GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 2, 2025

Linzi Gotham
Ghotra Alf Inc
3820 Sundridge Pl
Saginaw, MI 48603

RE: License #: AL730418080
Investigation #: 2025A0580026
Close to Home Assisted Living Side 1

Dear Linzi Gotham:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730418080
Investigation #:	2025A0580026
Complaint Receipt Date:	03/06/2025
Investigation Initiation Date:	03/11/2025
Report Due Date:	05/05/2025
Licensee Name:	Ghotra Alf Inc
Licensee Address:	3820 Sundridge Pl Saginaw, MI 48603
Licensee Telephone #:	(989) 545-8407
Administrator:	Linzi Gotham
Licensee Designee:	Linzi Gotham
Name of Facility:	Close to Home Assisted Living Side 1
Facility Address:	2142 N. Center Rd. Saginaw, MI 48603
Facility Telephone #:	(989) 401-3581
Original Issuance Date:	09/27/2024
License Status:	TEMPORARY
Effective Date:	09/27/2024
Expiration Date:	03/26/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Kasey Bingham gave Resident A her medication at the wrong time which led to Resident A passing out.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/06/2025	Special Investigation Intake 2025A0580026
03/06/2025	APS Referral Allegations shared with APS.
03/11/2025	Special Investigation Initiated - On Site Unannounced onsite inspection.
03/11/2025	Contact - Face to Face Interview with Resident A.
03/11/2025	Contact - Face to Face Interview with LD Gotham.
03/11/2025	Contact - Document Received Medication Log for Resident A rec'd.
03/14/2025	Contact - Document Received Email of documents from Linzi Gotham.
05/01/2025	Contact – Telephone call made Call to Kasey Bingham, Direct Staff.
05/01/2025	Contact – Telephone call made Call to Latonya Prince, Direct Staff.
05/01/2025	Contact – Telephone call made Call to A & D Waiver assigned case manager for Resident A.
05/02/2025	Contact – Telephone call received Call from A & D Waiver assigned case manager for Resident A.

05/02/2025	Contact - Document Received Email of documents from Linzi Gotham.
05/02/2025	Contact – Telephone call made Call to Olivia Gornto, former employee.
05/02/2025	Exit Conference Exit with LD Gotham.

ALLEGATION:

Staff Kasey Bingham gave Resident A her medication at the wrong time which led to Resident A passing out.

INVESTIGATION:

On 03/06/2025, I received a complaint via LARA-BCHS-Complaints. On 03/06/2025, I made a referral to Adult Protective Services, sharing the allegations alleged in this complaint.

On 03/11/2025, I conducted an unannounced onsite inspection at Close to Home Assisted Living, Side 1. Contact was made with Jenny Ireland, Home Manager (HM). HM Ireland stated that Resident A attends dialysis and is served breakfast at 6am on those days in order to receive her fast-acting insulin before attending. On the days when Resident A does not attend dialysis, Resident A is given her long-term insulin and eats breakfast at its regular time of 8am. HM Ireland confirmed that Resident A did pass out as alleged. On the day of the incident, staff, Kasey Bingham passed Resident A's fast acting medication as listed, however, Resident A had not eaten. Resident A is usually provided with food when she takes her fast-acting insulin. On this day Resident A had not eaten. A couple of hours later staff contacted her stating that Resident A is non-responsive.

On 03/11/2025, I conducted an interview with Resident A. Resident A stated staff, Kasey Bingham came in and got her up for her medication. Resident A stated that she began feeling funny about 8am, thinking it was related to the fact that she hadn't eaten. Resident A stated that she passed out somewhere between 8-8:30am and was found by staff, Latonya Prince and Olivia Gornto. 911 was called and she was taken to the hospital. Resident A stated that she later found out that staff Bingham had given her the short-term insulin when she should have given her the long- term insulin. Resident A stated that staff Bingham came to her later and apologized. Resident A stated that she is considering moving from the facility as well as pursuing legal action.

On 03/11/2025, while onsite, I spoke with the Licensee Designee, Lindsay Gotham. LD Gotham stated that the day in question, 02/22/2025, was a non-dialysis day for

Resident A. Resident A was given the correct medication, however, Resident A should have been given food with her insulin medication. Staff Bingham was written up for lack of communication and failing to ensure that Resident A followed through with eating once the medication was administered.

On 03/11/2025, while onsite, I obtained a copy of the February 2025 Medication log for Resident A. The log reflects that Resident A is prescribed Basaglar Kwikpen. The medication log reflects that on 2/22/2025, Resident A was administered her 8 am Basaglar Kwikpen by staff, Kasey Bingham [at 6am]. There are no written instructions indicating that Resident A needs to eat food prior to being given insulin. Resident A's medication log indicates at 8:00am, inject 6 units Basaglar Kwikpen every morning (except for Dialysis days- inject 4 units) and inject 10 units Sub-Q at bedtime. Resident A is also prescribed Insulin Glargine U100 Pen. At 8:00am, inject 6 units every morning (except for Dialysis days- inject 4 units) and inject 10 units Sub-Q at bedtime. Both medications are repeated for 8pm.

On 03/14/2025, I received a copy of the Incident Report (IR) dated 02/22/2025. The IR states that on 02/22/2025, at 8:05am, staff Latonya Prince, went to Resident A's room to get her up for the day. Staff Prince greeted Resident A. Resident A's head was down and she did not respond. Staff Prince went and got staff Olivia Gornto and requested that she check Resident A's blood sugar levels. Resident A's levels would not read on the glucometer. Staff Prince called management, who informed her to call 911. Staff Price then followed the dispatcher instructions until EMS arrived. Corrective measures include following the discharge instructions upon being released from the hospital and ensuring Resident A eats when taking her insulin medication.

The MyMichigan Medical Center Discharge Summary for Resident A indicates that Resident was hospitalized on 02/23/2025-02/28/2025, for prolonged Q-T Interval on ECG (Cardiac Progressive Care). Resident A's medication was changed and a new medication was added. Resident A's Basaglar Kwikpen and Insulin Glargine U100 Pen were discontinued. Resident A is now prescribed Insulin Glargine U100 Pen. Inject 0.14 mL (14 units total) under skin daily and Fiasp FlexTouch U-100 Insulin. Inject 7 Units under the skin 3 times a day with meals.

The AFC assessment plan for Resident A is not complete as it does not indicate who will supervise and administer Resident A's medication.

On 05/01/2025, I interviewed Kasey Bingham, Direct Staff. Staff Bingham has worked for the corporation for 11 years, having begun working at the current facility since February 2024. Staff Bingham stated that on the day in question (2/22/2025), she'd worked the midnight shift, which ends at 7am. Staff Bingham stated that she took Resident A's blood sugar levels (informing her of what they were) and then administered Resident A's insulin medication around 6:00am. Staff Bingham did not provide Resident A with any food due to Resident A stating that she would be getting up for breakfast. Staff Bingham stated that she was written up, however, she believes that she followed protocol, passing Resident A's medication as prescribed. Resident A was

not scheduled to attend dialysis on this day. Staff Bingham stated that she felt terrible about what occurred and apologized to Resident A.

On 05/01/2025, I interviewed Latonya Prince, Direct Staff. Staff Prince stated that on the day in question she went to Resident A's room to get her up and wheel her into the dining area for breakfast. Resident A was observed slumped in her chair. Staff Prince greeted Resident A, who did not respond. Staff Prince stated that Resident A usually responds to her by waving and smiling, however, Resident A gave no response. Staff Price proceeded to rub Resident A's arm, inquiring if she was ok. Resident A could barely raise her head, however, she looked up, waved her hand and slumped back over. Staff Prince realized something was wrong and requested staff assistance in obtaining her blood sugar levels. Resident A's levels would not be read on the glucometer. Management and 911 were called. Staff Prince stated that it is her understanding that Resident A was not scheduled to attend dialysis and was given her fast acting insulin, when she should have been given her slow acting insulin because she had not eaten. Staff Prince stated that when she passes the Basaglar Kwikpen on dialysis days, she ensures Resident A gets food, due to her early morning dialysis schedule.

On 05/01/2025, I spoke with LD Gotham seeking clarification. LD Gotham stated that Resident A is prescribed both Basaglar Kwikpen and Insulin Glargine U100 Pen to be taken in the morning. Resident A can take either, but not both. If Resident A is attending dialysis, she usually takes the Basaglar Kwikpen, is given food and refuses the Insulin Glargine U100 Pen. While the physician's order does not specify that the insulin is taken with food, staff generally are aware that insulin should be taken with food. If Resident A is not going to dialysis, she takes Insulin Glargine U100 Pen (slow acting), refuses the Basaglar Kwikpen, and eats breakfast at regular mealtimes.

On 05/01/2025, I placed a call to Marsharee Canada, Case Manager (CM) at A & D Waiver, assigned to Resident A. A voice mail message was left requesting a return call.

On 05/02/2025, I spoke with CM Canada who stated that she was informed of the circumstances surrounding Resident A passing out on the day which it occurred. CM Canada stated that Resident A was not given the wrong medication as alleged. Resident A did not eat when taking her insulin medication, causing her to pass out. CM Canada stated that she believes that it was an accident that could have been prevented by both Resident A and facility staff. CM Canada stated that she has no concerns regarding the care Resident A is receiving at the facility. CM Canada stated that she would not allow Resident A to remain at the facility if she suspected any mistreatment.

On 05/02/2025, I reviewed the Verification of Direct Staff Training Log used by Close to Home Assisted Living. The log indicates that staff Kasey Bingham has been trained in Medication Administration. I also reviewed the Employee Warning Notice, which constitutes as a write-up, written on 03/04/2025. The warning indicates that as a manager, staff Bingham is expected to give directions and follow-up with the staff that

work under her guidance, ensuring that her guidance is followed. Staff Bingham was provided with a verbal warning.

On 05/02/2025, I interviewed Olivia Goronto, former staff, as she is no longer employed by the corporation. Former Staff Gornto stated she recalls that on 02/22/2025, staff Latonya Prince called her to Resident A's room to assist, due to Resident A being non-responsive. 911 was called, instructing them to get her to the floor, to which she still did not respond. Former Staff Gornto stated that she always ensured Resident A received food when giving her Basaglar Kwikpen injection.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It was alleged that Staff Kasey Bingham gave Resident A her medication at the wrong time which led to the resident passing out. HM Jennifer Ireland stated that staff Bingham passed Resident A's medication as listed, however, Resident A had not eaten, resulting in her passing out. Resident A stated that on 2/22/2025, staff Bingham had given her the short-term insulin when she should have given her long term insulin, causing her to pass out. LD Gotham stated that Resident A is prescribed both Basaglar Kwikpen and Insulin Glargine U100 Pen to be taken in the morning. Resident A can take either, but not both. LD Gotham stated that when Resident A is not going to dialysis, Resident A usually takes the Insulin Glargine U100 Pen (slow acting) medication. Resident A should have been given food with her insulin medication. On 2/22/2025, Resident A did not go to dialysis. The February 2025 Medication log for Resident A indicates that Resident A was administered Basaglar Kwikpen on 02/22/2025, by staff, Kasey Bingham [at 6am]. Resident A's medication log indicates at 8:00 am, inject 6 units Basaglar Kwikpen every morning (except for Dialysis days- inject 4 units) and inject 10 units Sub-Q at bedtime. Resident A is also prescribed Insulin Glargine U100 Pen. At 8:00am, inject 6 units every morning (except for Dialysis days- inject 4 units).

	The Incident Report (IR) dated 02/22/2025 was reviewed. It indicates Resident A was found unresponsive at 8:05 am. 911 was called. Corrective measures include following the discharge instructions upon being released from the hospital and ensuring Resident A eats when taking her insulin medication. The MyMichigan Medical Center Discharge Summary for Resident A was reviewed. Resident A was hospitalized on 02/23/2025-02/28/2025, for prolonged Q-T Interval on ECG (Cardiac Progressive Care). Resident A's medication was changed and a new medication was added. Direct Staff, Kasey Bingham, stated that she gave Resident A her Basaglar Kwikpen insulin medication at 6:00 am. Resident A is prescribed Basaglar Kwikpen At 8:00 am, per the Feb 2025 Medication Log. Direct Staff, Latonya Prince, stated that it is her understanding that Resident A was not scheduled to attend dialysis and was given her fast acting insulin, when she should have been given her slow acting insulin because she had not eaten. Based upon my investigation, which consisted of interviews with LD Linzi Gotham, facility staff members, Resident A, CM Marsharee Canada, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The AFC assessment plan reviewed for Resident A is not complete as it does not indicate who will supervise and administer Resident A's medication.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The AFC assessment plan for Resident A does not contain information indicating who will supervise and administer Resident A's medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/02/2025, I conducted an exit conference with LD Gotham. LD Gotham was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

Sabrina McGowan May 2, 2025

Sabrina McGowan Date
Licensing Consultant

Approved By:

Mary Holton May 2, 2025

Mary E. Holton Date
Area Manager