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 #:	2025A0356042
	ADDENDUM REPORT
	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.

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

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 AND ADDENDUM REPORT

I. IDENTIFYING INFORMATION

License #:	AM610259339
Investigation #:	2025A0356042
Complaint Receipt Date:	06/04/2025
Investigation Initiation Date:	06/06/2025
Report Due Date:	08/03/2025
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 medication was not administered as prescribed causing hospitalization.	Yes

III. METHODOLOGY

06/04/2025	Special Investigation Intake 2025A0356042
06/04/2025	APS Referral Joe Clark, open APS case.
06/04/2025	Special Investigation Initiated - Telephone Health West case manager, Elizabeth Anderson. Relative #1, Licensee Designee, Mark James.
06/06/2025	Contact - Document Sent Joe Clark, Muskegon Co. DHHS, APS.
06/06/2025	Contact-Document Received Trinity Health ER notes.
06/19/2025	Inspection Completed On-site
06/19/2025	Contact - Face to Face Resident A
07/21/2025	Contact - Telephone call made John "June" Chandler, Direct Care Worker.
07/21/2025	Contact - Telephone call made Bryce Welsh, Pharm D, Guardian Pharmacy.
07/21/2025	Contact - Document Received Resident A's MARs, IR
07/21/2025	Contact - Document Sent Mark James, Licensee Designee.
07/28/2025	Contact-Telephone call made Relative #1 and Resident A.
07/29/2025	Contact-Document Sent

	Relative #2
07/30/2025	Exit Conference- Mark James, Licensee Designee.

ALLEGATION: Resident A's medication was not administered as prescribed causing hospitalization.

INVESTIGATION: On 06/04/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that Resident A did not receive Lantus insulin over the previous weekend (05/31/2025-06/01/2025). As a result, Resident A ended up in the ER (emergency room) on 06/01/2025 with elevated blood glucose and in DKA (diabetic ketoacidosis). The complainant reported that the Adult Foster Care home ran out of insulin and because of that, Resident A went into DKA resulting in EMS (emergency medical services) being called and his subsequent hospitalization. The complainant reported concern due to the lack of care Resident A received at the home. Joe Clark, Adult Protective Services Worker, Department of Health and Human Services, has an open investigation.

On 06/04/2025, I interviewed Mark James, Licensee Designee via telephone. Mr. James stated Resident A's Novolog medication was refilled on Thursday, May 29, 2025. Mr. James reported Resident A needed a new prescription for the Lantus, which is the night-time, long-lasting insulin because there were no refills for it. Mr. James reported Resident A's blood sugar was 500 and he was sent to the hospital.

On 06/04/2025, I received a telephone call from Elizabeth Anderson, Health West case manager. Ms. Anderson reported that Resident A was hospitalized with a blood sugar level over 600 due to not receiving his diabetes medication, Lantus.

On 06/06/2025, I interviewed Relative #1 via telephone. Relative #1 stated medication issues with Resident A continue at the facility and they will be moving Resident A from the facility because of staff's inability to properly manage Resident A's medications, mainly his diabetes medications. Relative #1 confirmed the information in the allegation to be accurate and stated Resident A's Lantus medication was not available at the facility at the end of May, beginning of June causing Resident A's sugar to skyrocket causing hospitalization.

On 06/09/2025, I received and reviewed Trinity Health Emergency Center-Muskegon Hospital notes dated 06/01/2025. The attending physician was Dr. Whitaker. The notes documented Resident A, *'presented to the emergency department for evaluation of altered mental status and hypotension. Patient presented to the emergency department via EMS who provided radio report indicating that the patient had blood sugar in the 500's and when they moved him over to the cot had a syncopal episode and became unresponsive. He was hypotensive and they were unable to palpate radial pulse, however he maintained a carotid pulse. On arrival,*

the patient tells me that he was not feeling well this morning and felt like both his legs were numb when he went to get up. He states that he is a type 1 diabetic and has been out of his Lantus for the last 2 days. He has not had any insulin today; he has been taking his short acting insulin over the last 2 days. He states that he has been taking all his other mediations including medication for seizures.' The report documented Resident A's POCT (point of care test) Glucose, Blood-abnormal at 563 and 555.' The medical decision-making section of the ER report documented Resident A's glucose as 645 and documented, *'overall, labs are consistent with moderate DKA and acute kidney injury super imposed on patients baseline stage III CKD (chronic kidney disease). 2 bag method was initiated for treatment of his DKA per protocol.'*

I reviewed the history and physical report as part of the Trinity Health ER notes dated 06/01/2025 by R. Schlager, PA (physician's assistant). The notes documented Resident A, *'reports he ran out of his Lantus 2 days ago. He states he still lives in his AFC facility although there is a note that says he was discharged from there. RN does verify that he was picked up from the AFC facility. Unsure why he would've run out of his Lantus.'*

On 06/19/2025, I conducted an unannounced inspection at the facility. DCW (direct care worker) Stephanie Gregory was working and stated she was new to the facility as staff and was not working on 06/01/2025 when Resident A was hospitalized.

I interviewed Resident A privately at the facility. Resident A stated his sugar was high and he did not have his Lantus medication. Resident A stated DCW, John "June" Chandler ordered both Novolog and Lantus medications, but the pharmacy only sent the Novolog, not the Lantus so he went without Lantus for two days. Resident A stated he tested his own blood sugar level, and it was 600, he told DCW Dinah Johnson, she called EMS and he was transported to the hospital. Resident A stated he was with Mr. Chandler when Mr. Chandler called Guardian pharmacy and ordered both Lantus and Novolog at the same time. Resident A stated he heard Mr. Chandler order both medications, this call occurred before the medications ran out and it was in enough time for the medications to get to the AFC home so he would not go without them. Resident A stated he may have needed a new prescription for the Lantus medication, but Resident A is unable to tell me a date or give me any indication as to when Mr. Chandler's call to the pharmacy took place.

On 06/19/2025, I reviewed Resident A's assessment plan for AFC residents signed by Mark James, Licensee Designee and Resident A as his own guardian. The assessment plan documented that staff at the home were responsible for administering all Resident A's medications.

On 07/21/2025, I interviewed Mr. Chandler via telephone. Mr. Chandler stated Resident A got the Lantus medication and stated the Lantus medication is administered as an evening medication. Mr. Chandler stated he mainly works during the daytime but knows Resident A got the medication and the medication was

available for administration. Mr. Chandler stated Resident A has a relative that brings him sweets and surmised that Resident A took the sweets to his room and ate them all at once causing his blood sugar to skyrocket. Mr. Chandler stated Resident A reported that he (Resident A) came downstairs from his room and got a shot to bring his blood sugar down, he had Lantus and Novolog available. Mr. Chandler stated at the end of May, there was one pen of Lantus medication and one pen of Novolog medication left, they were the last ones, so he (Mr. Chandler) called in both medications, prior to June 1, 2025. Mr. Chandler stated the Novolog came immediately, but the Lantus required a new prescription, and the pharmacy had to call Resident A's insurance company before they could fill it. Mr. Chandler stated the Lantus medication came the following day but the exact dates this all took place are unclear. Mr. Chandler confirmed that Resident A went to the hospital on 06/01/2025 due to high blood sugar levels and stated he thought Resident A returned to the facility the following day. Mr. Chandler reiterated that Resident A had Lantus medication available for administration and did not run out.

On 07/21/2025, I reviewed the IR (Incident Report) dated 06/02/2025 for Resident A's hospitalization. The IR documented on 06/02/2025, 9:30a.m., written by DCW Dinah Johnson documented the following, *'I called for meds this morning at 9 a.m. (Resident A) said he couldn't get up, I said, what's your sugar, he said 540-550. I called 911 for him to be taken to the hospital.'* *Resident A went to the hospital on 06/01/2025. Licensee Designee, Mark James, reported staff had the date wrong and the IR should be dated 06/01/2025.'

On 07/21/2025, I interviewed Bryce Welsh, Pharm D. Guardian Pharmacy. Mr. Welsh reported on 12/16/2024, he sent a box of Lantus to the facility which was a 68-day supply. Then, in January 2025, a new prescription for Lantus was received for Resident A and Mr. Welsh filled the script and sent it to the facility on 01/10/2025. The instructions were inject 20 units 1 time daily and this was for 75 days. Mr. Welsh stated that meant mid-May 2025 on or about May 8, 2025, Resident A would have run out of Lantus if they had used up the 68-day box, which they could have kept using that until it was gone and then moved on to use the 75 days of the medication. Mr. Welsh stated unless they had a back supply of Lantus medication at the facility for some reason that they gave Resident A once they ran out, they should have run completely out of the medication on or about May 8, 2025. Mr. Welsh stated the pharmacy did not receive any refill requests from the facility from 01/10/2025 until 06/01/2025 at 8:14a.m. when they received a call-in request from staff for Lantus. Mr. Welsh explained that insurance does play a role in the filling of medications. Mr. Welsh stated if there is an attempt to fill the medication before it is time to refill the medication, insurance would not pay for it. Mr. Welsh stated had staff tried to request a refill of the Lantus medication on 06/29/2025 for example, after the pharmacy had sent a 75-day supply on 06/01/2025, insurance would not pay for it. Mr. Welsh stated he would not expect that insurance had anything to do with this incident because he did not see any request from the facility, or any attempt for the pharmacy to fill Resident A's Lantus in May 2025 when the medication should have

run out. Mr. Welsh stated the first request after the January 2025 fill was on June 1, 2025, at 8:14a.m. *06/01/2025 is the date Resident A went to the hospital.

On 07/21/2025, I reviewed the MARs (medication administration records) for the months of May and June 2025 for Resident A.

- May 2025 MAR documented Lantus SOLOS INJ 100/ML, 01/07/2025, inject up to 20 units subcutaneously once daily per insulin instructions administered at 9:00a.m. each day from 05/01/2025-05/31/2025.
- June 2025 MAR documented Lantus SOLOS INJ 100/ML, 01/07/2025, inject up to 20 units subcutaneously once daily per insulin instructions administered at 9:00a.m. on 06/01/2025, on 06/02/2025-06/04/2025 the MAR is marked with an 'H' which meant Resident A was in the hospital, and administered again from 06/05/2025-06/11/2025 and administered 06/14/2025-06/15/2025. The medication was 'DC'd' on 06/16/2025 which meant it was discontinued, and the MAR documented the discontinuation of the Lantus on 06/16/2025 at 9:22a.m.
- The MAR documented no administration of Lantus on 06/12/2025-06/13/2025 as documented by a ~~0.~~ A review of the notes documented on 06/12/2025 and 06/13/2025, the Lantus was marked as 'patient unable to take medication.'
- The June 2025 MAR documented Lantus SOLOS INJ 100/ML, inject up to 20 units subcutaneously once daily per insulin instructions beginning 06/16/2025 at 8:00p.m. and documented the medication as administered from 06/16/2025-06/30/2025.

On 07/28/2025, I interviewed Relative #1 and Resident A via telephone. Relative #1 stated, Resident A has been discharged from the facility and lives elsewhere now. Resident A stated he has a Dexcom sensor on his arm that gives him a blood glucose reading on a receiver. Resident A stated he told staff at the facility his blood sugar reading and staff administered all his medications. Resident A stated he did not self-administer any of his medications nor did he store any medications in his room. Resident A reiterated that he was standing next to Mr. Chandler when Mr. Chandler called in a refill to the pharmacy of both Novolog and Lantus medications and stated he believed the call was prior to his hospitalization on 06/01/2025 but cannot recall the exact date. Resident A also stated he believed Mr. Chandler called the pharmacy for Novolog and Lantus at the same time and that the Novolog medication was delivered, but the Lantus was not. Resident A stated he had Lantus available to him in the facility, and it was administered as prescribed until two days prior to his hospitalization on 06/01/2025 when he missed two days of the medication and ended up in the hospital. Resident A stated Relative #2 never brought him candy that he ate causing his blood sugar to rise past 500.

I interviewed Relative #1 via telephone and Relative #1 stated Resident A was taken off Lantus in December 2024 and put on an insulin pump that only administered Novolog. Relative #1 stated sometime towards the end of December 2024, Resident A was put on the insulin pump and then taken off the insulin pump and put back on both Novolog and Lantus shots a few weeks later in January 2025 when the insulin

pump trial failed and Resident A ended up in the hospital. The use of the insulin pump could have resulted in Lantus being available in the facility for Resident A to use from the previous, December 2024 prescription and staff may have administered it through the month of May 2025, when the pharmacy surmised the Lantus should have run out on or about 05/08/2025. Relative #1 stated that even though Resident A used the Dexcom sensor or the finger stick method to get his blood sugar reading, staff at the facility were responsible for the ordering, administering and documenting of all Resident A's medications.

On 07/29/2025, I interviewed Relative #2 via telephone. Relative #2 stated she never brought Resident A candy or snacks that would cause his blood sugar to rise to the point of hospitalization. Relative #2 stated the issue is the facility ran out of Resident A's nightly insulin Lantus, "plain and simple."

On 07/30/2025, I conducted an exit conference with Licensee Designee, Mark James. Mr. James stated staff did nothing wrong, they had the medication, they tried to give Resident A a 30-day notice and a 24-hour discharge, but due to licensing rules they were not able to issue 24-hour notice and had to keep Resident A beyond the 30 days. Mr. James stated he did not want staff to have to continue to deal with these medication complaints. Mr. James stated he did not think this outcome was fair and did not agree with the conclusion of this 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 residents 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 that Resident A did not receive Lantus insulin resulting in hospitalization with elevated blood glucose and in DKA (diabetic ketoacidosis). The complainant reported the home ran out of insulin. Mr. Welsh stated according to pharmacy records, Resident A's Lantus prescriptions were filled in December 2024 and in January 2025 and should have run out on or about 05/08/2025 unless the facility had left over Lantus medication for use. The pharmacy did not receive any refill requests from the facility

	from 01/10/2025 until 06/01/2025 at 8:14a.m. when they received a call-in request from staff for Lantus, the morning of Resident A's hospitalization. Based on my investigative findings through interviews with staff, relatives, Resident A, the pharmacist, a review of hospital ER notes and Resident A's MARs, it is apparent that Resident A did not receive his medication Lantus as prescribed. It is also apparent the documentation of this medication's administration in the home is not accurate. There is a preponderance of evidence to indicate that Resident A's Lantus medication was not administered as prescribed resulting in his 06/01/2025 hospitalization. Therefore, a violation of this appliable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

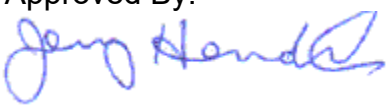
IV. RECOMMENDATION

I recommend the submission of a corrective action plan that includes updated training for staff on the administration and documentation of resident medications.

07/30/2025

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



07/30/2025

Jerry Hendrick — Date
Area Manager

ADDENDUM to SI2025A0356042: Licensee Designee Mark James failed to cooperate with the department regarding the outcome of this Special Investigation.

INVESTIGATION: On 07/30/2025, I attempted to conduct an exit conference with Mr. James, Licensee Designee, via telephone regarding this special investigation. I Informed Mr. James that I was recommending a corrective action plan (CAP) be submitted and he stated he did not agree with the information, analysis, and outcome of this special investigation. Mr. James stated staff did nothing wrong and refused to discuss the information in the special investigation any further. Mr. James stated he wanted to speak to someone else about this complaint but did not want to review the report with the Area Manager, Jerry Hendrick. Mr. James stated he would like to speak to someone in Lansing. The special investigation report requested a corrective action plan, due on 08/16/2025.

On 08/01/2025, I received a text message from Mr. James. He apologized for disagreeing with the special investigation violation but wrote that he knew this was going to happen, he wanted to discharge Resident A when Resident A was hospitalized, and he had the opportunity to discharge him. However, Mr. James stated Area Manager Jerry Hendrick, and I told him he could not discharge Resident A so he did not discharge Resident A and ended up with a substantiated complaint.

On 08/04/2025, I emailed the special investigation report to Mr. James and requested that he review the information in the report and decide then if he still wanted to speak to Division Director Jay Calewarts in Lansing. If so, I would send the report to Mr. Calewarts for review and provide Mr. James with his telephone number.

On 08/11/2025, I texted Mr. James and notified him that I had sent the special investigation report to him for review and asked if he had read it. I requested that Mr. James let me know if he would agree to submit a corrective action plan or if he still wanted to speak to Mr. Calewarts about the report.

On 08/14/2025, I emailed the special investigation report to Mr. James again for review. I had not received any response back from Mr. James and asked him to either submit a Corrective Action Plan, or if he still disagreed with the report and wanted to discuss it further with Mr. Calewarts to let me know.

On 08/18/2025, I emailed the Area Manager, Jerry Hendrick, and reported that I had sent the special investigation report two times via email to Mr. James and texted Mr. James two times asking what he would like to do and if he wanted to discuss this report further with Mr. Calewarts, to let me know.

On 08/19/2025, I emailed Mr. Hendrick and Mr. Calewarts and stated I would like to give Mr. James the opportunity to discuss the special investigation report with Mr.

Calewarts per Mr. James' request even though Mr. James had not responded to my emails or texts to date.
On 08/19/2025, I sent the special investigation report to Mr. Calewarts. Mr. Calewarts stated that he would read the report and agreed to discuss the report with Mr. James if Mr. James chose to contact him.

On 08/20/2025, I texted Mr. James and informed him that I sent the special investigation to Mr. Calewarts for review and I provided Mr. James with Mr. Calewarts' direct telephone number to contact him.

On 08/21/2025, I texted Mr. James and encouraged him to call Mr. Calewarts if he wished to discuss the investigation report.

On 08/21/2025, Mr. James texted me and wrote that he will call Mr. Calewarts later that day or the next. Mr. James wrote that he previously had a lot going on, but he is now able to focus on handling this issue.

On 09/04/2025, I texted Mr. James and informed him that if he wished to discuss this matter with Mr. Calewarts, he would need to contact him by Friday, September 5, 2025. I informed Mr. James that Mr. Calewarts was waiting to hear from him to discuss this report. I informed Mr. James that if we are unable to resolve this matter, our recommendation would be changed from requesting a Corrective Action Plan to a revocation of the license.

As of 09/19/2025, I had not received a response from Mr. James to my last text message, nor have I not received a Corrective Action Plan from him addressing the violation cited in this special investigation report. In addition, Mr. Calewarts contacted me on 09/19/2025 and confirmed that Mr. James had not yet contacted him to discuss special investigation 2025A0356042.

On 09/22/2025, I conducted an exit conference with Licensee Designee, Mark James via telephone. Mr. James stated he had been on vacation for the past three weeks and could not respond. Mr. James stated he does not understand how we can request the revocation of the license when the issues in the original report do not rise to the level of a revocation. Mr. James stated he does not agree with any of the information, analysis, or conclusion of either part of this report.

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:	Mr. James has not responded to my repeated requests for a Corrective Action Plan or to contact Mr. Calewarts to review this special investigation. Despite multiple email and text message requests, Licensee Designee Mark James failed to cooperate with the department regarding this Special Investigation. Based on my investigative findings, there is a preponderance of evidence to show that Licensee Designee Mark James failed to cooperate with the department regarding this Special Investigation. Therefore, a violation of this appliable rule is established and the recommendation has been amended.
CONCLUSION:	**VIOLATION ESTABLISHED**

V. RECOMMENDATION

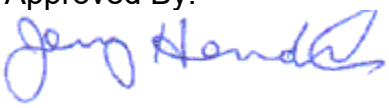
Due to Mr. James not providing a CAP for SI2025A0356042 and his failure to cooperate with this investigation, I recommend the status of this license changed to a six-month provisional license.

10/09/2025

_____

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



10/09/2025

_____

Jerry Hendrick — Date
Area Manager