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 #:	2026A0356019
	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 #:	2026A0356019
Complaint Receipt Date:	01/16/2026
Investigation Initiation Date:	01/20/2026
Report Due Date:	03/17/2026
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?
Resident A's health care needs were not met in the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/16/2026	Special Investigation Intake 2026A0356019
01/16/2026	APS Referral Stephanie Kindle, APS, Muskegon County DHHS.
01/20/2026	Special Investigation Initiated - Telephone Amy VanZant, PW services, legal guardianship services.
01/22/2026	Contact - Telephone call made Eric Hilt, Health West RN.
01/29/2026	Contact - Telephone call made Eric Hilt, RN.
02/05/2026	Contact - Telephone call made Eric Hilt, RN. (Out of office.)
02/11/2026	Contact - Telephone call received Eric Hilt, RN.
02/17/2026	Inspection Completed On-site
02/17/2026	Contact - Face to Face Resident A, John "June" Chandler.
02/17/2026	Contact - Document Received Reviewed Resident medications.
02/17/2026	Contact - Telephone call made PW Services, Amy VanZant, supervisor.
02/17/2026	Contact - Telephone call made Eric Hilt, RN, Health West. Nichole Schneider, HW case manager
02/23/2026	Contact-Document received Resident A documents

03/09/2026	Contact - Telephone call made Integrated health, Chloe Bayne. Dinah Johnson, DCW. Mark James, Licensee Designee.
03/10/2026	Contact-Telephone call made PW Services, Amy VanZant and Karen Ellison. Integrated Health, Kristin Hayford.
03/27/2026	Exit conference-Mark James, Licensee Designee.

ALLEGATION: Resident A's health care needs were not met in the facility.

INVESTIGATION: On 01/16/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that Resident A has a guardian through PW Services and on 01/05/2026, Resident A was seen in ER (emergency room) for a wound on his foot. Resident A was prescribed antibiotics for the wound and staff were told he needed to be seen at the wound clinic. The complainant reported that staff have been cleaning the wound at the home with regular alcohol. Staff at the facility reported they have never received antibiotics, and they were unaware that Resident A needed to be seen at the wound clinic even though the hospital notes clearly stated that. The complainant reported today that Resident A was complaining about the wound and he is in pain. The wound on his foot is completely opened. Resident A's guardians were made aware of this today by Eric Hilt, RN at Health West CMH, Muskegon County and stated the home staff did not make them aware of this and when they called the home last week to check on Resident A, staff did not mention a wound on Resident A's foot. APS (adult protective services) Stephanie Kindle, Muskegon County DHHS (Department of Health and Human Services) has an open investigation.

On 01/20/2026, I interviewed Amy VanZant, PW Guardianship Services supervisor. Ms. VanZant stated they serve as the court appointed guardian for Resident A. Ms. VanZant stated they were never notified by Resident A or staff from the home when Resident A went to the ER for the wound on his foot. Ms. VanZant stated Resident A was hospitalized for psychiatric reasons at Bronson Hospital in Battle Creek from 12/01/2025-12/22/2025 and they, as Resident A's guardian, were not notified until Health West case manager, Nichole Schnieder and Eric Hilt, RN informed them. Ms. VanZant stated Resident A went to the ER at Trinity Health on 01/05/2026 for a wound on the bottom of his foot and again, Health West notified them of this hospital visit. Ms. VanZant stated Mr. Hilt informed her that Resident A had gone to ER, the wound on his foot was cleaned and debrided, he was sent home with antibiotics and a wound clinic care referral, but PW Services knew nothing about it. Ms. VanZant stated Resident A should not get any type of medical care without his guardians knowing about it. Ms. VanZant stated the home should notify the guardians of any

hospital visits and send guardianship paperwork to the ER with Resident A so the doctors know he is legally guarded.

On 02/11/2026, I interviewed Eric Hilt, RN, Health West. Mr. Hilt stated Resident A spent a month as an in-patient at a psychiatric hospital and came out on new medications. He has court ordered injectable medication and requires a higher level of care. Mr. Hilt stated due to this, they (Health West) are checking on Resident A more often. Mr. Hilt stated on 01/14/2026, DCW (direct care worker) Dinah Johnson brought Resident A to Health West for a weekly blood draw and that is when Resident A reported he had a wound on his foot, that it hurt, and he was having a difficult time walking. Mr. Hilt stated Ms. Johnson reported that she had been cleaning the wound with alcohol and Resident A yells when she cleans the wound. Mr. Hilt stated he also discovered that on 01/05/2026, Resident A went to Trinity Health ER due to the wound on his foot. Resident A was supposed to start taking an anti-biotic and go to the wound clinic per discharge instructions from Trinity Health ER. Mr. Hilt stated on 01/14/2026, after seeing Resident A at Health West, he dropped supplies off to the home for care of the wound, and he contacted Resident A's guardians, PW Services, to inform them of Resident A's visit to the ER. Mr. Hilt stated Resident A's guardians did not know anything about this. Mr. Hilt stated when he went to the home to drop off supplies for Resident A, DCW John "June" Chandler said Resident A did not come home from the ER with any medications or wound care referral information. Mr. Hilt stated Resident A was supposed to begin a 7-day course of Keflex antibiotic on 01/05/2026. Mr. Hilt stated as far as he knew, as of 01/14/2026, Resident A still had not gotten the antibiotic medication. Mr. Hilt stated the prescription for Keflex from the ER most likely never got filled. The prescription was sent to CVS care mark mail service pharmacy, but the home uses Guardian pharmacy. Mr. Hilt stated on 01/14/2026, he took a picture of Resident A's foot, sent it to Dr. Gabriel Devivo (Resident A's primary care physician) and Dr. Devivo prescribed Bactrim (rather than Keflex) to be administered for a week from 01/15/2026 through 01/21/2026.

Mr. Hilt stated Ms. Schneider took Resident A to see Dr. Devivo for a follow-up appointment at Integrated Health on 02/03/2026, and Resident A's wound was much better than when he (Mr. Hilt) saw it. Mr. Hilt stated Chloe Bayne at Integrated Health had set up an initial wound care appointment at Trinity Wound Care on 01/19/2026 and Resident A was a "no-show". Mr. Hilt stated the appointment was rescheduled for 01/27/2026 and that appointment was also a "no-show".

On 02/17/2026, I interviewed Nichole Schneider, Health West, case manager, via telephone. Ms. Schneider stated they usually call the home and inform them of Resident A's appointments so someone at the home should have known about Resident A's wound care appointments. Ms. Schneider stated approximately a week ago, Resident A saw Dr. Devivo, his primary care physician, and the wound on his foot looked "good and healed." Ms. Schneider stated to her knowledge, Resident A never went to the wound care clinic.

On 02/17/2026, I conducted an unannounced inspection at the facility and interviewed Resident A in his room. Resident A stated he went to the hospital for his foot. Initially Resident A stated he was not given any discharge paperwork from the hospital. When questioned further, Resident A told me that he did not give any of the DCW's at the home any discharge paperwork and that he kept the paperwork himself. Resident A reached into his pocket and pulled out folded notebook papers. He stated those were his own notes and an appointment card for a future appointment. He handed the appointment card to me, and I gave it to Mr. Chandler. Resident A was unable to produce any discharge papers from the ER visit on 01/05/2026. Resident A stated he cannot remember if his guardian was there when he was in ER or if he went to any other appointments since the ER visit.

On 02/17/2026, I conducted an unannounced inspection at the home and interviewed DCW John "June" Chandler. Mr. Chandler stated Resident A showed his foot to DCW Dinah Johnson, and Ms. Johnson sent Resident A to the hospital. While at the hospital, they wrapped his foot and sent him back home. Mr. Chandler stated when Resident A returned home from the ER, he said he had no discharge paperwork and ran upstairs to his room. Mr. Chandler stated he had no idea that Resident A had a prescription for Keflex or wound care and it was only when Resident A went to Health West that everything from the ER visit was figured out. Mr. Chandler acknowledged he did not call PW Services to inform them that Resident A had gone to the ER and he did not know if Ms. Johnson called them. Mr. Chandler stated he does not think Resident A ever received wound care for his foot, but he has seen the wound. He stated there is only a small scab on it, and it appears to be healed. Mr. Chandler stated if he had been given the paperwork from the ER, he would have made the appointments for Resident A for wound care. Mr. Chandler stated he did not know anything about missed appointments in January 2026.

Mr. Chandler stated Resident A never received the medication Keflex after the 01/05/2026 ER visit. On 01/14/2026, a script for Bactrim medication was received and given to Resident A beginning on 01/15/2026 through 01/21/2026.

On 02/17/2026, I reviewed Resident A's MAR (medication administration record) for January 2026. The MAR documented that Resident A was prescribed Bactrim DS/Septra DS, take one tablet by mouth twice daily for 7 days. The Bactrim was ordered on 01/14/2026 and signed by staff at the facility as administered at 9:00a.m. and 8:00p.m. from 01/15/2026 through 01/21/2026. The January MAR does not show that Keflex medication from Resident A's 01/05/2026 ER visit was ever added to the MAR for administration.

On 03/09/2026, I interviewed DCW Dinah Johnson via telephone. Ms. Johnson stated Resident A got the wound on his foot after a stay at a psychiatric hospital in the beginning of January. Ms. Johnson stated she asked Resident A what happened, but he did not know. Ms. Johnson stated she took Resident A to Integrated Health for his foot to be seen by his primary care physician. Ms. Johnson stated it was late in the day and they could not see him so she took Resident A

home and cleaned the wound with alcohol. Ms. Johnson stated she told Mr. Chandler that she would take Resident A to the ER but it was too late into Mr. Chandler's shift so she waited until the following day and took Resident A to Trinity Health ER. Ms. Johnson stated she dropped Resident A off and picked him up but did not accompany Resident A into the ER. Ms. Johnson stated when she picked Resident A up, she asked him for the discharge paperwork and he said he did not get any. Ms. Johnson stated the wound was bandaged up. Ms. Johnson stated she was aware of a wound care appointment for Resident A but he missed it because of the snowy weather in January. Ms. Johnson stated, "everything was shut down" and so Resident A missed that appointment. Ms. Johnson was not aware of medications prescribed in the ER because Resident A did not produce any discharge paperwork. Ms. Johnson stated Health West prescribed Resident A some medications but by the time he got the script for the medications, his foot wound had healed. However, staff at the facility still gave him the antibiotic medication.

Ms. Johnson stated Resident A has a representative payee but he does not have a guardian. Ms. Johnson stated PW services is Resident A's payee only and he has a case worker at Health West.

On 03/09/2026, I interviewed Mark James, Licensee Designee via telephone. Mr. James stated Resident A has a representative payee through PW Services, but Resident A is not guarded. Mr. James stated he was not aware of Resident A's missed wound care clinic appointments or medication.

On 03/09/2026, I reviewed Resident A's assessment plan and resident care agreement (RCA). Both the assessment plan and RCA are not signed by PW services as Resident A's legal guardian nor is there any indication on the documents that Resident A is legally guarded.

On 03/10/2026, I interviewed Karen Ellison and Amy VanZant from PW services. Ms. Ellison and Ms. VanZant stated they were appointed Resident A's legal guardian and representative payee on 10/25/2022 and they are successor guardians for Julie Sauter from Lighthouse guardianship services upon her retirement and closing of her business. Ms. VanZant and Ms. Ellison stated Resident A has been under legal guardianship for years. Ms. VanZant stated she visits Resident A at the facility regularly and always introduces herself as Resident A's guardian and that she has never met Mr. James but knows and talks to June "Johnnie" Chandler. Ms. VanZant stated she sees Mr. Chandler every time and they discuss issues such as Resident A's bike, clothing and funds. Ms. VanZant stated she was at the home on 02/19/2026 and met DCW Stephanie Gregory and discussed Resident A's checks with her. Ms. VanZant stated Mr. Chandler knows they are Resident A's legal guardians and her business card is on the bulletin board hanging near the medication cart just inside the entrance to the home. Ms. VanZant and Ms. Ellison stated they were never told about wound care clinic appointments, so Ms. VanZant called Mr. Chandler and Mr. Chandler told her that Resident A's heel wound was healing well and he did not need wound care. Ms. VanZant and Ms. Ellison stated

both times Resident A went to the hospital in January 2026; they were notified by Health West staff, Nichole Schneider and Eric Hilt, not by staff of the home.

On 03/10/2026, I interviewed Kristie Hayford, nurse at Integrated Health. Ms. Hayford stated Chloe Bayne was the nurse case manager for Resident A but Ms. Bayne is out of the office and unavailable for several days. Ms. Hayford stated Resident A was seen once for a foot wound by Dr. Devivo and the wound was improving. Ms. Hayford stated their office did not make a referral to the wound clinic, but that Trinity ER made the referral. Ms. Hayford stated Ms. Bayne scheduled a wound clinic appointment for Resident A on 01/29/2026 because he missed an appointment on 01/19/2026. Ms. Hayford stated the notes indicate that Ms. Bayne notified staff at the home of the appointment, but the notes do not document the name of the staff at the home that was notified. Ms. Hayford stated they have PW services listed as Resident A's legal guardians.

On 03/12/2026, I received and reviewed the Trinity Health Muskegon Hospital Emergency Center provider notes dated 01/05/2026, written by Desiree Elliot, PA (Physician Assistant). The notes documented the following information, *'Medical Decision Making, Patient presents to the ED for evaluation of left foot pain. Patient's ABC's and vitals were assessed and both of which are unremarkable. History was obtained from the patient. Physical exam reveals left foot wound. Labs and imaging were ordered. Patients presenting complaint and vital signs as documented by nursing staff was reviewed. Patient present with a large open wound on the left foot. He stated he pounded it on the ground and that is how it started. There is no signs of surrounding erythema or edema or drainage. Patient is diabetic so we will x-ray to make sure there is no osteomyelitis. Patient only states has been ongoing for a few days so I do question if this has not been longer. X-ray of the left foot reviewed by my supervision physician showing no obvious signs of osteomyelitis. Patient's wound was cleansed here, he is given Keflex and I will refer him to the wound clinic. He is advised to call and make this appointment. His caregivers were also given this information. In the meantime, advised him to get rechecked immediately with any new or worsening symptoms including increased redness, swelling, abnormal drainage or pain. I asked him to gently wash it with soap and water twice daily then bandage it to keep it clean. Patient stated his understanding with this plan and had no further questions. The above treatment plan was discussed and agreed upon with my attending physician, Dr. Cook (Dr. Timothy Cook, DO). Admission was considered. After consideration of the patient's diagnosis, stability and expected response to treatment, it was felt that the patient could safely be discharged with an appropriate outpatient treatment and follow up plan. This was discussed with the patient, and they are in agreement with the plan. Disposition and Plan: All potential treatments were discussed with patient [and family] and we shared decision making. Ultimately, I feel patient [is safe for discharge/warrants admission]. [Patient was] comfortable with being discharged at this time. They were instructed to follow up with [his/her] [primary care] in [3-4 days] for reassessment. We discussed emergent reasons to return to the emergency department. The case was reviewed with the attending physician listed above who agreed with the workup and plan. Start taking*

these medications, cephalexin (Keflex) 500 mg capsule, take 1 capsule (500mg total) by mouth 4 times daily for 7 days. Qty: 28 each, Refills: 0.'

On 03/27/2026, I conducted an exit conference with Mr. James via telephone. Mr. James stated follow-up by staff should have been done upon Resident A's discharge from the ER on 01/05/2026. Mr. James stated he believed that PW Services acted as Resident A's representative payee only, and not his legal guardian, they have never provided the facility with guardianship paperwork and have not inquired about reviewing and signing annual facility paperwork to make it known that they are the legal guardians of Resident A. Mr. James stated he will review this report, and discuss with staff.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	The complainant reported Resident A never received antibiotics or wound clinic care prescribed to him on 01/05/2026 after an ER visit. Resident A's legal guardians were not notified by home staff of the ER visit either before or after the ER visit. There is evidence to show that after Resident A went to the ER on 01/05/2026, he was prescribed the antibiotic Keflex and wound care through Trinity Health wound care clinic. There is also evidence to show that Resident A never made it to his wound care clinic appointments on 01/19/2026 and 01/29/2026 nor did he receive the antibiotic prescribed on 01/05/2026. Evidence shows that Resident A has a court appointed guardian through PW Services. PW Services reported they were not informed of Resident A's ER visit or what the discharge instructions for follow-up care were. Resident A did not produce any discharge instructions when staff at the home requested it, but staff did not inquire or follow up in any way regarding the outcome of Resident A's ER visit beyond asking Resident A for discharge paperwork. The licensee and staff of the home failed to make a reasonable attempt to obtain discharge instructions or make Resident A's guardians aware that Resident A required medical care. This failure resulted in Resident A not receiving prescribed medication and not receiving recommended wound care. Therefore, a violation of

	this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 02/23/2026, I reviewed Resident A's assessment plan dated 06/06/2025, signed by Mr. James, Licensee Designee and Resident A. The assessment plan does not have a designated representative named, nor is the assessment plan signed by Resident A's legal guardian, PW services.

On 03/09/2026, I interviewed Mr. James via telephone. Mr. James stated Resident A has a representative payee but to his knowledge, Resident A does not have a legal guardian.

On 03/10/2026, I interviewed Karen Ellison and Amy VanZant, PW Services via telephone. Ms. Ellison and Ms. VanZant stated Resident A's legal, court appointed guardianship was established on 10/25/2022. Ms. Ellison and Ms. VanZant stated they have not reviewed or signed an assessment plan for Resident A since 2023. Ms. Ellison stated the last plan she reviewed and signed was on 12/14/2023 with Mr. James.

On 03/27/2026, I conducted an exit conference with Mr. James via telephone. Mr. James stated he had no idea Resident A had legal guardianship through PW Services, and therefore, he did not seek them out to complete or sign the assessment plan with them.

APPLICABLE RULE	
R 400.685(4)	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident A's assessment plan was not completed with or signed by Resident A's legal guardian, PW services since 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 02/23/2026, I reviewed Resident A's resident care agreement dated 09/06/2025, signed by Mr. James, Licensee Designee and Resident A. The resident care agreement is not signed by Resident A's legal guardian, PW services.

On 03/09/2026, I interviewed Mr. James via telephone. Mr. James stated Resident A has a representative payee but to his knowledge, Resident A does not have a legal guardian.

On 03/10/2026, I interviewed Karen Ellison and Amy VanZant, PW Services via telephone. Ms. Ellison and Ms. VanZant stated Mr. James knows they are Resident A's guardians. Ms. Ellison and Ms. VanZant stated Resident A's legal, court appointed guardianship was established on 10/25/2022. Ms. Ellison and Ms. VanZant stated they have not reviewed or signed a resident care agreement for Resident A "for years." Ms. Ellison and Ms. VanZant stated the last RCW reviewed and signed was in February 2023 by Ms. Ellison and Mr. James. Ms. Ellison and Ms. VanZant stated there was a cost-of-living increase in January 2026 and there still has been no new RCA reviewed or signed by PW services.

On 03/27/2026, I conducted an exit conference with Mr. James via telephone. Mr. James stated he had no idea Resident A had legal guardianship through PW Services, and therefore, he did not seek them out to complete or sign the resident care agreement with them.

APPLICABLE RULE	
R 400.685(9)	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident, resident's designated representative, or responsible agency at least annually or more often if necessary. Any changes to the resident care agreement must be re-signed by all applicable parties. If the annual review results in no changes to the resident care agreement the resident care agreement does not need to be re-signed but the licensee shall document that all applicable parties were contacted and agreed that no changes were necessary.
ANALYSIS:	Resident A's resident care agreement was not completed with or signed by Resident A's legal guardian, PW services since 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 10/13/2025, Mr. James signed a settlement agreement with Jay Calewarts, Director, AFC Division, Bureau of Community Health Systems. This agreement was 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 (#6), documented that 'American AFC Inc. agrees to have all direct care staff who dispense medications take the departments medication training on December 10th, 2025, take the bureau's online medication trainings "Medication Management in Adult Foster Care Group Homes" and "Reducing Medication Errors and the Six Rights of Medication Administration," along with any other medication training the licensee believes staff should take. American AFC Inc. will provide the bureau with a list of direct care staff that dispense medications and their contact information so that they can be registered for the December 10, 2025, virtual training. The bureau's online training can be found at www.youtube.com/@LARA-BCHS/videos.'

On 03/11/2026, I emailed Mikki Streeter, Section Manager, Adult Foster Care Division, Policy, Training, and Enforcement Section and inquired about training for the staff at this home as specified in the Settlement Agreement dated 10/13/2025. Ms. Streeter responded to my email and stated she, *'offered to do an "in person" training in the GR* (Grand Rapids) *office for Mark and his team, but he indicated that he preferred the virtual option. Below is the last correspondence I had with him, where I sent him the link to register for the December 10th medication training. Per my records, Mark and the staff members did not attend this training. We also had another virtual medication training on February 18. They did not attend this training either. His email with Jay indicated he was looking for other training options, so hopefully he arranges training somewhere.'*

On 03/17/2026, I inquired about medication training with Mr. James via text message. Mr. James stated he and his staff took medication training in February 2026 through Alison training company. I requested that he send verification of the training.

On 03/17/2026, Mr. James sent a training certificate and transcript from Alison training for himself and Mr. Chandler. The training dates on the certificate and transcript was 03/17/2026.

I interviewed Mr. James via telephone, and he explained that the training was offered as free training and he and staff took it in February 2026. Mr. James explained when he tried to print the certificates, that is when the training site required payment and put today's date, 03/17/2026, on the certificate and transcript and not the date the training was actually taken in February 2026.

On 03/18/2026, Mr. James sent verification of staff, Stephanie Gregory's training certificate and transcript, both showed the date of the training completed as 03/18/2026.

On 03/19/2026, Mr. James sent verification of staff, Dinah Johnson's training certificate and transcript, both showed the date of the training completed as 03/19/2026.

On 03/23/2026, I received an email from Mr. Calewarts. Mr. Calewarts stated an agreement was never made for Mr. James and his staff to take online training that does not specifically relate to state of Michigan Adult Foster Care licensing requirements.

On 03/24/2026, Ms. Streeter emailed correspondence she had with Mr. James regarding training. Ms. Streeter documented the following; '*October 14, 2025, we offered to schedule an in-person medication training for Mr. James and his staff at the Grand Rapids (GR) office. November 4, 2025, Mr. James indicated that traveling to the GR office would be difficult. He shared that he had been in contact with HealthWest in Muskegon County, which provides medication training for Specialized AFC Homes, and that they would be providing him with cost information for staff training. November 5, 2025, I reminded Mr. James that the AFC Division would be offering a free virtual medication training on December 10, 2025. He responded that he planned to attend our training. November 5, 2025, I provided Mr. James with the registration link and asked that all attending staff register promptly to secure their spots. At this time, it does not appear that Mr. James or his staff registered for or attended the December 10 training. It is unclear whether he ultimately pursued training through HealthWest.'*

On 03/27/2026, I conducted an exit conference with Mr. James via telephone. Mr. James stated he did not realize that the settlement agreement was so specific as to what medication training he and his staff were required to receive. Mr. James stated he examined the LARA-BCHS training, training through HealthWest and ultimately decided pursue the Alison virtual training. Mr. James stated the training he and his staff took through Alison was thorough and challenging. Mr. James stated he thought he was able to seek out medication training on his own and decide the best training for himself and his staff and that is why he chose this training.

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.
ANALYSIS:	The stipulation #6 documented in the Settlement Agreement dated 10/13/2026, all direct care staff who dispense medications were to complete the department's medication training on December 10, 2025. Ms. Streeter verified that she offered to provide in-person training to Mr. James and his staff but Mr. James stated he preferred a virtual option. None of the staff attended the 12/10/2025 training. Mr. Calewarts stated an agreement was never made for Mr. James and his staff to take an alternative training that does not relate to state of Michigan Adult Foster Care licensing requirements. A violation of this rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

NOTE: Previous quality of care violations were established on 10/06/2025 (SI 2025A0583055) and on 07/30/2025 (SI 2025A0356042). A Corrective Action plan was received on 10/10/2025 for SI 2025A0583055 and on 10/10/2025 for SI 2025A0356042. On 10/20/2025, the facility was placed on a six-month provisional license per the established settlement agreement.

IV. RECOMMENDATION

I recommend the revocation of this license based on repeated Quality of Care violations.

Elizabeth Elliott

03/30/2026

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

Jerry Hendrick

03/30/2026

Jerry Hendrick — Date
Area Manager