



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 7, 2025

Naomi Kennedy  
Kennedy's Care Enterprise Inc.  
27509 Cherry Hill Rd.  
Inkster, MI 48141

RE: License #: AS820246773  
**Leader Home**  
**15755 Leader Street**  
**Taylor, MI 48180**

Dear Ms. Kennedy:

Attached is the Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and rules. Your Adult Foster Care small group home license and special certification are renewed. The license and special certification is valid only at your present address and is 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 that reads "K. Robinson".

K. Robinson, MSW, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 919-0574

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820246773
<b>Licensee Name:</b>	Kennedy's Care Enterprise Inc.
<b>Licensee Address:</b>	27509 Cherry Hill Rd. Inkster, MI 48141
<b>Licensee Telephone #:</b>	(313) 274-0044
<b>Licensee/Licensee Designee:</b>	Naomi Kennedy
<b>Administrator:</b>	Naomi Kennedy
<b>Name of Facility:</b>	Leader Home
<b>Facility Address:</b>	15755 Leader Street Taylor, MI 48180
<b>Facility Telephone #:</b>	(734) 946-7978
<b>Original Issuance Date:</b>	05/01/2002
<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): 12/10/2024

Date of Bureau of Fire Services Inspection if applicable:

Date of Health Authority Inspection if applicable:

No. of staff interviewed and/or observed 02

No. of residents interviewed and/or observed 01

No. of others interviewed 01 Role: Program Coordinator

- Medication pass / simulated pass observed? Yes ☐ No ☒ If no, explain.  
Resident left shortly after my arrival. No other residents were home to simulate medication pass.
- 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.  
No residents available.
- 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.
- 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.

### IV. RECOMMENDATION

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

A handwritten signature in blue ink that reads "K. Robinson".

01/07/25

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Kara Robinson  
Licensing Consultant

Date