



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 5, 2024

John Winden
Close To Home Assisted Living, Saginaw LLC
1805 South Raymond
Bay City, MI 48706

RE: License #: AL730398656
Investigation #: 2024A0580024
Close to Home Assisted Living Saginaw Side 2

Dear John Winden:

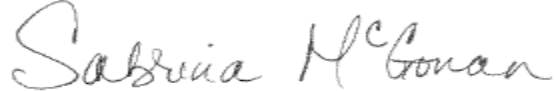
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 signature is written in black ink and is positioned below the word "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 #:	AL730398656
Investigation #:	2024A0580024
Complaint Receipt Date:	02/15/2024
Investigation Initiation Date:	02/20/2024
Report Due Date:	04/15/2024
Licensee Name:	Close To Home Assisted Living, Saginaw LLC
Licensee Address:	1805 South Raymond Bay City, MI 48706
Licensee Telephone #:	(989) 401-3581
Administrator:	John Winden
Licensee Designee:	John Winden
Name of Facility:	Close to Home Assisted Living Saginaw Side 2
Facility Address:	2160 N. Center Rd Saginaw, MI 48603
Facility Telephone #:	(989) 778-2575
Original Issuance Date:	07/07/2020
License Status:	REGULAR
Effective Date:	01/07/2023
Expiration Date:	01/06/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Sometime in January, staff Paul Shade assaulted Resident A.	Yes

III. METHODOLOGY

02/15/2024	Special Investigation Intake 2024A0580024
02/20/2024	Special Investigation Initiated - Letter A referral was made to APS sharing the allegations.
02/20/2024	APS Referral A referral was made to APS sharing the allegations.
02/23/2024	Inspection Completed On-site An unannounced onsite inspection was conducted.
02/23/2024	Contact - Face to Face Interview with Resident A.
02/23/2024	Contact - Document Received Email received from Linzi Gotham, Management Staff.
02/27/2024	Contact - Telephone call made Call to direct staff, Paul Shade.
03/15/2024	Contact - Telephone call made Call to direct staff, Paul Shade.
04/02/2024	Contact - Document Sent Copy of police report requested.
04/02/2024	Contact - Document Received Police report received.
04/02/2024	Contact - Telephone call made Call to A & D Waiver Supports Coordinator, Tom Kubiack.
04/04/2024	Contact - Telephone call received. Call from A & D Waiver Supports Coordinator, Tom Kubiack.
04/05/2024	Contact - Document Received Copy of incident report received.

04/05/2024	Exit Conference An exit conference was held with the licensee designee, John Winden.
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ALLEGATION:

Sometime in January, staff Paul Shade assaulted Resident A.

INVESTIGATION:

On 02/15/2024, I received a complaint via BCAL Online Complaints.

On 02/20/2024, I made a referral to Adult Protective Services (APS) sharing the allegations.

On 02/23/2023, I conducted an unannounced onsite inspection at Close to Home Assisted Living Side 2. Contact was made with management staff, Linzi Gotham, who stated that neither Resident A, nor staff Dennis Wahl reported an incident occurred between Resident A and Paul Shade. Linzi Gotham added that staff Paul Shade had expressed that Resident A called him a racial slur. Resident A has been refusing showers and being very mean, and racist to staff. As a result, Linzi Gotham gave Resident A a 30-day discharge notice to vacate the facility.

On 02/23/2024, I spoke with Resident A, who stated that staff Paul Shade did slap him. None of the other residents witnessed it to his knowledge and if so, no one will say anything. Resident A added that he gets mistreated all the time and wants to leave the facility, however, he has nowhere else to go. Resident A was observed while in his room lying in his bed.

While onsite other residents were observed in their rooms. Some of the residents were sitting in their chairs watching television, while others were lying down in bed. No concerns regarding their care were noted. Resident B stated that he has never witnessed staff Paul Shade be abusive to any residents and he likes residing in the home. Resident C stated that he has no knowledge of staff Paul Shade being mean or abusive to any residents. Resident D denied staff being abusive towards her. Resident D stated that she has not witnessed any staff be abusive to residents.

On 02/23/2023, I received an email from Linzi Gotham which stated, "I just wanted to follow up with you on today's allegations. We did a complete investigation and asked Paul [Shade] if there was ever an altercation between himself and Resident A. He admits to slapping the resident. He stated that Resident A hit him, and he hit him back. I filed a police report this evening with Saginaw Township and immediately terminated his position with our company".

On 02/27/2024, I made a call to direct staff, Paul Shade. There was no answer. A voice mail message was left requesting a return call.

On 03/15/2024, I made Call to direct staff, Paul Shade. There was no answer. A voice mail message was left requesting a return call.

On 04/02/2024, I sent a records Request to Saginaw Township Police Department for a copy of Report #24-71800660, involving Resident A. The department also confirmed that the case has been closed with no further investigation and no criminal charges pursued.

On 04/02/2024, I received a copy of Police Report #24-71800660 completed on 02/23/2024 @ 10:00pm, by Reporting Officer, Frankie Landman of the Saginaw Township Police Department. The report states that officers were dispatched to the facility due to receiving a call from the manager, Linzi Gotham, indicating that one of her workers, Paul Shade assaulted a resident approximately 2 months ago. Upon arrival officers spoke with Linzi Gotham, who stated that she was just notified of the incident earlier that day. Manager Gotham adds that APS was made aware of the incident. Manager Gotham also reported that after speaking with staff Paul Shade, he admitted to assaulting the resident. Officer Landman spoke with Resident A who stated that staff Paul Shade came in his room and tried to make him take medication that he did not want. Resident A reported that staff Shade grabbed him by the arm and started throwing him around like a rag. When asked for more specific information, Resident A could only recall an assault happened and not all the details. Resident A showed the officer a scabbed area on his right arm near his elbow that he claims was from the assault. Resident A added that he receives a lot of verbal abuse, but this was the first time something physically happened.

Officer Landman spoke with staff Paul Shade in the manager's office. Staff Shade reported that he observed Resident A in the hall of the building moving in his wheelchair. Staff Shade observed Resident A intentionally stop in front of another resident and tried to ram them. Staff Shade approached Resident A and said in his ear, "you're not going to do that". Staff Shade said Resident A then called him a "nigger" and smacked him in the face. Staff Shade then smacked Resident A in the face. Staff Shade then got in front of Resident A, who "squared up" with him and staff Shade struck him in the face with an open hand smack. Staff Shade stated that after the altercation he and Resident A went their separate ways. Staff Shade further advised that he documented the altercation in the nurse's book. The entry was made on 01/08/2024, stating that Resident A reacted violently, and aggressive measures had to be taken in defense.

Manager Gotham advised that Resident A is often violent and racist to other residents and is being evicted from the home soon because of this behavior. Manager Gotham adds by no means was this acceptable behavior for her staff to react to Resident A or his behavioral issues. Manger Gotham terminated Paul Shade's employment while officers were on scene without issue.

On 04/02/2024, I placed a call to Tom Kubiack of A & D Waiver, supports coordinator for Resident A. A voice mail message was left requesting a return call.

On 04/04/2024, I spoke with Tom Kubiack of A & D Waiver, supports coordinator for Resident A. Supports Coordinator Kubiack stated that he was just recently made aware of the allegations this week and was also informed that a police report was made. Supports Coordinator Kubiack acknowledged that a 30-day discharge notice for Resident A has been received and he and the guardian have been actively seeking placement. However, Support Coordinator Kubiack stated that with the racist behaviors Resident A presents, no new placement has been found. He is pleased with the fact that staff Paul Shade has been terminated from the facility.

On 04/05/2024, I received a copy of the incident report dated 02/24/2024. The report, completed by Manager Linzi Gotham, indicates that on 02/02/23 she was notified that staff, Paul Shade may have slapped a resident. Actions taken included an internal investigation. The accusation was founded. The police were called, and a report was filed. Staff Shade was immediately fired and escorted out of the building. Corrective measures included a staff meeting being held with all current staff and continued education on how to handle difficult situations appropriately.

APPLICABLE RULE	
R 400.15308	Resident behavior interventions prohibitions.
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	<p>It was alleged that sometime in January, staff Pall Shade assaulted Resident A.</p> <p>Resident A stated that staff Paul Shade did slap him as alleged.</p> <p>Manager Linzi Gotham stated that she was not informed of the physical altercation by neither Resident A nor staff Paul Shade. Once investigated, Paul Shade was terminated, and a police report was filed.</p> <p>Staff Paul Shade stated to Officer Frankie Landman of the Saginaw Township Police Department that Resident A called him a “nigger” and smacked him in the face, and he smacked Resident A back twice as a result.</p>

	<p>The incident report dated 02/24/2024 was reviewed.</p> <p>Based on the interviews conducted and the information gathered throughout the course of this investigation, a review of the incident report dated 02/23/2024, and Police Report #24-71800660, completed by Officer Frankie Landman of the Saginaw Township Police Department, there is enough evidence to support the rule violation.</p> <p>A & D Waiver Supports Coordinator for Resident A, Tom Kubiack stated that he was just recently made aware of the allegations and is pleased with the fact that staff Paul Shade has been terminated from the facility.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 04/05/2024, I conducted an exit conference with the licensee designee John Winden. John Winden was informed of the findings of this investigation.

IV. RECOMMENDATION

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

Sabrina McGowan April 5, 2024

 Sabrina McGowan Date
 Licensing Consultant

Approved By:
Mary Holton April 5, 2024

 Mary E. Holton Date
 Area Manager