



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

December 21, 2023

Louis Hill  
Hill's Support Services Inc  
PO Box 648  
Inkster, MI 48141

RE: License #: AS820281136  
**Kean Home**  
**26645 Kean Street**  
**Inkster, MI 48141**

Dear Mr. Hill:

Attached is the Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and rules. Your license and special certification are renewed. They are valid only at your present address and are nontransferable.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (313) 456-0380.

Sincerely,

A handwritten signature in blue ink, appearing to read "Edith Richardson".

Edith Richardson, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 919-1934

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
RENEWAL INSPECTION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820281136
<b>Licensee Name:</b>	Hill's Support Services Inc
<b>Licensee Address:</b>	PO Box 648 Inkster, MI 48141
<b>Licensee Telephone #:</b>	(313) 671-8188
<b>Licensee/Licensee Designee:</b>	Louis Hill, Designee
<b>Administrator:</b>	Tracy Hill
<b>Name of Facility:</b>	Kean Home
<b>Facility Address:</b>	26645 Kean Street Inkster, MI 48141
<b>Facility Telephone #:</b>	(313) 633-9153
<b>Original Issuance Date:</b>	04/13/2006
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL
<b>Certified Programs:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. METHODS OF INSPECTION**

Date of On-site Inspection(s): 11/30/2023

Date of Bureau of Fire Services Inspection if applicable:

Date of Health Authority Inspection if applicable:

No. of staff interviewed and/or observed	2
No. of residents interviewed and/or observed	6
No. of others interviewed	1 Role: Administrator

- Medication pass / simulated pass observed? Yes  No  If no, explain.
- Medication(s) and medication record(s) reviewed? Yes  No  If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes  No  If no, explain.
- Meal preparation / service observed? Yes  No  If no, explain.
- Fire drills reviewed? Yes  No  If no, explain.
- Fire safety equipment and practices observed? Yes  No  If no, explain.
- E-scores reviewed? (Special Certification Only) Yes  No  N/A  If no, explain.
- Water temperatures checked? Yes  No  If no, explain.
- Incident report follow-up? Yes  No  If no, explain.  
N/A
- Corrective action plan compliance verified? Yes  CAP date/s and rule/s:  
N/A
- Number of excluded employees followed-up? N/A
- Variances? Yes  (please explain) No  N/A

**III. DESCRIPTION OF FINDINGS & CONCLUSIONS**

This facility was determined to be in substantial compliance with rules and requirements.

The facility is in compliance with all applicable rules and statutes.

**IV. RECOMMENDATION**

I recommend issuance of a 2-year regular adult foster care license.

A handwritten signature in blue ink, appearing to read "Edith Richardson".

Edith Richardson  
Licensing Consultant

12/21/2023  
Date