GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 6, 2025

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

RE: License #: AL730418081
Investigation #: 2025A0580039
Close to Home Assisted Living Facility Side 2

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.
- 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,

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 #:	2025A0580039
Complaint Receipt Date:	07/02/2025
Investigation Initiation Date:	07/03/2025
Report Due Date:	08/31/2025
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
Status:	REGULAR
Effective Date:	06/18/2025
Expiration Date:	06/17/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff were unresponsive on arrival, later found outside in a car, and appeared groggy and evasive, raising concerns about neglect.	No
Staff were unresponsive on arrival, later found outside in a car, and appeared groggy and evasive, raising concerns about supervision.	Yes

III. METHODOLOGY

07/02/2025	Special Investigation Intake 2025A0580039
07/03/2025	Special Investigation Initiated - Telephone Call to the complainant.
07/07/2025	APS Referral Referred to APS.
07/15/2025	Inspection Completed On-site Unannounced onsite. Contact with Linzi Gotham, Licensee Designee.
07/15/2025	Contact - Face to Face Interview with staff, Amiyia Daniels and Ashley Boihier.
07/15/2025	Contact - Face to Face Interview with Resident A.
07/24/2025	Contact - Telephone call received Call from the complainant.
07/30/2025	Contact - Telephone call made Call to former staff Kassie Cooke.
07/30/2025	Contact - Telephone call made Interview with former staff, Kassandra Mulligan.
08/04/2025	Contact - Document Received Staff schedule document received.
08/06/2025	Contact - Telephone call made

	Call to LD Linzi Gotham.
08/06/2025	Exit Conference Exit Conference with LD Linzi Gotham.

ALLEGATION:

Staff were unresponsive on arrival, later found outside in a car, and appeared groggy and evasive, raising concerns about neglect.

INVESTIGATION:

On 07/02/2025, I received a complaint via LARA-BCHS-Complaints. On 07/03/2025, I placed a call to the complainant who reiterated the allegations.

On 07/07/2025 I made a referral to Adult Protective Services (APS). The allegations in this investigation were shared with APS

On 07/15/2025. I made an unannounced onsite inspection at Close to Home Assisted Living Side 2. Contact was made with the Licensee Designee (LD), Linzi Gotham. LD Gotham stated that she was made aware of the situation. LD Gotham denied that the 3 staff were in a car as alleged. Direct care staff members Amiya Daniels (caregiver staff at Close to Home Assisted Living Side 3) and Ashley Boiher (caregiver staff sat Close to Home Assisted Living Side 1) stepped outside for a break, while staff member on duty Kassie Cooke (Close to Home Assisted Living Side 2) joined them shortly thereafter. Kassandra Mulligan (Med Passing Staff) remained inside. Staff reported that while on break they observed a stranger flashing a flashlight into residents' bedroom windows, which made them nervous. LD Gotham stated that staff members Kassie Cooke and Kassandra Mulligan are no longer employed at the facility. LD Gotham denied that their firing was related to these allegations.

On 07/15/2025, while onsite, I interviewed direct staff members Amiya Daniels and Ashley Boiher, both of whom were working on the night in question. Daniels and Boiher denied that they were sitting in a car as alleged. Staff Daniels and Boiher stated that while standing outside on break they observed a stranger flashing a flashlight into residents' bedroom windows, which made them nervous, as they did not know who it was. Staff Daniles and Boiher addressed the stranger, informing him that someone was inside to answer the door.

On 07/15/2025, while onsite, I interviewed Resident A. Resident A stated that she is treated well by staff in the facility and has no other complaints.

On 07/24/2025, I received a call from the complainant, who stated although he did shine the flashlight through the window, he only shined it down the hallway, not in residents' rooms.

On 07/30/2025, I placed a call to former staff Kassie Cooke. The telephone number of record for former staff Cooke is no longer in service.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	It was alleged that staff were unresponsive on arrival, later found outside in a car, and appeared groggy and evasive, raising concerns about neglect. Licensee Designee, Linzi Gotham, denied that the 3 staff were in a car as alleged. Staff reported that while on break they observed a stranger flashing a flashlight into residents' bedroom windows, which made them nervous. Staff, Amiya Daniels and Ashley Boiher, denied that they were sitting in a car as alleged. Staff Daniels and Boiher stated that while standing outside on break they observed a stranger flashing a flashlight into residents' bedroom windows, which made them nervous, as they did not know who it was. Resident A stated that she is treated well by staff in the facility and has no other complaints. The complainant stated although he did shine the flashlight through the window, he only shined it down the hallway, not in residents' rooms. Based upon my investigation, which consisted of interviews with facility staff members, Resident A, and Licensee Designee Linzi Gotham, and the complainant, there is not enough evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

It was alleged that staff were unresponsive on arrival, later found outside in a car, and appeared groggy and evasive, raising concerns about supervision.

INVESTIGATION:

On 07/15/2025 Licensee Designee (LD), Linzi Gotham. LD Gotham stated that it is her understanding that Resident A was brought back to the facility around 2am in the morning. Normally, the facility would receive a call when a resident is returning, however, this time they did not. After reviewing her cameras, it was determined that staff members Amiya Daniels (caregiver staff at Close to Home Assisted Living Side 3) and Ashley Boiher (caregiver staff at Close to Home Assisted Living Side 1) stepped outside for a break, while staff member on duty Kassie Cooke (caregiver staff at Close to Home Assisted Living Side 2) and Kassandra Mulligan (Med Passing Staff) remained inside. Staff Kassie Cooke then stepped outside briefly with the other 2 staff, while staff Kassandra Mulligan remained inside assisting another resident.

On 07/15/2025, staff Daniels and staff Boiher, stated that they went out for a break together, while staff Kassie Cooke and Kassandra Mulligan remained in the building. Staff Kassie Cooke stepped outside for a brief moment while they were on break and all 3 went back inside at the same time. Staff Kassandra Mulligan was still inside the building, assisting a resident, which caused the delay in answering the door.

On 07/15/2025, while onsite, I interviewed Resident A. Resident A stated that it did take a while for staff to open the door, however, she does not believe that the facility knew that she was returning that night.

On 07/24/2025, the complainant stated that the hospital is responsible for contacting the facility when a patient is being discharged back into the home. The complainant is not sure if the facility was contacted prior to the resident drop-off. The complainant stated that there was another incident where he was transporting a resident back to the facility and it took 15 minutes before someone answered the door. The complaint stated that this incident occurred around midnight, although he is not sure of the day.

On 07/30/2025, I placed a call to former staff Kassie Cooke. The telephone number of record for former staff Cooke is no longer in service.

On 07/30/2025, I interviewed former staff, Kassandra Mulligan. Staff Mulligan estimates that it took about 10 minutes for her to answer the door due to assisting a resident with a brief change.

On 08/04/2025, I received a copy of the staff schedule for Close to Home Assisted Living-Side 2. The schedule reflects that staff member Kassie Cooke as the only caregiver staff on duty when the allegations were made.

On 08/06/2025, I spoke with LD Gotham who stated that there are currently 12 residents in the facility. I also advised LD Gotham that based on the schedule, it appears that staff Cooke left the residents alone when she stepped outside for a break.

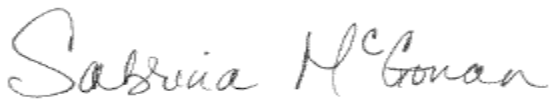
APPLICABLE RULE	
R 400.15206	**Staffing requirements**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	It was alleged that staff were unresponsive on arrival, later found outside in a car, and appeared groggy and evasive, raising concerns about supervision. Licensee Designee, Linzi Gotham, stated that it is her understanding that Resident A was brought back to the facility around 2am in the morning. Caregiver staff, Kassie Cooke was outside on break, while staff Kassandra Mulligan remained inside assisting another resident. LD Gotham who stated that there are currently 12 residents in the facility. Staff Daniels and staff Boiher, stated that they went out for a break together. Staff Kassie Cooke stepped outside for a brief moment while they were on break and all 3 went back inside at the same time. Staff Kassandra Mulligan was still inside the building, assisting a resident, which caused the delay in answering the door. Resident A stated that it did take a while for staff to open the door, however, she does not believe that the facility knew that she was returning that night. The complainant stated that the hospital is responsible for contacting the facility when a patient is being discharged back into the home. The complainant is not sure if the facility was contacted prior to the resident drop-off. The complainant adds that there was another incident where he was transporting a resident back to the facility and it took 15 minutes before someone answered the door. The complaint stated that this incident occurred around midnight, although he is not sure of the day. Former staff, Kassandra Mulligan, estimates that it took about 10 minutes for her to answer the door due to assisting a resident with a brief change.

	The June 2025 staff schedule for Close to Home Assisted Living Side 2, reflects that staff member Kassie Cooke as the only caregiver staff on duty at the time the allegations were made. Based upon my investigation, which consisted of interviews with facility staff members, Resident A, Licensee Designee Linzi Gotham, and the complainant, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/06/2025, I conducted an exit conference with Licensee Designee, Linzi Gotham. LD Gotham was informed of the findings of this investigation.

IV. RECOMMENDATION

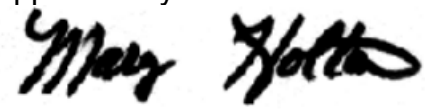
Upon the receipt of an acceptable corrective action, no change to the status of the license is recommended.



August 6, 2025

Sabrina McGowan — Date
Licensing Consultant

Approved By:



August 6, 2025

Mary E. Holton — Date
Area Manager