



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 14, 2026

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

RE: License #: AL730418082
Investigation #: 2026A0580047
Close to Home Assisted Living Saginaw Side 3

Dear Hari Singh:

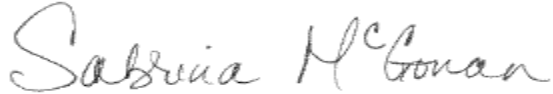
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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 #:	AL730418082
Investigation #:	2026A0580047
Complaint Receipt Date:	07/27/2026
Investigation Initiation Date:	07/29/2026
Report Due Date:	09/25/2026
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 Saginaw Side 3
Facility Address:	2168 N. Center Rd. Saginaw, MI 48603
Facility Telephone #:	(989) 401-3581
Original Issuance Date:	03/03/2025
License Status:	REGULAR
Effective Date:	09/03/2025
Expiration Date:	09/02/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was allowed access to a cleaning product which he allegedly drank.	Yes

III. METHODOLOGY

07/27/2026	Special Investigation Intake 2026A0580047
07/29/2026	Special Investigation Initiated - On Site Unannounced onsite.
07/29/2026	Contact - Face to Face Attempted interview with Resident A.
07/29/2026	Contact - Document Received Documents received.
07/29/2026	Contact - Document Received Facility Documents rec'd.
07/30/2026	Contact - Telephone call made Call to Resident Guardian A.
07/30/2026	Contact - Document Received Copy of Resident A's medical records received.
07/30/2026	Contact - Telephone call made Call to Licensee Designee Singh.
08/03/2026	Contact - Telephone call made Interview with Direct Care Staff, Sam Kureshi.
08/03/2026	Contact - Telephone call made Interview with Direct Care Staff, Nia Garcia.
08/03/2026	Contact - Telephone call made Call to former DCW, Tasia Huntley.
08/06/2026	Contact - Telephone call made Interview with management staff, Kassie Cooke

09/03/2026	Contact - Telephone call made Call to Resident B.
09/04/2026	APS Referral Allegations shared with APS.
09/14/2026	Exit Conference Exit Conference with Licensee Designee, Hari Singh.

ALLEGATION:

Resident A was allowed access to a cleaning product which he allegedly drank.

INVESTIGATION:

On 07/27/2026, I received a complaint via LARA-BCHS-Complaints.

On 07/29/2026, I conducted an unannounced onsite inspection at Close to Home Assisted Living Side 3. Contact was made with Home Manager (HM), Jennifer Ireland. HM Ireland stated that on the day in question, the air quality in the state was poor and Resident A wanted to go outside and smoke. Staff suggested he stay inside; however, he chose to go out. After eating dinner, Resident A threw up. Staff, Tasia Huntley cleaned it up with Mr. Clean cleanser, however, once finished she sat it on the table next to him and walked away. It is her understanding that Resident B yanked the cleaner away from him before he drank it. Resident A also denied that he drank the cleaner. The EMTs were called because staff thought that Resident A drank the cleaner. The manager on duty, Kassie Cooke, was written up in relation to this incident while staff Huntley was fired. Documentation was requested.

On 07/29/2026, while onsite, I observed Resident A while in his room. Resident A was not able to effectively communicate; therefore, he was unable to be interviewed. When asked a question about how he was feeling, Resident A did shake his head yes in response to feeling good, when asked a question in relation to his health. Resident A was adequately clothed and groomed. He appeared to be receiving adequate care.

On 07/29/2026, I received a copy of the documentation requested. The AFC Assessment Plan for Resident A indicates that Resident A can talk but makes no sense and is hard to understand. The Incident Report (IR) dated 07/16/2026 states that Resident A vomited all over his floor. Cleaned up vomit. While cleaning staff Tasia Huntley dumped Mr. Clean on the floor and left the bottle sitting on a table near Resident A. Resident A went to smell it and the resident who resides next door, Resident B took it out of his hands. Staff Huntley stated that she believes that he drank the cleaner. Staff contacted 911. Discharge instructions to be followed upon release.

The 07/16/2026 Covenant Healthcare After Visit Summary indicates that Resident A was seen for ingestion (overdose, accidental) and diagnosed with Ingestion of nontoxic substance, accidental or unintentional. Resident A received lab tests and given sodium chloride. The instruction states that fortunately, the Mr. Clean was non-toxic. Poison control was contacted and after a period of observation, Resident A was cleared to be discharged, with instructions to return if Resident A develops vomiting or abdominal pain.

On 07/30/2026, I interviewed Public Guardian A. Public Guardian A stated that she has documentation from the hospital, per the emergency department results, that reflects that Resident A did in fact ingest the cleaning solution and she is concerned regarding Resident A's safety. Public Guardian A agreed to send a copy. Public Guardian A also stated that the home manager denied that Resident A drank the solution. Per Resident A, he wants to move from the home.

On 07/30/2026, I received a copy of the Summary of Care provided to Resident A by Covenant Healthcare, during his visit on 07/16/2026. The summary indicates that Resident A is a 63-year-old male transferred from Close to Home Assisted Living, after he accidentally ingested Mr. Clean. The patient has a history of a stroke with right hemispheric infarct and is wheelchair-bound. He wheeled himself outside today. AFC staff feels after being out in the extreme heat he came back in and was very thirsty. He found a bottle of the cleaner and drank that trying to quench his thirst. On arrival, the patient is awake and alert. He has an expressive aphasia and is unable to voice any concerns. The history from above was taken from the paramedics who also provided me with a bottle of what he had ingested. A full bottle contains 23 oz of cleaner and there are approximately 3 to 4 oz remaining in the bottle.

On 07/30/2026, I interviewed Licensee Designee (LD) Hari Singh. LD Singh stated that there were 2-3 other people present who stated that Resident A did not drink the cleaner. In addition, Resident B stated that he snatched the cleaner preventing Resident A from drinking the cleaner. LD Singh stated that the staff made an error in leaving the cleaner in Resident A's presence. The cleaner is non-toxic. Staff also gave the bottle to the ambulance. Staff Huntley no longer works for the facility. LD Singh admitted that staff should have contacted the guardian as well.

On 08/03/2026, I interviewed Direct Care Worker (DCW), Sam Kureshi. DCW Kuresi recalled that he was the medication passer on duty. After Resident A threw up Staff Huntley helped clean Resident A and change his clothes. Staff Huntly left the cleaning solution on the table and Resident A picked up the bottle. Staff Kureshi stated that the top was still on the bottle and he's pretty sure that Resident A did not drink the contents, however, Resident A was sent out to the hospital.

On 08/03/2026, I interviewed DCW, Nia Garcia. DCW Garcia stated that while working with another resident, Staff Huntley informed her that Resident A had thrown up. After cleaning Staff Huntley stated that she went to put his clothes in the washer and left the

cleaner on the floor. Staff Huntly stated that Resident A drank the solution, however, when asked if he drank it, Resident A shook his head no.

On 08/03/2026, I called former DCW, Tasia Huntley. There was no answer. A voice mail message was left requesting a return call.

On 08/06/2026, I interviewed Assistant Manager, Kassie Cooke. Staff Cooke stated that it is her understanding that Resident A had thrown up and the staff the cleaned it up left the floor cleaner in his presence. Resident B stated that Resident A did not drink the cleaner, however, Staff Huntley said that Resident A did drink the cleaner, therefore Resident A was sent out for medical treatment.

On 09/03/2026, I interviewed Resident B. Resident B stated that Resident A did not drink the cleaning solution as alleged. Resident B stated that he was in the hall and as he turned around, he saw Resident A pick the cleaning solution as if he were going to drink it. Resident B stated that he snatched the cleaning solution from Resident A before he drank it.

On 09/04/2026, I made a referral to Adult Protective Services (APS). I shared the allegations alleged in this complaint.

On 09/14/2026, I conducted an exit conference with Licensee Designee, Hari Singh. LD Singh. LD Singh stated that cleansers have been locked away and will only be accessible to cleaning staff. LD Singh was informed if the findings of this investigation.

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 Resident A was allowed access to a cleaning product which he allegedly drank. Home Manager, Jennifer Ireland, stated that it is her understanding that Resident B yanked the cleaner away from Resident A before he drank it. Resident A also denied that he drank the cleaner. The EMTs were called because staff thought that Resident A drank the cleaner. Resident A was not able to effectively communicate; therefore, he was unable to be interviewed. Resident A did shake his head yes in response to feeling good. Resident A was adequately clothed and groomed. He appeared to be receiving adequate care.

	The AFC Assessment Plan for Resident A indicates that Resident A can talk but makes no sense and is hard to understand. The Incident Report (IR) dated 07/16/2026 states that Resident A vomited all over his floor. Cleaned up vomit. While cleaning staff Tasia Huntley dumped Mr. Clean on the floor and left the bottle sitting on a table near Resident A. Resident A went to smell it and the resident who resides next door, Resident B took it out of his hands. Staff Huntley stated that she believes that he drank the cleaner. Staff contacted 911. Discharge instructions to be followed upon release. Both the Covenant Healthcare After Visit Summary and the Summary of Care were reviewed. Public Guardian A stated that she is concerned regarding Resident A's safety. Per Resident A, he wants to move from the home. Licensee Designee Hari Singh stated that there were 2-3 other people present who stated that Resident A did not drink the cleaner. LD Singh stated that the staff made an error in leaving the cleaner in Resident A's presence. LD Singh admits that staff should have contacted the guardian as well. Direct Care Worker (DCW), Sam Kureshi stated that the top was still on the bottle and he's pretty sure that Resident A did not drink the contents, however, Resident A was sent out to the hospital. DCW, Nia Garcia stated that after cleaning, Staff Huntley stated that she went to put his clothes in the washer and left the cleaner on the floor. Staff Huntly stated that Resident A drank the solution, however, when asked if he drank it, Resident A shook his head no. Staff Cooke stated that Resident B stated that Resident A did not drink the cleaner, however, Staff Huntley said that Resident A did drink the cleaner, therefore Resident A was sent out for medical treatment. Resident B stated that Resident A did not drink the cleaning solution as alleged. Resident B stated that he snatched the cleaning solution from Resident A before he drank it.
--	--

	Based upon my investigation, which consisted of interviews with multiple facility staff members and residents, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the allegation, due to the resident's safety being compromised.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



September 14, 2026

Sabrina McGowan
Licensing Consultant

Date

Approved By:



September 14, 2026

Mary E. Holton
Area Manager

Date