GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 13, 2026

Laura Kujawski
Care And Comfort AFC, LLC
40796 Ruggero St
Clinton Township, MI 48038

RE: License #: AS500418411
Investigation #: 2026A060401
Care and Comfort AFC Group Home

Dear Ms. Kujawski:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

A previous recommendation was made for revocation in Special Investigation Report #2025A0604020 dated 10/02/2025. That recommendation remains in effect.

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 (248) 972-9136.

Sincerely,

Kristine Cilluffo

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500418411
Investigation #:	2026A0604010
Complaint Receipt Date:	01/21/2026
Investigation Initiation Date:	01/21/2026
Report Due Date:	03/22/2026
Licensee Name:	Care And Comfort AFC, LLC
Licensee Address:	40796 Ruggero St Clinton Township, MI 48038
Licensee Telephone #:	(517) 455-9900
Administrator:	Laura Kujawski
Licensee Designee:	Laura Kujawski
Name of Facility:	Care and Comfort AFC Group Home
Facility Address:	40796 Ruggero Street Clinton Township, MI 48038
Facility Telephone #:	(586) 372-6116
Original Issuance Date:	08/28/2024
License Status:	REGULAR
Effective Date:	02/28/2025
Expiration Date:	02/27/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff are working multiple days in a row by themselves.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/21/2026	Special Investigation Intake 2026A0604010
01/21/2026	Special Investigation Initiated - Letter Sent email to licensee and applicant requesting resident and employee records.
01/23/2026	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff, Kristi Aikins, Resident A, Resident B, Resident C and Relative 1. Observed Resident D.
01/23/2026	APS Referral I made a referral to Adult Protective Services (APS). Assigned to Debra Johns.
01/23/2026	Contact - Document Sent Email to licensee and Serenity Homes
01/25/2026	Contact - Document Received Received resident and employee records requested from Soniya Varghese by email
01/27/2026	Contact - Document Sent Email to and from Soniya Varghese
01/28/2026	Contact - Document Sent Email to and from Soniya Varghese
01/29/2026	Contact - Document Received Email from APS Worker, Debra Johns. Sent return email
01/30/2026	Contact - Document Received Email from Soniya Varghese. Sent return email.
02/01/2026	Contact - Document Received Email from Soniya Varghese

02/02/2026	Contact - Document Received Email to and from Soniya Varghese
02/05/2026	Contact - Document Received Email from APS Worker, Debra Johns
02/06/2026	Contact - Document Sent Email to Debra Johns
02/10/2026	Inspection Completed On-site Completed onsite inspection and investigation. Interviewed Soniya Varghese and Nimmy Cherian. Observed residents in home.
02/10/2026	Contact - Document Received Email from Debra Johns. Received copies of incident reports and picture of bruise. APS will be substantiating allegation. Sent return email.
02/10/2026	Contact - Document Sent Email to and from Nimmy Cherian and Soniya Varghese
02/11/2026	Contact - Document Received Email from Debra Johns with hospital discharge papers. Sent return email.
02/27/2026	Exit Conference Completed exit conference with Care and Comfort Licensee Designee, Laura Kujawski and Serenity Homes applicants, Soniya Varghese and Nimmy Cherian.

ALLEGATION:

Staff are working multiple days in a row by themselves.

INVESTIGATION:

I received a licensing complaint regarding Care and Comfort AFC Group home on 01/21/2026. It was alleged that owner is unlicensed. Staff are unlicensed. One employee works Monday, 8am to Friday 8am and one other works the remainder. Staff have 1099 for shifts at 24 hours each with a rate of $250 for the weekdays and $350 for weekend shifts. No overtime and staff are responsible for all four to six patients by themselves even without sleep. Sonia Varghese is owner. Kristi works weekends and Clarice works all week. No medical license for anyone.

The license for the Care and Comfort AFC Group Home is scheduled to be revoked on or before 03/19/2026. On 11/19/2025, a settlement agreement was signed after a recommendation was made for revocation of the license for the Care and Comfort AFC Group Home in Special Investigation Report #2025A0604020 dated 10/02/2025. The terms of the settlement agreement include the following:

> Care and Comfort AFC, LLC understands that license #AS500418411, located at 40796 Ruggero Street, Clinton Township, MI 48038 will be revoked, effective four (4) months from the signature date of the representative of the Bureau of Community and Health Systems or upon issuance of an adult foster care license to a potential applicant for the facility located at 40796 Ruggero Street, Clinton Township, MI 48038, whichever occurs first.
>
> Care and Comfort AFC, LLC may continue to provide adult foster care to the residents of license #AS500418411 until the effective date of revocation of license #AS500418411 or until an adult foster care license is issued for the facility located at 40796 Ruggero Street, Clinton Township, MI 48038, whichever occurs first.

On 11/30/2025, Serenity Homes At Clinton Twp LLC submitted an application to become licensed at the address. There is currently an open enrollment for Serenity Homes At Ruggero Dr (AS500420117). Soniya Varghese is listed as the licensee designee for the application and Nimmy Cherian is listed as the administrator. On 12/01/2025, Serenity Homes entered into a management agreement with Care and Comfort AFC to operate the home during the licensing process.

I completed an unannounced onsite investigation on 01/23/2026. I interviewed Staff, Kristi Aikins, Resident A, Resident B, Resident C and Relative 1. I observed Resident D who was sleeping during investigation.

On 01/23/2026, I interviewed Staff, Kristi Aikins. Ms. Aikins daughter was also present at home due to school cancellation. Ms. Aikins stated that they currently have four residents at the home. She indicated that the new owner recently changed their schedule to 24-hour shifts. They previously had eight-hour shifts. One staff works Friday 8:00 am to Monday 8:00 am. Other staff works from Monday 8:00 am to Friday 8:00 am Ms. Aikins stated that she may close her eyes on the couch in living room to be near residents. She does bed checks every two hours. Ms. Aikins stated that no one ever sleeps in basement. The other staff, Clarice, does the same thing and will stay in living room on couch. She also indicated that residents have alarms to alert staff. Resident A and Resident C are verbal and have bed alarms. Resident B is verbal and one person can assist her with transfers with Hoyer lift. Resident D has a monitor in her room as well. Ms. Aikins did not report that any neglect or accidents have occurred due to the new schedule. Ms. Aikins stated that the owners come out at least one to two times a day and stay for an hour or so. Soniya will also come in to assist if necessary. Nimmy Cherian comes in sometimes and believes she visited the home twice last week. She indicated that the previous owners, “Yogi” and Rick are done.

On 01/23/2026, Staff Kristi Aikins showed me staff schedule on app in her phone. Staff, Clarice Richardson was scheduled from 8:00 am- 8:00 am on 01/19/2026-01/22/2026. Ms. Aikins was scheduled from 8:00 am- 8:00 am on 01/23/2026-01/24/2026.

On 01/23/2026, I interviewed Relative 1. Resident 1 was visiting Resident A during my onsite investigation. She indicated that she is now able to care for Resident A with home care services and he will be returning home next Thursday, 01/29/2026. Relative 1 stated that there are always staff at home, and she has not found them sleeping. However, she believed they were tired from working 24-hour shifts. They used to have eight-hour shifts. She stated that she had a few concerns that she had reported to Soniya. She stated that one person can transfer Resident A, however, they are supposed to get his walker and then move him to the chair. Relative 1 stated that Staff, Clarice, did not do that and Resident A ended up on floor. He was not injured. Soniya was going to address this with Clarice. She stated that Clarice is new and has only worked at home for about three weeks. It is only Clarice and Kristi working at home. She stated that Kristi is excellent. Relative 1 stated that Resident A has an alarm to alert staff if needed. Relative 1 also stated that Clarice had also complained that she was tired because she had to change Resident A three to four times when he had multiple bowel movements at night. Also, she stated that Resident A had a urology appointment and was found to have “gunk” around his penis. She stated that she had asked staff twice to make sure he was clean for his appointment. Relative 1 stated that urologist documented this in letter and it was given to Soniya.

On 01/23/2026, I interviewed Resident B. She stated that she has lived at home since February 2025 and she “can’t complain”. She stated, “so far, so good”. She stated that the home has caregivers 24 hours a day and there are always staff at the home. Staff assist her with everything she needs. Staff assist her with hygiene, bring her meals and change her. They use a Hoyer lift for transfers. Resident B stated that she has an alarm so she can reach caregivers. Staff do respond when she uses her alarm and help her as much as they can. Resident B stated that she administers her own medications. Resident B did not have any concerns to report about the home.

On 01/23/2026, I interviewed Resident C. He stated that he is doing ok and indicated that he gets help with the things he needs. He receives his medication and enough food to eat. He stated that there is not always staff, however, he was unable to provide any additional information. He did not report any concerns.

On 01/25/2026, I received copies of December 2025 and January 2026 staff schedules by email from Soniya Varghese. December 2025 schedule indicates that the home previously had three shifts from 8:00 am-4:00 pm, 4:00 pm- 12:00 am, and 12:00 am-8:00 am. On 01/04/2026, schedule changes to the same staff working two shifts from 7:00 am- 7:00 pm and 7:00 pm and 7:00 am. Soniya and Nimmy are also listed on schedule after this date as on call or scheduled for brief shifts such as 10:00 am- 12:00 pm and 4:00 pm-6:00 pm.

On 01/25/2026, I received copy of Resident A's assessment plan dated 08/25/2025 by email from Soniya Varghese. The plan states, "Resident currently wheelchair, bed bound. Use Hoyer lift for transfer. Staff will help transfer." Use of assistive devices include hospital bed, walker/wheelchair, Hoyer lift, shower chair and side rail. Plan also indicates that the resident needs assistance with personal hygiene.

On 01/25/2026, I received Resident A's appointment record from the Michigan Institute of Urology dated 01/15/2026 by email from Soniya Varghese. The report states, "A 16 French Foley catheter was inserted into the bladder using sterling technique. The patient was taught routine catheter care. Office provided patient with catheter supplies (MIU supply). A bedside bag was connected. Hand irrigation of the bladder with sterile water was performed. Notes: Foley was completely clogged when I removed it - wife in room showed her; will go 3 weeks drained approx. 250cc when new foley inserted. Pt's penis full of build up and gunk- lives in home they have HCN- will give orders for weekly flushes and cleaning daily". An order was provided dated 01/15/2026 that stated (Resident A) is in need of weekly cath flushes with 50cc Sterile water and Flat Tip Syringe. Also, daily washes around penis are needed with antibacterial soap. Will see patient back in 3 weeks for a foley change in office.

On 01/25/2026, Ms. Varghese also provided training verification signed by herself and Clarice Richardson on foley catheter care by email. She stated in email, "We reevaluated the staff catheter care regimen and training provided on the same. (Resident A) is receiving Skilled Homecare Nursing services through Tone Home Health care and we have brought this to the RN's attention as we also noticed clogging and hematuria. Communicated with (Resident A's) spouse on the same as catheter flushing requires Skilled Nursing care which would be within the scope of the homecare Nurse case manager. We also provided them with a copy of the letter."

On 02/05/2026, I received an email from APS Worker, Debra Johns. Ms. Johns indicated that she completed visit with her client (Resident A) on 02/04/2026 and he was observed to have a significant bruise on his back. Resident A moved out of the Care and Comfort home on 01/29/2026 and returned home. His wife reported he had a fall at the AFC home the day he left. He was transported to the hospital for treatment and sent home the same day. Ms. Johns indicated that she spoke to his home care nurse today and she informed her that the hospital paperwork shows nothing about a "possible fall". She reported he was sent to the hospital for a possible TIA - which is not true. Concerns were reported regarding the home and that they allegedly cover up information.

On 02/10/2026, I received incident reports and picture of Resident A's bruise by email from Debra Johns by email. The picture shows a large purple bruise on right side of Resident A's back. Incident report dated 01/29/2026 states that Resident A started to say he felt weak and spouse was on way to pick him up. Staff attempted to transfer Resident A from the edge of bed, and he started leaning to the left side and staff had to lower him to the floor. Staff called 911 immediately and resident was taken to Henry Ford Macomb Hospital. I also received incident report dated 01/22/2026. Incident report states that while getting resident out of bed to wheelchair he lost his balance. Staff,

Clarice Richardson, lowered him to the ground safely and called for assistance. Resident did not have any injuries. Owners were notified and came to assist resident off the floor into wheelchair. Will use walker for assistance in the future.

On 02/11/2026, I received Resident A's discharge papers from Henry Ford Macomb Hospital dated 01/29/206 by email from APS Worker, Debra Johns. Ms. Johns indicated that she would be substantiating former caregiver for neglect based on inability to transfer properly. Report states that resident was seen for chief complaint of diarrhea and fatigue and concern for TIA. Per facility staff he has been in rehab for five months and was getting ready for discharge when staff noticed he was leaning to the right and became concerned and called ambulance. Resident denied any new onset confusion, weakness, or blurry vision, and did not have any falls or head trauma. Since yesterday, nursing staff at his facility state he has been having multiple bouts of diarrhea and patient denies abdominal pain, nausea and vomiting. The discharge papers do not note bruise on back. Skin condition is listed as warm, dry, intact, no rashes. Blood pressure is noted at high at 155/73. Resident was discharged same day and advised to follow up with primary care in the next two days for diarrhea and fatigue.

On 02/10/2026, I had a face-to-face meeting with Soniya Varghese and Nimmy Cherian at the Care and Comfort Home. Ms. Varghese stated that there are currently three residents at home. They signed a management agreement and took over effective 12/01/2025. Ms. Varghese indicated that when they began operating home, they had a lot of work to do to clean up home and terminated some of the staff. They went to 24-hour staffing because they had two staff left and the staff agreed and wanted to work those shifts. Staff are no longer working more than 24 hours. Ms. Varghese stated that Staff, Clarice Richardson, quit about two weeks ago. Staff, Kristi Aikins, recently quit, however, asked to return after leaving. Ms. Varghese stated that Ms. Richardson was a good staff, however, felt like she was being attacked by Relative 1 and Resident B. Ms. Varghese stated that Resident A was seen by PT before his urology appointment and there was concern that he may have a bowel obstruction. They were advised to give him prune juice and he had six bowel movements that evening and had to be cleaned several times. Ms. Varghese stated that Resident A required a one-person assist and Clarice had to lower him to floor when getting him up during first incident that was reported regarding transfer. He did not have any bruises or injuries. Nimmy Cherian stated that she was present on 01/29/2026 when Resident A was taken to hospital. She indicated that 911 was called because he had diarrhea, high blood pressure and was leaning to one side. They thought he may be having a TIA, however, he was not. Ms. Cherian stated that Resident A began leaning to one side while being transferred and had to be lowered to floor. She believes he hit his right side on wheelchair when being lowered. She indicated that he had a finger size bruise on his right side.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection

	of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	The Care and Comfort AFC Group Home is not providing adequate supervision. 24-hour care and supervision are required and it is not sustainable for staff to work three to four days in a row without scheduled time for sleep or breaks. On 01/23/2026, I completed an unannounced onsite investigation and interviewed staff, Kristi Aikins. Ms. Aikins confirmed that staff are working multiple 24-hour shifts in a row. Ms. Aikins showed me staff schedule on app in her phone. Staff, Clarice Richardson was scheduled from 8:00 am- 8:00 am on 01/19/2026-01/22/2026. Ms. Aikins was scheduled from 8:00 am- 8:00 am on 01/23/2026-01/24/2026. Ms. Aikins stated that residents have alarms to alert staff and new owners, Soniya Varghese and Nimmy Cherian come to check on home and come in if needed. Staff stay in living room to be near residents' bedrooms during sleeping hours. Ms. Varghese also confirmed that staff were working 24-hour shifts and indicated that schedule would be changed and staff would work no more than 24 hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	On 01/25/2026, I received copy of Resident A's assessment plan dated 08/25/2025 by email from Soniya Varghese. The plan indicates, "Resident currently wheelchair, bed bound. Use Hoyer lift for transfer. Staff will help transfer." Use of assistive

	devices include hospital bed, walker/wheelchair, Hoyer lift, shower chair and side rail. Plan also indicates that the resident needs assistance with personal hygiene. Appointment record from the Michigan Institute of Urology dated 01/15/2026 confirms that Resident A was seen for catheter appointment and was found not to be adequately cleaned. Also, two incident reports were provided indicating Resident A ended up on floor while being transferred by Staff, Clarice Richardson. Reports do not indicate that Ms. Richardson used Hoyer lift to transfer Resident A as indicated in his assessment plan or used a walker as described by Relative 1. APS Worker, Debra Johns indicated that she completed visit with Resident A on 02/04/2026 and he was observed to have a significant bruise on his back. Resident A moved out of the Care and Comfort home on 01/29/2026 and returned home. Hospital discharge papers from incident on 01/29/2026 do not note any falls or bruises, however, Nimmy Cherian indicated that only a finger size bruise was observed on Resident A. She believed he hit wheelchair when being lowered to floor.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/23/2026, I completed an unannounced onsite investigation. I interviewed Staff, Kristi Aikins. Ms. Aikins confirmed that staff are working multiple 24-hour shifts in a row. Ms. Aikins stated that she may close her eyes on couch in living room to be near residents. Ms. Aikins stated that no one ever sleeps in the basement. The other staff, Clarice, does the same thing and will stay in living room on couch.

APPLICABLE RULE	
R 400.657	**Bedrooms.**
	(2) Living rooms, dining rooms, hallways, or other rooms that are not ordinarily used for sleeping, or a room that contains a required means of egress, must not be used for sleeping purposes by anyone.

ANALYSIS:	On 01/23/2026, Staff Kristi Aikins reported that staff are working 24-hour shifts. Staff are using living room to “close their eyes” or sleep during shifts to be near resident bedrooms. A living room should not be used for sleeping purposes by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 01/23/2026, I completed an unannounced onsite investigation. During the onsite investigation, I interviewed Resident B in her bedroom. I observed that Resident B had a canvas tote with medication packs on her bedside table. Resident B stated that she can administer her own medications. I informed Resident B that medications still need to be stored in a locked location if she is self-administering them. Resident B stated that she had a lockbox available with her items being stored in basement. I informed Staff, Kristi Aikins, that medications need to be put in locked location and sent email to licensee and new provider informing them that medications needed to be locked up immediately.

On 01/25/2026, I received letter from Resident B’s doctor by email from Soniya Varghese. The letter had visit date of 03/24/2025 from M. Kahmamouei, MD and stated, “It is my medical opinion that (Resident B) is able to self-administer her medications at this time”.

On 01/28/2026, I received photos by email from Soniya Varghese with medications in a lockbox.

I completed an exit conference with Care and Comfort Licensee Designee, Laura Kujawski and Serenity Homes applicants, Soniya Varghese and Nimmy Cherian on 02/27/2026. Serenity Homes is currently operating the Care and Comfort home under a management agreement. I sent email to Ms. Kujawski, Ms. Varghese and Ms. Cherian informing them of the violations found and that a copy of the special investigation report would be mailed once approved. I also informed them that the recommendation for revocation made in Special Investigation Report 2025A0604020 dated 10/02/2025 remains in effect. I requested that they contact me with any questions or if they had questions once reviewing report.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or

	drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	On 01/23/2026, I completed an unannounced onsite investigation. I observed that Resident B had a canvas tote with medication packs on her bedside table. Resident B had physician authorization to administer her own medication; however, they were not being stored in a locked location.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

A recommendation for revocation of the license was made in Special Investigation Report #2025A0604020 dated 10/02/2025 and the licensee has agreed to the revocation and to close effective 03/19/2025 via settlement.

Kristine Cilluffo 02/27/2026

Kristine Cilluffo Date
Licensing Consultant

Approved By:

Jay Calewarts For 03/13/2026

Denise Y. Nunn Date
Area Manager