get the insulin pump and because she has one herself, knew how to operate the pump and was able to help Resident A with

changing the cartridges. Relative #1 stated the cartridges needed to be changed every three days and she would pick Resident A up and take him to her house and change the cartridge. Relative #1 stated she asked Mr. R. James to learn how to maintain the insulin pump, but he stated he did not think it was something he could do, then close to the date the pump failed. He has told her he would try to learn the pump. Relative #1 stated she typed up instructions and gave them to Mr. R. James on 01/02/2025 but the pump failed that day and Resident A ended up in the ER and then he was put back on the previous way of administering his insulin.

On 03/20/2025, I reviewed Trinity Health ER notes dated 10/09/2024. The notes were written by Dr. Timothy Cook, DO. The notes documented the following information: *'Chief complaint: seizures. History of presenting illness: Does have a known seizure history and for the last couple of days his AFC home has been unable to get his Vimpat. Last seizure was a couple of months ago. History is limited but EMS states they were called to the home due to patient having a seizure, was a bit postictal. Medical Decision Making: Most recent seizure was about 2 months ago. He has been off his Vimpat for the last 2 days. He is given a dose in the emergency department. I suspect the breakthrough seizure was secondary to the absence of the Vimpat. Did reach out to the AFC home who stated that they need a prescription. This was sent to Guardian pharmacy as requested. He is monitored in the emergency department for a period of time and has no recurrent seizure-like activity. He is back to baseline. At this time stable for discharge home.'*

On 03/20/2025, I interviewed Ben Borton, Trinity Health Endocrinology, DNP (Doctor of Nursing practice) via telephone. Mr. Borton stated the insulin pump was installed in December 2024 and Relative #1 accompanied Resident A to all his appointments. Mr. Borton stated Resident A and Relative #1 were trained on how to operate the pump. Mr. Borton stated he knew staff at the facility assisted Resident A with glucose monitoring and assumed the support system at the facility was adequate to take on monitoring and assisting Resident A with the insulin pump. Mr. Borton stated the insulin cartridges had to be changed out every three days so his office requested Mr. R. James attend an appointment with Resident A so that could be kept up at the facility, but it did not happen before the pump failed and Resident A went to the hospital. Mr. Borton stated the facility is currently administering Resident A's medications as they did prior to the installation of the insulin pump.

On 03/24/2025, I conducted an exit conference with Licensee Designee, Mark James via telephone. Mr. James stated Resident A's Vimpat was administered as documented by staff on the MAR and anyone that accompanies Resident A to doctor's appointments needs to relay information to staff so they know any changes made or new equipment prescribed. Mr. James stated he will discuss with staff and review the report.

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:	The complainant reported Resident A's seizure medication, Vimpat, was not administered causing hospitalization. The complainant reported Resident A was also hospitalized due to hyperglycemia due to a failed insulin pump. Resident A's seizure medication Vimpat and Zonisamide is documented as being administered as prescribed. Trinity Health ER notes document Resident A's seizure onset is suspected to be from the absence of Vimpat medication between 10/07/2024-10/09/2024. Resident A's insulin injections were being managed by staff until and insulin pump was placed on Resident A's arm on or about 12/06/2024. The pump automatically administered Resident A's insulin until the cartridge ran out on or about 01/02/2025 and Resident A was hospitalized. Staff at the facility had no background, training or knowledge of how to monitor or maintain Resident A's insulin pump and when it failed on or about 01/02/2025, it caused Resident A to be hospitalized. In addition, while Resident A's Vimpat is documented as administered on the MAR for 10/07/2024, 10/08/2024 and 10/09/2024, ER notes document Resident A's seizure onset and hospitalization on 10/09/2024 was suspected to be due to the lack of Vimpat medication in the home and the failure to administer that medication as prescribed. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: On 02/13/2024, I interviewed Mr. Chandler at the facility and requested IR's (Incident Reports) for Resident A's hospitalization on 10/09/2024 and any hospitalizations in January 2025. Mr. Chandler stated at that time that he did not know of any IR's that were written for those dates or incidents. Mr. Chandler stated Resident A did not go to the hospital on his shift either time, and was not aware of any IR's written for Resident A's hospitalizations.

On 03/19/2025, I texted Mr. Chandler and asked if there were any IR's for Resident A's hospitalizations and Mr. Chandler confirmed that he has not seen any IR's documenting incidents surrounding Resident A's hospitalizations.

On 03/19/2025, I texted Mark James, Licensee Designee and asked if there are any IR's for Resident A's hospital visits in October 2024 and January 2025. Mr. M. James stated staff are looking for them but have not located them yet. Mr. M. James stated staff also do not recall Resident A going to the hospital.

On 03/24/2025, I conducted an exit conference with Licensee Designee, Mark James via telephone. Mr. James stated staff do not recall hospitalizations involving Resident A and that is why there were no IR's filled out. Mr. James stated he will discuss with staff and review the report.

R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (b) Any accident or illness that requires hospitalization. (c) Incidents that involve any of the following: (ii) Hospitalization.
ANALYSIS:	Staff at the facility are unable to produce incident reports documenting Resident A's ER visit on 10/09/2024 for a seizure and his hospitalization on 01/02/2025 due to the failure of his insulin pump. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

03/21/2025

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

03/21/2025

Jerry Hendrick — Date
Area Manager