GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2025

Cavel Young
Comfort Living Home L.L.C. #2
2111 N. Drake Rd.
Kalamazoo, MI 49006

RE: License #: AS390402639
Investigation #: 2025A0578044
Comfort Living Home #2

Dear Cavel Young:

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) 335-5985.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS390402639
Investigation #:	2025A0578044
Complaint Receipt Date:	08/05/2025
Investigation Initiation Date:	08/06/2025
Report Due Date:	10/04/2025
Licensee Name:	Comfort Living Home L.L.C. #2
Licensee Address:	2111 N. Drake Rd. Kalamazoo, MI 49006
Licensee Telephone #:	(269) 760-1182
Administrator:	Cavel Young
Licensee Designee:	Cavel Young
Name of Facility:	Comfort Living Home #2
Facility Address:	2918 W. Milham Avenue Portage, MI 49024
Facility Telephone #:	(269) 760-1182
Original Issuance Date:	06/11/2020
License Status:	REGULAR
Effective Date:	06/08/2025
Expiration Date:	06/07/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Emergency services personnel were sent to this facility to assist Resident A after Resident A's repeated requests for assistance from direct care staff went unanswered. When emergency services arrived at the facility, they observed licensee designee Cavel Young asleep at the kitchen counter.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/05/2025	Special Investigation Intake 2025A0578044
08/05/2025	APS Referral
08/06/2025	Special Investigation Initiated - On Site
08/06/2025	Special Investigation Completed On-site -Interview with licensee designee Cavel Young. Interview with direct care staff Lilian Kwamboka.
08/06/2025	Contact-Document Reviewed -*Medication Administration Records* for Resident A for August 2025.
08/06/2025	Contact-Document Reviewed -*Assessment Plan for AFC Residents* for Resident A, dated 07/11/2025.
08/06/2025	Contact-Document Reviewed -Senior Care Partners *PACE Face Sheet Report* for Resident A, dated 07/11/2025.
08/06/2025	Contact-Document Reviewed -*After Visit Summary* for Resident A from Bronson Hospital on 08/02/2025.
08/06/2025	Contact-Face to Face -Interview with Senior Care Partners PACE case manager Julie Clark
08/06/2025	Contact-Face to Face -Interview with Resident A.

08/21/2025	Contact-Documentation Received -*Prehospital Care Report Summary* from Life EMS for Resident A, dated 08/02/2025.
09/02/2025	Contact-Face to Face -Interview with Life EMS worker Camden Patmos.
09/18/2025	Contact-Face to Face -Interview with Life EMS worker Josiah Fuller.
09/23/2025	Exit Conference. -With licensee designee Cavel Young.

ALLEGATION:

Emergency services personnel were sent to this facility to assist Resident A after Resident A's repeated requests for assistance from direct care staff went unanswered. When emergency services arrived at the facility, they observed licensee designee Cavel Young asleep at the kitchen counter.

INVESTIGATION:

On 08/05/2025, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant reported Resident A uses a power wheel chair due to a right leg amputation and is unable to care for her daily needs but does not have a legal guardian. Complainant reported on 08/02/2025, Resident A was discharged from a hospital to this facility. Complainant reported that Resident A was not checked on for at least four hours. Complainant reported Resident A was hurting and needed to urinate and had not been moved and needed her medication. Complainant reported Resident A had been yelling loudly to request assistance from direct care staff. Complainant reported emergency medical personnel were sent to the facility and knocked on multiple doors and announced themselves while wearing bright uniforms and there was no response from any direct care staff at this facility. Complainant reported licensee designee Cavel Young was observed sleeping at the kitchen counter and eventually woke up and made eye contact with emergency medical personnel and then went into another room. Complainant reported that emergency medical personnel entered the facility when Cavel Young reported Resident A was fine and had been given her medication. Complainant reported Resident A was concerned that Cavel Young would tamper with her medications by putting something in them. Complainant reported Resident A was too fearful to stay in the facility and was transported back to the hospital. Complainant clarified there may have been other direct care staff in the basement of the facility.

On 08/21/2025, I received the *Prehospital Care Report Summary* from Life EMS for Resident A, dated 08/02/2025. The *Prehospital Care Report Summary* for Resident A documented that at 12:06AM, Life EMS workers were dispatched to this facility with no lights or sirens. The *Prehospital Care Report Summary* for Resident A identified Resident A's "chief complaint" as needing to use the bathroom and take her medications and have a drink of water. The *Prehospital Care Report Summary* for Resident A documented that Resident A uses a power chair for mobility and could not self-transfer at this time. The *Prehospital Care Report Summary* for Resident A documented that EMS staff knocked on the front and back door with no response from direct care staff. The *Prehospital Care Report Summary* for Resident A documented that EMS staff returned to the rear of the facility and knocked again on the door and saw a staff sleeping. The *Prehospital Care Report Summary* for Resident A documented this staff woke up, looked at EMS staff, and walked into another room. The *Prehospital Care Report Summary* for Resident A documented that Resident A reported she had called out for staff with no response and had not been given assistance since Resident A returned to this facility at 6PM. The *Prehospital Care Report Summary* for Resident A documented Resident A asked for a bed pan to urinate. The *Prehospital Care Report Summary* for Resident A documented that Resident A expressed concern over Cavel Young administering her medications, as Resident A suggested Cavel Young may put a harmful substance in her liquid medications. The *Prehospital Care Report Summary* for Resident A documented that Cavel Young was asked why she did not answer the door for EMS staff and Cavel Young became hostile, raising her voice at EMS staff. The *Prehospital Care Report Summary* for Resident A documented that Resident A wanted the hospital to review her current medications and was concerned about her diagnosis of atrial fibrillation and wanted to be returned to the hospital. The *Prehospital Care Report Summary* for Resident A documented that Resident A did not show any signs or symptoms of any difficulty breathing, dizziness, vertigo, abdominal pain, diarrhea chills or any traumatic injury.

On 08/06/2025, I completed an unannounced investigation on-site and interviewed licensee designee Cavel Young regarding the allegations. Cavel Young denied the allegations and reported that Resident A was diagnosed with clostridium difficile colitis, and while at the hospital, Resident A was verbally aggressive regarding infection control procedures that required all her belongings to be placed in hospital bags, and hospital staff to sanitize her hospital treatment room. Cavel Young reported when she arrived at this facility, Resident A did not want her room to be cleaned with sanitizing spray and instead wanted sanitizing wipes to be used, and Cavel Young obtained these to continue sanitizing Resident A's bedroom while at the facility. Cavel Young reported Resident A was provided with a call light in her bedroom. Cavel Young reported Resident A has a history of abusing this call light and using it multiple times during a shift, but Resident A was still provided with a call light. On the night of the allegations, Cavel Young reported she was sitting at the kitchen counter and did not hear any of the emergency personnel announcing themselves but heard two knocks. Cavel Young reported in response, she went to all

the resident bedrooms to ensure none of the residents needed assistance. Cavel Young reported she specifically checked on Resident A and Resident A reported she was fine. Cavel Young reported she was returning to the kitchen when she observed emergency personnel entering the facility. Cavel Young reported emergency personnel informed her that someone had called them regarding Resident A needing assistance. Cavel Young reported she informed emergency personnel that Resident A had a call light and had not used it. Cavel Young reported emergency personnel entered Resident A's bedroom and was rude when asking Cavel Young for a bedpan which was provided for Resident A.

Cavel Young denied knowing why Resident A did not call her for help or would report that Cavel Young was unable to provide Resident A with assistance. Cavel Young reported Resident A's heartrate was a bit high and emergency personnel reviewed this concern with staff from Senior Care Partners PACE. Cavel Young reported for these reasons, Resident A was taken back to the hospital. Cavel Young reported Senior Care Partners PACE worker Julie Clark could verify that Resident A could be difficult to work with. Cavel Young reported Julie Clark is in this facility visiting Resident A and others at least once a week. Cavel Young denied knowing why the emergency personnel would report she was sleeping if she was not. Cavel Young reported the emergency personnel were rude to her and she denied being asleep when emergency personnel arrived. Cavel Young reported the reason emergency personnel were reporting she was asleep was because she did not allow emergency personnel staff to be rude to her. Cavel Young demonstrated the wearable call light that was provided to Resident A.

Cavel Young reported two other staff were working at this facility at the time of the allegations but were present in the basement while Cavel Young was on the main floor. Cavel Young was asked to provide a staff schedule that identified direct care staff that were working on 08/02/2025. Cavel Young reported not having a written staff schedule that would include the direct care staff that worked on 08/02/2025.

While at the facility, I interviewed direct care staff Lilian Kwamboka regarding the allegations. Lilian Kwamboka reported working at this facility for almost a week. Liliam Kwamboka acknowledged working on the day of the allegations but clarified that she was not aware that emergency medical personnel had arrived at the facility and did not know the reason for emergency medical personnel being at the facility.

Shortly thereafter, Lilian Kwamboka approached me and reported she did recall the allegations and clarified during her first interview she "forgot" the details of the allegations. Lilian Kwamboka acknowledged that emergency personnel came to the front door and entered the facility and assisted Resident A along with another direct care staff. Lilian Kwamboka could not recall any details of this incident and Lilian Kwamboka's recollection did not match Cavel Young's description of the incident or information provided by Complainant.

On 08/06/2025, I reviewed the *Medication Administration Records* for Resident A for August 2025 and observed them to be complete with no documentation of missed or refused medications.

On 08/06/2025, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 07/11/2025. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A does not walk and has a residual left leg stump with no prosthetic. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A uses a wheelchair and requires assistance to mobilize and position. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A needs assistance with toileting and can use a bed pan and urinal. The *Assessment Plan for AFC Residents* for Resident A documented Resident A's assistive devices as a wheelchair, hoyer lift, and hospital bed. The *Assessment Plan for AFC Residents* for Resident A did not identify any type of supervision requirements, such as one on one staffing or line of sight supervision.

On 08/06/2025, I reviewed the Senior Care Partners *PACE Face Sheet Report* for Resident A, dated 07/11/2025.The *PACE Face Sheet Report* for Resident A documented that Resident A can display frequent mood swings, angry outbursts and has the "need to be the center of attention".

On 08/06/2025, I reviewed the *After Visit Summary* for Resident A from Bronson Hospital on 08/02/2025. The *After Visit Summary* for Resident A from Bronson Hospital documented Resident A was treated for acute kidney injury but came with a diagnosis of heart failure with reduced ejection fraction, chronic obstructive pulmonary disease, severe obesity, unspecified weakness and clostridium difficile colitis.

On 08/06/2025, I interviewed Senior Care Partners PACE case manager Julie Clark regarding the allegations. Julie Clark reported Resident A had called her and Relative A1 and Resident A reported she had "called out" for staff and no staff had responded. Julie Clark reported Resident A expressed a desire to return to the hospital and that Resident A had verbally expressed not liking licensee designee Cavel Young and did not like that Cavel Young and her staff had inventoried Resident A's personnel belongings when Resident A returned to this facility. Julie reported Resident A was returned to this facility as Resident A really liked the staff that worked at this facility and the level of care provided. Julie Clark reported she did not know what made Resident A so upset but clarified that Resident A had been at this facility for less than eight hours before she returned to the hospital.

Julie Clark reported that Resident A is not always truthful and clarified that she doesn't believe Resident A is intentionally lying but believes what she is saying. Julie Clark reported Resident A is diagnosed with bipolar disorder and can be manipulative. Julia Clark reported Resident A is relatively new to Senior Care Partners PACE. Julie acknowledged that Cavel Young was denying the allegations but was unsure who to believe. Julia acknowledged she is visiting this facility several

times a month for Resident A and other residents and has not had previous concerns. Julie Clark clarified that Resident A was provided with a call light and is capable of using this call light and is unsure why Resident A did not use this call light on the night of the allegations. Julie Clark confirmed seeing this call light in use by Resident A at this facility and reported the time it takes staff to respond to this call light is “less than two minutes”. Julie Clark expressed suspicion when Resident A reported she was yelling from her bedroom, as Julie Clark has previously heard Resident A yelling in this facility and it can be heard from the kitchen of this facility. Julie Clark reported she and Relative A1 called Cavel Young’s personal cell phone the night of the allegations and Cavel Young did not respond. Julie Clark reported she was told by Cavel Young that her personal cell phone ringer was turned off.

On 08/06/2025, I interviewed Resident A regarding the allegations. Resident A acknowledged living at this facility before and commented the staff at this facility are “wonderful”. Resident A reported when looking for a discharge placement, she agreed on being discharged to this facility due to her previous experience. Resident A reported being discharged to this facility at 6:45PM and was offered a meal of fish and ice cream. Resident A reported she denied this meal, and was offended that she was not offered food later in the evening. Resident A reported she arrived at this facility with two hospital bags and was upset with Cavel Young opening these bags and going through their contents to inventory her belongings. Resident A reported bringing a bed pan with her from the hospital. Resident A reported being asked if she was independent with this bed pan and reported informing Cavel Young that she would like a direct care staff present just in case she needed assistance. Resident A reported having intestinal issues that give her frequent bowel movements. Resident A reported frustration with not having a glass of water next to her bed. Resident A reported she thought someone would come and check on her, but she called out for assistance at 10:30PM and had no response. Resident A reported calling for staff assistance from her bedroom eleven different times, with fifteen minutes occurring between each time. Resident A acknowledged using a call light in this facility before but denied being provided with a call light when she returned to this facility on 08/06/2025. Resident A later recanted her statement and reported she used the call light once to obtain assistance from direct care staff. Resident A reported she called Cavel Young by telephone on at least two different occasions with no response. Resident A reported feeling “miserable” and calling a relative who must have notified Senior Care Partners Pace. Resident A reported after emergency personnel arrived; she was able to utilize her bed pan. Resident A could not recall the medication she had not received on the evening of the allegations but clarified that her concern was that Cavel Young would somehow cause her harm or poison her medications because she called emergency personnel to respond to the facility. Resident A could not identify why she had these concerns. Resident A acknowledged being returned to the hospital due to her concerns.

On 09/02/2025, I interviewed Life EMS worker Camden Patmos regarding the allegations. Camden Patmos acknowledged responding to this facility with Life EMS worker Josiah Fuller on the day of the allegations. Camden Patmos confirmed

knocking several times on the front door of this facility and announcing themselves with no response from anyone inside this facility. Camden Patmos reported he and Josiah Fuller went to the back door of this facility in an attempt to make contact with someone when Camden Patmos observed from a window a person sitting on the stool at a kitchen island with their head in their arms and this person appeared to be sleeping. Camden Patmos acknowledged later identifying this person as licensee designee Cavel Young. Camden Patmos reported knocking on this door and observed Cavel Young look at him and then leave the room. Camden Patmos reported wearing high visibility reflective clothing and it was very apparent he was working for an ambulance service. Camden Patmos reported he did not know if Cavel Young had gone to the front door and decided to enter the facility through the unlocked rear door. Camden Patmos reported finding Cavel Young with Resident A. Camden Patmos reported Cavel Young was verbally hostile towards he and Josiah Fuller, and reported he was not accustomed to this response when arriving on scene. Camden Patmos reported Resident A wanted to be returned to the hospital and they accommodated Resident A's request. Camden denied looking at any of Resident A's *Medication Administration Records* when collecting documentation to provide to the hospital.

On 09/18/2025, I interviewed Life EMS worker Josiah Fuller regarding the allegations. Josiah Fuller acknowledged responding to this facility with EMS worker Camden Patmos. Josiah Fuller reported not having much information when responding to the call, other than Resident A reporting her "needs were not being met". Josiah Fuller reported he knocked on the front door of this facility and announced himself as a Life EMS worker several times with no response. Josiah Fuller reported he went to the back of the facility while Camden Patmos called Senior Care Partners PACE for additional information. Josiah Fuller reported he observed someone sleeping in a bedroom at this facility but did not know at the time this facility was an adult foster care. Josiah Fuller reported going back to the front of the facility and speaking with Camden Patmos, who informed him that Senior Care Partners PACE confirmed that Resident A was inside the facility, and that Resident A had expressed concern that none of the staff had checked on her and she needed to use the bathroom. Josiah Fuller reported he and Camden Patmos went to the back of the facility and observed a rear door that Josiah Fuller had not noticed before. Josiah Fuller reported that Camden Patmos approached the door and verbally reported at that time that he could see someone sleeping. Josiah Fuller acknowledged that he did not directly observe this person sleeping but clarified that when they knocked on this door and announced themselves, he directly observed this person look at them and then leave the room. Josiah Fuller reported he and Camden Patmos then entered the facility and announced themselves as ambulance services. Josiah Fuller reported he was then approached by licensee designee Cavel Young, who commented, "oh, why are you here"? Josiah Fuller reported Camden Patmos attended to Resident A while he spoke to Cavel Young and asked why she did not respond to their attempts to enter the facility and to clarify what had happened when they knocked on the back door. Josiah Fuller reported that he did not get a clear answer and that Cavel Young was "rambling" but told him she

thought he was other direct care staff on-site and that she had gone to check on residents. Josiah Fuller clarified that Cavel Young became hostile and raising her voice when he began to ask Cavel Young questions regarding their repeated knocking and announcing. Josiah Fuller reported that Cavel Young had gotten so loud that Camden Patmos came to check on him.

Josiah Fuller reported Resident A had reported no one had checked on her for a “few hours” and that Resident A reported she had been yelling for “hours”. Josiah Fuller denied that Resident A had reported missing any of her medications but expressed a concern that Cavel Young would tamper with her medications in some way. Josiah Fuller reported he did not observe Resident A with any kind of call light and did not observe any other staff. Josiah Fuller clarified that Cavel Young had informed him that several staff were downstairs in the basement of this facility, but Josiah Fuller reported no interaction with this staff.

APPLICABLE RULE	
R 400.14206	**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:	Based upon my investigation, which consisted of interviews with Resident A, Life EMS worker Josiah Fuller, Life EMS worker Camden Patmos, and licensee designee Cavel Young, as well as a review of pertinent documentation relevant to this investigation, there was not sufficient direct care staff on duty to respond to Resident A’s request for assistance, or sufficient staff on duty to respond to emergency personnel who were sent to the facility to provide emergency assistance to Resident A. During interviews, Life EMS worker Josiah Fuller and Life EMS worker Camden Patmos reported repeatedly knocking on the doors of this facility and announcing themselves with no response from any direct care staff at this facility. A *Prehospital Care Report Summary* from Life EMS for Resident A documented that after repeatedly attempting to make contact with someone at this facility, Life EMS staff observed an unresponsive staff sleeping at this kitchen counter. In an interview, Resident A reported calling out repeatedly for assistance with getting water and using the bathroom before resorting to using her personal cell phone to call for assistance from another agency. In an interview, Resident A and Senior Care Partners PACE case manager Julie Clark reported calling Cavel Young’s personal cell phone on the night of the allegations with no response. As such, this facility did not have

	sufficient direct care staff on duty at all times to provide for the supervision, personal care and protection of residents at this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 08/06/2025, during an unannounced investigation on-site at this facility, I asked licensee designee for a copy of her staff schedule to verify what direct care staff were working on the day of the allegations. Cavel Young reported she did not have a staff schedule available.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	During an unannounced investigation on-site, licensee designee Cavel Young disclosed not maintaining a record or a schedule of direct care staff that were working at this facility when Resident A was requesting assistance with personal care with no response and when emergency personnel responded to this facility to render aid to Resident A with no response.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

09/23/2025

Eli DeLeon Date
Licensing Consultant

Approved By:

09/24/2025

Dawn N. Timm Date
Area Manager