



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 2, 2026

Hari Singh
Ghotra Alf Inc
2160 N. Center Rd.
Saginaw, MI 48603

RE: License #: AL730418081
Investigation #: 2026A0580045
Close to Home Assisted Living Facility Side 2

Dear Hari Singh:

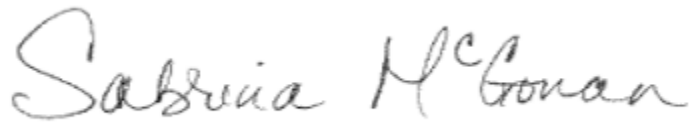
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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,

A handwritten signature in cursive script that reads "Sabrina McGowan". The ink is dark and the signature is fluid, with the first and last names being more prominent than the middle name.

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 #:	AL730418081
Investigation #:	2026A0580045
Complaint Receipt Date:	07/14/2026
Investigation Initiation Date:	07/14/2026
Report Due Date:	09/12/2026
Licensee Name:	Ghotra Alf Inc
Licensee Address:	2160 N. Center Rd. Saginaw, MI 48603
Licensee Telephone #:	(989) 545-8407
Administrator:	Hari Singh
Licensee Designee:	Hari Singh
Name of Facility:	Close to Home Assisted Living Facility Side 2
Facility Address:	2160 N. Center Rd. Saginaw, MI 48603
Facility Telephone #:	(989) 401-3581
Original Issuance Date:	12/18/2024
License Status:	REGULAR
Effective Date:	06/18/2025
Expiration Date:	06/17/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
An improper Hoyer lift transfer resulted in Resident A's ankle being broken.	Yes

III. METHODOLOGY

07/14/2026	Special Investigation Intake 2026A0580045
07/14/2026	APS Referral Denied by APS for investigation.
07/14/2026	Special Investigation Initiated - On Site Unannounced onsite.
07/20/2026	Contact - Document Received Documents received.
07/29/2026	Inspection Completed On-site Unannounced onsite.
07/30/2026	Contact - Telephone call made Call to LD Hari Singh.
08/03/2026	Contact - Telephone call made Interview with DS Henne.
08/06/2026	Contact - Telephone call received Interview with DS Flemming.
08/06/2026	Contact - Telephone call received Interview with Mgr. Kassie Cooke.
08/06/2026	Contact - Document Received Document received.
08/26/2026	Contact - Telephone call made Call to Corey Berden, Region 7 Supports Coordinator.

08/31/2026	Contact - Document Received Email from LD Singh.
08/31/2026	Contact - Telephone call made Interview with Resident A.
09/02/2026	Exit Conference Exit Conference with LD Singh.

ALLEGATION:

An improper Hoyer lift transfer resulted in Resident A's ankle being broken.

INVESTIGATION:

On 07/14/2026, I received a complaint via LARA-BCHS-Complaints. This complaint was denied by Adult Protective Services (APS) for investigation.

On 07/14/2026, I conducted an unannounced onsite inspection at Close to Home Assisted Living Side 2. Contact was made with office staff, Kasey Bingham. Staff Bingham stated that on the day in question, the Hoyer got stuck, as it did often, when transporting Resident A. Staff Bingham stated that as soon as Resident A was in the air, the Hoyer tilted over, causing her ankle and knee to hit the wall. Resident A's assigned Region 7 Supports Coordinator has been notified that her Hoyer lift needs to be replaced.

While onsite, I observed Resident A while sleeping in her room. Resident A appeared to be fine. No concerns regarding her care were noted at the time of the onsite inspection. Other residents in the facility were observed sitting in the dining room area of the facility. No concerns regarding their care were noted. The residents appeared to be receiving proper care.

On 07/20/2026, I received a copy of the documents requested via email from Licensee Designee, Hari Singh. LD Singh also stated that Direct Staff present on the day of the included Kassie Cooke, Tequila Henne, and Danielle Flemming. the AFC Assessment Plan for Resident A.

The AFC Assessment Plan for Resident A indicates that Resident A is not mobile and the use of a Hoyer Lift and an electric wheelchair. Resident A requires a 2-person assist with toileting, dressing, bathing and personal hygiene.

The Incident Report (IR) dated 07/12/2026, list staff members, Kassie Cooke, Danielle Flemming and Tequila Henne as the identified staff. The IR states that on 07/12/2026 staff was assisting Resident A to bed in Hoyer Lift. The Hoyer Lift became unbalanced

and Resident A was dropped onto her bed. Resident A stated that her left foot hit the wall. Staff notified management and sent Resident A to the hospital to be assessed.

The Covenant HealthCare After Visit Summary, dated 07/12/2026, states that Resident A was seen for left ankle pain. Resident A reported being transported in a Hoyer lift when her ankles hit up against the wall creating mild bilateral pain. Resident A reported that her left collar bone got bumped as well. Resident A also reported having received a Norco pain pill prior to arrival. Resident A received X-Rays of the left shoulder and ankle. The left ankle X-Ray demonstrates possible slight avulsion fracture of the left distal fibula. It does appear somewhat corticated in maybe old but will place patient in Aircast. The ankle mortise is normally aligned. No acute fracture identified. Left shoulder X-Ray was unremarkable. Resident A was discharged back to the AFC. Orthopedic follow-up for monitoring to be arranged.

On 07/29/2026, I conducted a follow-up unannounced onsite inspection. Resident A no longer resides at the facility. Other residents were seen in both the dining and living room area of the facility, as well as in their bedrooms. No concerns regarding their care were noted.

On 07/30/2026, I interviewed LD Singh. LD Singh stated that he is not sure if Resident A broke her foot as alleged. LD Singh stated that he's not sure what exactly happened with the Hoyer lift, however, no one informed him that it had been malfunctioning.

On 08/03/2026, I interviewed Direct Staff (DS), Tequila Henne. DS Henne stated that she was the assigned medication passer for the evening and was not in the room when the incident occurred. Upon hearing the commotion staff informed her that the Hoyer had fallen and Resident A nicked her foot as a result. DS Henne could not recall who was assisting Resident A at the time of the incident, however, she does recall that it was 3 people.

On 08/06/2026, I interviewed DS Danielle Fleming. DS Flemming recalled stated that she came in the room afterwards and did not see what occurred. DS Flemming stated that she cannot recall who was assisting Resident A at the time the Hoyer lift gave out.

On 08/06/2026, I interviewed Staff Kassie Cooke. Staff Cooke stated that she was the manager on duty at the time of the and was not in the room at the time of the incident. Staff Cooke stated that DS Flemming came and informed her that Hoyer Lift gave out while lifting Resident A, and her foot hit the wall as a result. Resident A requested to be sent out to the hospital. Staff Cooke stated that she does not recall the names of the staff members working with Resident A during the time of the incident.

On 08/06/2026, I received a different IR dated 07/12/2026. This IR states that on 07/12/2026, at 5:30pm, staff was assisting Resident A to bed in Hoyer lift. Hoyer lift became unbalanced and Resident A was dropped on her bed. Resident A stated that she hit her left foot on the wall. Staff notified management and sent Resident A out to

the hospital to be assessed for foot pain. This IR identifies DS Flemming as the staff on duty.

On 08/26/2026, I contacted Area Agency on Aging Region 7 Supports Coordinator, Corey Berden. A voice mail message was left requesting a return call.

On 08/31/2026, I received an email from LD Singh stating that per Region VII, Resident A has moved to a facility called Optalis Health & Rehabilitation, located in Grand Rapids, near where her family lives. Region VII no longer provides Resident A services, having closed her file effective 07/27/2026. Attached to the email was the July 2026 staff schedule indicating that DS Flemming and DS Henne were the staff on duty 07/12/2026, during 2nd shift.

On 08/31/2026, I placed a call to Resident A. Resident A stated that on the day in question staff were rushing to get her hooked on the Hoyer, next thing she knows, she fell on the bed and hit her foot against the wall. Resident A stated that this was the second incident where she was dropped. Resident A stated that her foot is broken and she remains in a cast.

Special Investigation Report #2026A0580025 dated April 30, 2026, cited violation to R 400.681(1) due to a resident leaving the facility unsupervised. The corrective action plan dated 05/01/2026 and signed by the licensee designee, Hari Singh states that he will be more careful when accepting new residents as the facility is not equipped to handle residents with elopement issues. All doors have been fixed to lock properly and will be evaluated monthly to ensure proper working order.

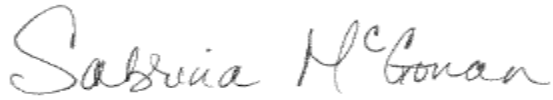
On 09/02/2026, I conducted an exit conference with LD Hari Singh. LD Singh agreed to provide a corrective action plan.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	It was alleged that an improper Hoyer lift transfer resulted in Resident A's ankle being broken. Staff, Kasey Bingham, stated that as soon as Resident A was in the air, the Hoyer tilted over, causing her ankle and knee to hit the wall. Resident A's assigned Region 7 Supports Coordinator has been notified that her Hoyer lift needs to be replaced. Staff members Danilee Flemming, Tequila Henne, and Kassie Cooke all denied being present when Resident a was dropped.

	The July 2026 staff schedule indicating that DS Flemming and DS Henne were the staff on duty 07/12/2026, during 2nd shift. The AFC Assessment Plan for Resident A indicates that Resident A is not mobile and the use of a Hoyer Lift and an electric wheelchair. Resident A requires a 2-person assist with toileting, dressing, bathing and personal hygiene. The IR dated 07/12/2026, list staff members, Kassie Cooke, Danielle Flemming and Tequila Henne as the identified staff. The IR states that on 07/12/2026 staff was assisting Resident A to bed in Hoyer Lift. The Hoyer Lift became unbalanced and Resident A was dropped onto her bed. Resident A stated that her left foot hit the wall. Staff notified management and sent Resident A to the hospital to be assessed. A second IR received, 07/12/2026, states that on 07/12/2026, at 5:30pm, staff was assisting Resident A to bed in Hoyer lift. Hoyer lift became unbalanced and Resident A was dropped on her bed. Resident A stated that she hit her left foot on the wall. The Covenant HealthCare After Visit Summary, dated 07/12/2026, states that Resident A received X-Rays of the left shoulder and ankle. The left ankle X-Ray demonstrates possible slight avulsion fracture of the left distal fibula. Resident A stated that on the day in question staff were rushing to get her hooked on the Hoyer, next thing she knew, she fell on the bed and hit her foot against the wall. Resident A stated that this was the second incident where she was dropped. Resident A stated that her foot is broken and she remains in a cast. Based upon my investigation, which consisted of interviews with multiple facility staff members and Resident A, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the allegation.
CONCLUSION:	REPEAT VIOLATION ESTABLISHED SIR #2026A0580025 dated April 30, 2026.

IV. RECOMMENDATION

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

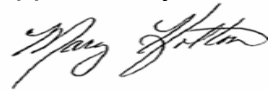


September 2, 2026

Sabrina McGowan
Licensing Consultant

Date

Approved By:



September 2, 2026

Mary E. Holton
Area Manager

Date