STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

March 24, 2026

Kennedy Shannon
Serenity House Residential Care Services LLC
21838 Van K Drive
Grosse Pointe Woods, MI 48236

RE: License #: AS500418639
Investigation #: 2026A0604008
Serenity House - Albany

Dear Ms. Shannon:

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 (248) 972-9136.

Sincerely,

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 #:	AS500418639
Investigation #:	2026A0604008
Complaint Receipt Date:	01/07/2026
Investigation Initiation Date:	01/08/2026
Report Due Date:	03/08/2026
Licensee Name:	Serenity House Residential Care Services LLC
Licensee Address:	21838 Van K Drive Grosse Pointe Woods, MI 48236
Licensee Telephone #:	(313) 587-0861
Administrator:	Kennedy Shannon
Licensee Designee:	Kennedy Shannon
Name of Facility:	Serenity House - Albany
Facility Address:	20757 Albany Ave Warren, MI 48091
Facility Telephone #:	(313) 587-0861
Original Issuance Date:	10/31/2024
License Status:	REGULAR
Effective Date:	04/30/2025
Expiration Date:	04/29/2027
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff, Serena Wilson-Allen engaged in verbal altercation with resident.	Yes
Staff is recording residents with Ring camera and personal phones.	Yes
Residents are told that living room is “staff television” and they must go to bedrooms if they want to watch something else.	Yes
Staff are not taking residents on required daily outings.	No
There is a piece of wood blocking back door.	Yes

III. METHODOLOGY

01/07/2026	Special Investigation Intake 2026A0604008. Assigned Special Investigation for Licensing Consultant, Eric Johnson
01/08/2026	Special Investigation Initiated - Letter Email to and from Complainant
01/12/2026	APS Referral Referral to Adult Protective Services (APS). Referral denied.
01/12/2026	Inspection Completed On-site Attempted unannounced onsite investigation. No one present at home.
01/12/2026	Contact - Document Sent Email to Licensee Designee, Kennedy Shannon
01/12/2026	Contact - Document Sent Emal to and from APS Worker, Debra Johns. Case not assigned for investigation.
01/13/2026	Contact - Document Sent Email to and from Michele McCormick, Recipient Rights
01/13/2026	Contact - Document Sent Email to Heather Shephard, Recipient Rights
01/14/2026	Contact - Document Received

	Email from Heather Shepherd. Sent return email.
01/14/2026	Contact - Document Received Email from Kennedy Shannon with copies of resident information records, staff list and resident register.
01/15/2026	Inspection Completed On-site Completed onsite investigation. Interviewed Home Manager, Markiesha Thomas, Resident A, Resident B and Resident C.
01/15/2026	Contact- Document Received Dismissed intake #208943 and #208936. SI already exists. Received additional information from intake email with same allegations.
01/22/2026	Contact - Document Received Email from Heather Shepherd
01/23/2026	Contact - Document Sent Email to Heather Shepherd
03/17/2026	Contact- Document Sent Email to Kennedy Shannon. Received additional documents by email from Kennedy Shannon including incident reports, assessment plans, recipient rights reports and corrective action, and outing logs
03/18/2026	Contact- Document Sent Email to and from Kennedy Shannon
03/23/2026	Contact- Document Sent Email to Kennedy Shannon. Received return email.
03/26/2026	Exit Conference Completed exit conference with Licensee Designee, Kennedy Shannon

ALLEGATION:

- **Staff, Serena Wilson-Allen engaged in verbal altercation with a resident.**
- **Staff are recording residents with Ring camera and personal phones.**
- **Residents are told that living room is “staff television” and they must go to bedrooms if they want to watch something else.**
- **Staff are not taking residents on required daily outings.**

INVESTIGATION:

A licensing complaint was received regarding Serenity House- Albany on 01/07/2026. It was alleged that the home is using a ring camera to record inside of the home. There is a camera in kitchen. Staff Serena Wilson-Allen engaged in a verbal altercation with a resident, Resident A, threatening that she would put her in a body bag. The residents are advised that the television in the living room is the "staff television" and that staff get to watch what they want and if the residents want to watch something else, they have to go into their bedrooms. Resident B reported that the staff in the home record her on their personal phones. She reported that since November 2024 she has been recorded at least 16 times by different staff members. There is a piece of wood blocking the back door. The piece of wood can be removed in order to exit the home, but would prevent someone (including emergency personnel if needed) from entering the home.

On 01/12/2026, I attempted an unannounced onsite investigation. There was no one present at the home. I did not observe any vehicles in driveway.

On 01/14/2026, I received pictures from Recipient Rights of Ring cameras. The pictures show Ring doorbells at the front and back of home. Box plugged inside of home is the Ring doorbell chime.

On 01/15/2026, a second licensing complaint was received. There are no diagnoses reported for Resident B. The Complainant alleged that staff are supposed to take residents on daily outings. The outings have been reduced to once a week. Staff have been observed yelling and calling Resident B out of her name. Staff have also been observed threatening to hit Resident B. Resident B has not been harmed.

On 01/15/2026, additional information was received from intake with same allegations. Resident C has a brain tumor. The Complainant alleged that staff are supposed to take residents on outings daily. The daily outings have been reduced to once a week. Staff have been observed yelling and calling Resident C out of her name. Staff have also been observed threatening to hit Resident C. Resident C has not been harmed.

On 01/15/2026, I completed onsite investigation. I interviewed Home Manager, Markiesha Thomas, Resident A, Resident B and Resident C.

On 01/15/2026, I interviewed Home Manager, Markiesha Thomas. She stated that the home does not have cameras inside the home recording the residents. They only have a Ring doorbell camera. The Ring doorbell camera was brought into the home to be charged. There are no cameras in resident bedrooms. She stated that staff are not recording residents on their phones. Ms. Thomas stated that there was one incident where Resident B came charging at staff with a frying pan. Staff felt threatened and recorded the incident on their phone. This is the one time she is aware of that a resident

was recorded by staff. Ms. Thomas stated that residents go back and forth with what they want to watch on television, so she lets staff take control of what they watch. Staff try to work with residents and compromise with what shows to watch. All the residents have televisions in their bedrooms if they want to watch something else. Ms. Thomas stated that she did talk to staff, Serena, regarding alleged “body bag” comment. She stated that Serena denied making the comment and said Resident A made a comment about her mother passing away. She stated that Serena has been written up before, but did not believe the write up was regarding her treatment of residents.

On 01/15/2026, I interviewed Resident A. She stated that she has lived at the home for a year and that it is “terrible”. She believes she will be leaving in a month. She indicated that the Home Manager, Markiesha and the Licensee, Kennedy, are good. She stated that Staff, Serena, is “the worst”. She stated a couple months ago Serena told her, “I’m gonna put you in a black body bag” and has said “I should hit you”. Serena has also called her a racist. She indicated that Heather Shepherd from recipient rights came to the home and spoke to her and Serena. Resident A stated that she was able to watch television in living room for first time yesterday. Serena would come in and change the channel to watch Westerns. Serena is the only staff that does this. Serena has turned the lights off and told her it was time to go to bed. Serena also took the Christmas lights down she put up. Resident A stated that Kennedy eliminated her community access. She was told she would have to stay on the porch. She stated that Serena has also been reported to the police. Serena mostly treats her this way and cannot stand her. She has also had issues with staff, Dora. Sometimes Dora will send them to bed. Dora and Serena are staff that yell. Staff make up rules. Resident A stated that she has not seen any cameras in home and that there is not a camera located in the kitchen. She stated that Resident B was being threatening and was recorded by staff. She heard Staff, Jasmine, recorded something but she did not see it. Resident A also indicated that her room was cold during the onsite investigation. I had a digital thermometer that read between 68.4 and 71.4 degrees Fahrenheit during the onsite investigation. I informed home manager during onsite investigation that Resident A felt her room was cold.

On 01/15/2026, I interviewed Resident B. She stated that she was doing “pretty good” She stated that she has lived in home since November 2024. Resident B indicated that she is moving out of the home tomorrow. Resident B stated that Staff, Serena, records her and her housemates whenever she comes to work. Serena also talks on her personal phone and tells family their business. This was brought to Kennedy’s attention. Resident B stated that Serena stopped doing this last Thursday. She only has had issues with Serena. She stated that Serena is very disrespectful and yells at residents. She waits until she is alone. Serena says this is “my tv” and you are free to go to room. Serena is the only staff who does this and has not stopped. They have to go watch television in bedroom. Resident B stated that the Ring doorbell is the only camera in the house.

On 01/15/2026, I interviewed Resident C. She stated that she has lived in the home for a year. It is going good and she has no issues. She stated that she has no issues with

staff and they seem to get along. She likes to stay in her bedroom. Resident C stated that she has not seen staff recording residents on their phones. She has not seen any cameras in the house. She stated that if they do not like what staff is watching on television in living room they must go to bedroom to watch television. It is mostly Serena who picks what they watch. Serena likes to watch Western movies. Resident C stated that she has not been mistreated by staff. She has seen Serena yell at Resident A and Resident B. She has no concerns to report.

On 03/17/2026, I received email from Licensee Designee, Kennedy Shannon, with incident reports, assessment plans, recipient rights reports and corrective action, and outing logs.

Incident reports were provided from July 2025- February 2025. Incident reports dated 11/16/2025 and 11/25/2025 indicate that there were concerns regarding Resident A's full community access and it was being addressed by medication review and notifying behavioral treatment team.

I reviewed current resident assessment plans for Resident A, Resident B and Resident C. None of the assessment plans indicated that residents are required to go on daily outings.

I reviewed outing logs provided for January, February and March 2026. Logs indicate that residents are taken on outings one to two times per week. Outings included Chili's, Walmart, Imperial Market, Five Below, Wendy's, Kroger, Nicky D's Coney Island and a Super Bowl Party.

I reviewed Recipient Rights investigation dated 02/11/2025. Report indicates that Staff, Serena Wilson-Allen admitted to recording Resident B on her personal phone and sending it to the provider. The video was reported to be approximately ten seconds long and of Resident B coming at her with a frying plan. It was reported that this occurred about five to six months ago. Home Manager, Markiesha Thomas and Licensee Designee, Kennedy Shannon, also confirmed the video. As a result, the licensee notified staff verbally and electronically not to use personal cell phones or recording devices to photograph or videotape residents.

I reviewed written reprimand dated 03/17/2026 and corrective action dated 03/20/2026 for Staff, Serena Wilson-Allen. Ms. Wilson-Allen was found to have used language to threaten or degrade a resident. It was determined she engaged in inappropriate, threatening and unprofessional communication. Corrective action indicates that Ms. Wilson-Allen was immediately moved to another home in January 2026 after complaint was made to avoid any ongoing conflict between staff and residents. Actions also include supervisory monitoring and recipient rights training.

On 03/26/2026, I received email from Licensee Designee, Kennedy Shannon. She indicated that there is no contractual obligation for daily outings. They are contracted to provide community outings and they provide one per week or four per month. There is

no resident in their care that has daily outings in their Individual Plan of Service. Ms. Kennedy indicated that these outings can include doctor's office, grocery shopping, movies, picnics, museums and other community locations. Ms. Shannon confirmed that Staff, Serena Wilson-Allen has been relocated and is no longer working at Serenity House-Albany.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(a) Use any form of punishment.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks.** **(iv) Threats.**
ANALYSIS:	On 01/15/2026, I completed an onsite investigation and interviewed Resident A, Resident B and Resident C. All three residents reported concerns regarding Staff, Serena Wilson-Allen. It was reported that she has made inappropriate comments and yells at residents. Also, all three residents indicated that Ms. Wilson-Allen would not allow them to watch what they wanted on living room television, and she would tell them to go to bedrooms. Resident A and Resident C stated that Ms. Wilson-Allen did this so she could watch Westerns. Resident A was only resident who stated that Staff, Dora, also yells at her and sends residents to bed. Staff, Serena Wilson-Allen, is no longer working at Serenity House- Albany. I reviewed written reprimand dated 03/17/2026 and corrective action dated 03/20/2026 for Staff, Serena Wilson-Allen It was determined she engaged in inappropriate, threatening and unprofessional communication. Corrective action indicates that Ms. Wilson-Allen was immediately moved to another home in January 2026 after complaint was made to avoid any ongoing conflict between staff and residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Residents were not being treated with dignity and respect by staff. On 01/15/2026, I completed an onsite investigation and interviewed Resident A, Resident B and Resident C. All three residents reported concerns regarding Staff, Serena Wilson-Allen. It was reported that she has made inappropriate comments and yells at residents. As of January 2026, Staff, Serena Wilson-Allen, is no longer working at home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(i) Participate in social and community group activities of choice.** **(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.** **(r) Have confidentiality of records.**

ANALYSIS:	There is not enough information to determine that residents are not participating in social and community group activities. Licensee Designee, Kennedy Shannon, indicated that they are not contracted to provide daily outings. Outing logs were provided and indicated residents are going on outings one to two times per week. Outings included local stores and restaurants. There is no information to determine that residents are being recorded by cameras inside of the home. The home is equipped with Ring doorbells. The box plugged inside the home is the doorbell chime and not a camera. None of the residents reported seeing cameras inside of the home. There was one confirmed incident that Staff, Serena Wilson-Allen, recorded Resident B on her personal cell phone. It was reported that Ms. Wilson- Allen recorded Resident B because she was coming at her with a frying pan and video was sent to licensee. As a result, the licensee notified staff verbally and electronically not to use personal cell phones or recording devices to photograph or videotape residents. Staff should not record or photograph residents on their personal devices for confidentiality and to protect their privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There is a piece of wood blocking back door.

INVESTIGATION:

On 01/13/2026, I received picture from recipient rights of exit door in laundry room. The door has a red exit sign. There are two metal brackets on each side, placed slightly above the center of the door. There is painted white piece of wood that appears to be part of a 2 X 4 that is placed horizontally across the door.

On 01/15/2026, I completed an onsite investigation. I observed exit doors of home. Home Manger, Markiesha Thomas, showed me side exit door that had two metal brackets on each side or door. The door exits through the laundry room. Ms. Thomas indicated that a piece of wood was placed in brackets to secure the door, however, it was removed the same day they were informed that it could no longer be used.

I completed an exit conference with Licensee Designee, Kennedy Shannon, on 03/23/2026. I emailed Ms. Shannon and informed her of the violations found and that a corrective action plan would be requested. I also informed her that a copy of the special

investigation report would be mailed once approved. I requested that Ms. Shannon contact me if she has any questions or has questions once reviewing report.

APPLICABLE RULE	
R 400.725	**Means of egress.**
	(1) A means of egress must be considered the entire way and method of passage through the facility and out an exit door to free and safe ground outside the facility and must be arranged and maintained to provide free and unobstructed egress from all parts of the facility.
ANALYSIS:	The side exit of the home was being obstructed by a piece of wood being placed across the door to prevent entry. The brackets to hold the wood should be removed to prevent this exit from being blocked in future.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in license status.

Kristine Cilluffo 03/23/2026

Kristine Cilluffo Date
Licensing Consultant

Approved By:

Jay Calewarts For 03/24/2026

Denise Y. Nunn Date
Area Manager