GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 1, 2025

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

RE: License #: AL730418081
Investigation: 2025A0580024
Close to Home Assisted Living Facility Side 2

Dear Linzi Gotham:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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

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 #:	2025A0580024
Complaint Receipt Date:	03/05/2025
Investigation Initiation Date:	03/06/2025
Report Due Date:	05/04/2025
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 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:	TEMPORARY
Effective Date:	12/18/2024
Expiration Date:	06/17/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A could barely walk, could not use the bathroom & had bruising after 7 days of placement. Resident A was not eating and is now on meds for UTI from being left in soiled briefs for too long.	No

III. METHODOLOGY

03/05/2025	Special Investigation Intake 2025A0580024
03/06/2025	APS Referral Referred to APS.
03/06/2025	Special Investigation Initiated - Letter A referral sharing the allegations was made.
03/11/2025	Inspection Completed On-site Unannounced onsite.
03/11/2025	Contact - Face to Face Interview with staff, Ashley Broiher.
03/11/2025	Contact - Face to Face Interview with staff, Amiyah Daniels.
03/11/2025	Contact - Face to Face Interview with staff, Sundra Jones.
03/11/2025	Contact - Face to Face Interview with Tara Moten, Floor Manager.
03/11/2025	Contact - Face to Face Interview with staff, Tiffany Westenburg.
03/11/2025	Contact - Document Received Video received.
03/14/2025	Contact - Document Received Email of documents requested was received.
04/28/2025	Contact – Telephone call made

	Call to Relative Guardian A.
04/28/2025	Contact – Telephone call made Call to Visiting Nurses of Saginaw.
05/01/2025	Exit Conference Exit with LD Gotham.

ALLEGATION:

Resident A could barely walk, could not use the bathroom & had bruising after 7 days of placement. Resident A was not eating and is now on meds for UTI from being left in soiled briefs for too long.

INVESTIGATION:

On 03/05/2025, I received a complaint via LARA-BCHS-Complaints. On 03/06/2025, I made a referral to Adult Protective Services. I shared the allegations alleged in this complaint.

On 03/11/2025, I conducted an unannounced onsite investigation at Close to Home 2. Contact was made with Jenny Ireland, Home Manager (HM). HM Ireland stated that Resident A was placed at the facility for a 1 week for respite care. HM Jenny denied the allegations, stating that Resident A never complained while at the facility. HM Ireland added that Resident A was able to walk out of the facility with the assistance of her walker on the day that Resident A left. HM Resident A entered the facility on 02/21/2025. Resident A was discharged on 03/02/2025.

On 03/11/2025, while onsite, I interviewed Ashley Broiher, Direct Staff. Staff Broiher stated residents who require brief changes are checked and changed every two hours, or more frequently, if needed. Staff Broiher stated that she did not work with Resident A when Resident A resided at the facility.

On 03/11/2025, while onsite, I interviewed Amiyah Daniels, Direct Staff. Staff Daniels stated residents that require assistance with their briefs are checked and changed every 2 hours.

On 03/11/2025, while onsite, I interviewed Sundrina Jones, Direct Staff. Staff Jones stated that she recalls Resident A not wanting to eat, always sitting her food down in front of her and just leaving it there. Staff Jones denied the allegations that Resident A was left in wet briefs, stating that she constantly checked and changed Resident A while on shift.

On 03/11/2025, while onsite, I interviewed Floor Manager (FM), Tara Moten. Tara Moten stated that when Resident A was residing in the facility, she always checked on her. Staff Moten recalled that Resident A did a lot of sitting or lying down due to missing her daughter. Staff Moten stated that on the day Resident A was discharged she recalled her daughter saying that she saw a bruise. Resident A physically walked out of the facility when she left.

On 03/11/2025, while onsite, I interviewed Tiffany Westenburg, Direct Staff. Staff Westenburg stated that she was not present when Resident A was discharged from the facility on Sunday, March 2nd, however, she'd seen Resident A the Friday before and there were no problems. Staff Westenburg stated that Resident A was self-feeding and had no falls that she was aware of. While a resident at the facility, Resident A was checked and changed every 2 hours.

On 03/11/2025, I received a copy of a video taken on 03/02/2025, sent to me by Licensee Designee, Lindsay Gotham. The video is taken from within the hallways of the facility and depicts Resident A walking down the hallway with the assistance of a walker. Resident A has her coat on, as if Resident A is preparing to leave. Resident A is accompanied by 2 individuals, 1 assisting Resident A as she walks, while the other is carrying Resident A's bags as Resident A prepares to exit the building.

On 03/14/2025, I received an emailed copy of the AFC Assessment Plan for Resident A. The assessment plan indicates that Resident A uses both a wheelchair and a walker for mobility. Resident a requires reminders as well as check and change assistance with briefs. Resident A requires reminders her to eat her food. Resident A requires staff assistance with personal hygiene, dressing and grooming. Resident A requires bathing assistance, which will be provided by hospice.

The Health Care Appraisal for Resident A was completed on 02/21/2025. The appraisal indicates that Resident A is diagnosed with Alzheimer's Disease and demonstrates signs of Cognitive Impairment, Delayed Speech, and Memory Loss. Resident A is oriented to person. Resident A is incontinent, weighs 137 lbs. and uses a walker for assistance.

On 04/28/2025, I spoke with Relative Guardian A who stated that she is Resident A's sole caretaker. Relative A stated that she placed Resident A at Close to Home Assisted Living Side 2 for respite care, confirming the dates of placement as 02/21/2025-03/02/2025. Relative A stated that when she dropped Resident A off, Resident A was fine. Resident A could feed and dress herself with prompting, due to her dementia. However, when Relative A picked Resident A up, Resident A was in bad shape. Relative A stated that Resident A could barely walk, was diagnosed with an E. coli UTI, dehydrated and confused. Resident A also had a bruise on each arm. Staff did not know how the bruise occurred and while it is possible that Resident A could have hit her arm, she found it strange that the bruises were on each arm, in the same area. While at the facility, Resident A also received care from her hospice team, Covenant Visiting Nurses

of Saginaw, who can verify the information. Resident A was not hospitalized after Resident A's stay at Close to Home.

On 04/28/2025, I spoke with RN Jennifer Grant of Visiting Nurses of Saginaw, assigned Hospice nurse assigned to Resident A. RN Grant stated that it is her understanding that Relative A needed respite care while on vacation. Resident A is eligible for 30 days of respite per calendar year via the waiver program. Relative A did express concern regarding the care provided to Resident A while at the facility. RN Grant stated that she requires management approval to discuss any further information.

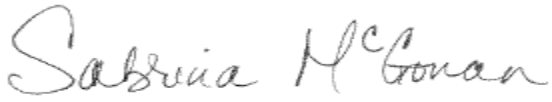
APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was alleged that after 7 days of placement, Resident A could barely walk, could not use the bathroom & had bruising. Resident A was not eating and is now on meds for UTI from being left in soiled briefs for too long. Home Manager, Jennifer Ireland, Floor Manager, Tara Moten, Direct Staff, Ashley Broiher, Amiyah Daniels, Sundrina Jones and Tiffany Westenburg denied the allegations. RN Grant stated that Relative A did express concern regarding the care provided to Resident A while at the facility. Video taken from within the hallways of the facility, which depicts Resident A walking down the hallway with the assistance of a walker, accompanied by 2 individuals, with 1 assisting her as she walks, was observed. The AFC Assessment Plan for Resident A was reviewed. The Health Care Appraisal for Resident A was reviewed. Relative Guardian A stated that when she placed Resident A at Close for respite care, Resident A could feed and dress herself with prompting, due to her dementia. When Relative A picked Resident A up, she was in bad shape, barely able to walk, was diagnosed with an E. coli UTI, dehydrated and confused. Resident A also had a bruise on each arm.

	Based on the Based upon my investigation, which consisted of interviews with multiple facility well as a review of relevant facility documents pertinent to the allegation, there is not enough evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 05/01/2025, I conducted an exit conference with Licensee Designee, Linzi Gotham. LD Gotham was informed of the findings of this investigation.

IV. RECOMMENDATION

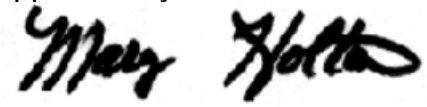
I recommend no change in the status of this license.



May 1, 2025

Sabrina McGowan Date
Licensing Consultant

Approved By:



May 1, 2025

Mary E. Holton Date
Area Manager