



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2025

Shamara Watkins
Harmony Hearts Village LLC
26730 Belanger St.
Roseville, MI 48066

RE: License #: AS500419205
Investigation #: 2025A0990023
Woods-IN Homes

Dear Ms. Watkins:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

A handwritten signature in cursive script that reads "L. Reed".

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500419205
Investigation #:	2025A0990023
Complaint Receipt Date:	09/24/2025
Investigation Initiation Date:	09/26/2025
Report Due Date:	11/23/2025
Licensee Name:	Harmony Hearts Village LLC
Licensee Address:	21700 Greenfield Rd. Oak Park, MI 48237
Licensee Telephone #:	(313) 442-3144
Administrator:	Justin Cain
Licensee Designee:	Shamara Watkins
Name of Facility:	Woods-IN Homes
Facility Address:	21725 Ulrich St. Clinton Township, MI 48036
Facility Telephone #:	(586) 510-0773
Original Issuance Date:	07/10/2025
License Status:	TEMPORARY
Effective Date:	07/10/2025
Expiration Date:	01/09/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On an unknown date, staff member LaTorsha Reddix "Ms. Tee" left knives with residents for self-defense while she went to the store, raising safety concerns despite no injuries occurring.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/24/2025	Special Investigation Intake 2025A0990023
09/24/2025	APS Referral Adult Protective Services (APS) complaint assigned at intake.
09/26/2025	Special Investigation Initiated - On Site I conducted an unannounced onsite. I interviewed six residents and direct care staff LaTorsha Reddix "Ms. Tee". I conducted a phone call with Shamara Watkins, licensee designee.
09/29/2025	Contact - Document Sent I emailed Ms. Watkins and requested documents from the resident records and Ms. Reddix, employee record.
09/29/2025	Contact - Document Received I received an email from Heather Horan, APS worker. Ms. Horan said that she is submitting her investigation for closure and not substantiating.
09/29/2025	Contact - Document Received I conducted a Workforce Background Check (WBC) for the home. There are no employees linked to the home.
09/29/2025	Contact - Document Sent I emailed Ms. Watkins informing her that there are no employees assigned to her license on the WBC website.
10/02/2025	Contact - Telephone call made I conducted a brief phone interview with Ms. Watkins.

11/19/2025	Contact - Telephone call made I contacted Guardian A. I left an email.
11/19/2025	Contact - Telephone call made I conducted a brief phone interview with Relative C.
11/19/2025	Contact - Telephone call made I conducted a phone interview with Relative D.
11/19/2025	Contact - Telephone call made I conducted a phone interview with Relative F.
11/19/2025	Contact - Document Sent I sent a follow-up email to Ms. Horan.
11/19/2025	Contact - Document Received I reviewed the resident Assessment Plans and Resident ID forms. I reviewed Ms. Reddix, employee record.
11/19/2025	Contact – Document Received I received an email from Guardian A.
11/25/2025	Exit Conference I conducted an exit conference with Ms. Watkins.

ALLEGATION:

On an unknown date, staff member LaTorsha Reddix “Ms. Tee” left knives with residents for self-defense while she went to the store, raising safety concerns despite no injuries occurring.

INVESTIGATION:

On 09/26/2025, I conducted an unannounced onsite. I interviewed direct care staff, LaTorsha Reddix, also called “Ms. Tee”. Ms. Reddix has worked at the home for one year, and her shift is 9 AM to 4:30 PM. Ms. Reddix is off on Wednesdays and Sundays. Ms. Reddix said that she is fully trained. Ms. Reddix said that there is no home manager, and she reports directly to Shamara Watkins, licensee designee. Ms. Reddix was informed of the allegations, and she denied that the incident occurred. Ms. Reddix said that Resident A “was acting weird” about one month ago. Ms. Reddix said that Resident A smoked marijuana as well. Ms. Reddix said that she never left the residents unsupervised. Still, Justin Cain, the administrator who resides in the home, is always there. Ms. Reddix said that when she left, she would tell Mr. Cain. She cannot say for sure if Mr. Cain always hears her when she tells him that she’s going. Ms. Reddix further said that she has never told residents to get a knife to protect themselves, nor

has she given them knives. Ms. Reddix said that she told the residents that if Resident A tried to do anything to them, they should protect themselves. Ms. Reddix said that Resident A at that time was making threats. Ms. Reddix said that she informed Resident A's case manager at that time that he was being verbally aggressive. I observed that Ms. Reddix was very off-putting, and when I asked her to bring the residents forward, she requested this very aggressively to most of them. I observed Mr. Cain at the home but did not interview him as he was leaving.

On 09/26/2025, I briefly interviewed Resident C. When I informed Resident C of the allegations, she said, "That's none of my business". Resident C appeared to be reluctant to speak. Resident C also had a visitor arrive and did not want to continue the interview.

On 09/26/2025, I interviewed Resident B. Resident B said that he does not have a legal guardian and has lived in the home for less than a year. Resident B said that he was never given a knife or left alone. Resident B said that Resident A is not the "most dangerous" person in the home, but Resident F is. He is not afraid of Resident F because he's not physically strong. Resident F uses a lot of profanity, but it is directed at the staff. Resident B said that overall, he feels safe at home and does not have any concerns. Resident B said that he will be moving out soon to live independently.

On 09/26/2025, I interviewed an occupant of the home that lives in a room and boarding home owned by Shamara Watkins, licensee designee. Occupant 1 said that he lives in a different house but is staying here temporarily. Occupant 1 said that he's been there since January 2025. Occupant 1 said that there was a day that Ms. Tee gave all the female residents knives to protect themselves from Resident A. Occupant 1 said that he did not get a knife. Occupant 1 said that Resident A was pretending to punch others, was angry, and threatening everyone.

On 09/26/2025, I interviewed Resident D. Resident D denied the allegations. She denied ever observing Resident A become violent or aggressive. Resident D said that Resident A is beneficial to her because he at times helps her stand up. Resident D said that she feels safe in the home.

On 09/26/2025, I interviewed Resident E. Resident E said that she does not have a legal guardian. Resident E said that Ms. Tee would never give her a knife. Resident E has no issues with Resident A. Resident E feels safe in the home and does not have any concerns.

On 09/26/2025, I interviewed Resident A. Resident A said that he has a legal guardian and a case manager. Resident A said that Ms. Tee gave a knife to Resident E and a former resident (name he did not recall). Resident A said that when he observed the knives, he collected them. Resident A said that Ms. Tee gave the knives to them to protect themselves from Resident F. Resident A said that "Resident F is 'schizo' and on edge". Resident A said that when he saw the knives, he took them and placed them back into the kitchen drawers. They were sharp knives. Resident A said that he believes

that Resident B was also given a knife. Resident A denied being aggressive towards others.

On 09/26/2025, I interviewed Resident F. Resident F does have a legal guardian but said that he did not like her. Resident F denied observing that Ms. Tee gave the other residents knives. Resident F said that he has not seen anyone being violent in the home. Resident F feels safe living at home but would prefer to live independently.

On 10/02/2025, I conducted a brief phone interview with Ms. Watkins. I explained the direct care qualifications and workforce background checks. Ms. Watkins was informed by email when the original license was issued and that she was sent a link regarding Workforce Background Checks. Ms. Watkins said that she would have Ms. Reddix complete her fingerprints as soon as possible. Ms. Watkins said that Occupant 1 is no longer in the home. He was one of the occupants from her room boarding home who had to be temporarily removed from there due to a fire. She thought that he had left and returned home and was not aware that he was still at home. Ms. Watkins was reminded of the conversation about the rooming people should not be moved into the house, and that she needed to find a different place for them to reside during emergencies.

On 11/19/2025, I conducted a brief phone interview with Relative C. Relative C was aware of the allegations and believed that the employee who gave the knives to residents was fired. Relative C does not have any concerns for Resident C. Relative C visits the home every other day and Resident C is receiving good care.

On 11/19/2025, I conducted a phone interview with Relative D. Relative D is the legal guardian of Resident D. Relative D speaks to Resident D daily as she resides out of state. Resident D has lived in the home for almost three years. Relative D was aware of the knife incident. Relative D said that back in September 2025, Ms. Tee tried to give residents knives for protection. Relative D said that Ms. Tee was terminated due to this incident. Relative D said that Ms. Tee was combative and had a "bad attitude" during most of her encounters. Relative D said that she has witnessed Ms. Tee become verbally aggressive towards some of the male residents. Relative D said that Resident D informed her that she witnessed Ms. Watkins and Ms. Tee argued about the knife incident before she was fired.

On 11/19/2025, I conducted a phone interview with Relative F, who said that the care that Resident F is receiving is good in the home. Relative F was going to move Resident F from home to a location closer to him, but Resident F does not want to move away. Relative F was not aware of the allegations. Relative F was aware that Ms. Tee was fired but did not know why.

On 11/19/2025 and 12/01/2025, I reviewed Ms. Reddix's employee record. After multiple emails and requests, I received the following documents from Ms. Watkins: Personnel policies, Job Description, First Aid/CPR training, Medication Administration training, Resident Rights training, Confidentiality policy training, Fire Safety training, Mandatory Reporting Policy training, Nutrition training, Resident Care Prohibited

Practices training, and AFC Rules/Statute review training. Ms. Reddix also had a completed job application: resume, verification of two reference checks, driver's license, and ICHAT. I reviewed Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F's assessment plans.

On 11/19/2025, I reviewed the termination letter addressed to Ms. Reddix. The letter was dated 10/05/2025. The reason for termination was as follows: Recent APS investigation, which provided residents with a knife, and attempts to remove a resident from their assigned residence and took the resident to the home of an unauthorized individual.

On 11/19/2025, I received an email from Guardian A. Resident A moved to a new home in October 2025. However, he doesn't like it and asked to be moved back home. Guardian A said that she didn't have any concerns while he was there. Guardian A said that she is planning to move him back with Ms. Watkins. Resident A is begging to go back. Guardian A said that she did hear about the knife incident from Resident A's case manager from Hope Network. Resident A never confirmed this. Guardian A did speak with Ms. Watkins, who stated that the incident never happened. Guardian A said that she still ended up moving Resident A to see if he would be able to handle a less restrictive environment. Guardian A noted that the move was not working out, and Resident A called Ms. Watkins himself to see if she would accept him back.

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:	<p>Based upon the investigation, there is evidence to support that direct care staff member LaTorsha Reddix gave a knife to at least two residents in September 2025. Ms. Reddix denied giving the residents knives but stated that Resident A was being verbally aggressive and she told the residents that if Resident A tried to do anything towards them, they should protect themselves.</p> <p>According to Occupant 1, there was a day that Ms. Tee gave all the female residents knives to protect themselves from Resident A. Occupant 1 said that he did not receive a knife. He also said that Resident A was punching at others. Resident A said that Ms. Tee gave a knife to Resident E and a former resident. Resident A said that he collected the knives from them.</p>

	<p>Resident A said that Ms. Tee gave the knives to them to protect themselves from Resident F.</p> <p>Relative C, Relative D, Relative F, and Guardian A were all aware of the knife incident. Ms. Reddix was terminated on 10/05/2025.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/29/2025, I conducted a Workforce Background Check (WBC) for the home. There are no employees linked to the home. I emailed Ms. Watkins, informing her that she needed to complete background checks immediately.

On 11/19/2025, I observed that Ms. Reddix did not have a physical at hire or a TB test.

On 11/25/2025, I conducted an exit conference with Ms. Watkins. Ms. Watkins said that Ms. Reddix's hire date is her original license date, 07/10/2025; however, Ms. Reddix has worked in the home for over a year, as she was unlicensed at the time. Ms. Watkins said that Ms. Reddix had been terminated; therefore, she never completed the fingerprints after I informed her that they had not been completed. Ms. Watkins was provided with technical assistance regarding assessment plans and placement agency, as this information was either incorrect or inaccurate. Ms. Watkins was informed of the rule violations. She later sent documents that were initially missing from Ms. Reddix's employee record. Ms. Watkins was informed of the recommendation and agreed to submit a corrective action plan.

APPLICABLE RULE	
400.734b	Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal

	<p>history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.</p>
<p>ANALYSIS:</p>	<p>Based upon the investigation, there is evidence to support that direct care staff Latorsha Reddix did not have a Workforce Background Check completed upon the official hire date of 07/10/2025.</p>
<p>CONCLUSION:</p>	<p>VIOLATION ESTABLISHED</p>

<p>APPLICABLE RULE</p>	
<p>R 400.631</p>	<p>Health screenings.</p>
	<p>(2) A licensee shall have on file a statement signed by a licensed physician or physician's designee attesting to the physical health of the licensee, staff, and members of the household. Statements for the licensee and administrator must be signed no more than 6 months before the issuance of a temporary license and at any other time requested by the department. Statements for staff and members of the household must be obtained within 30 days of employment</p>

	start date, assumption of duties, or occupancy in the facility.
ANALYSIS:	Direct care staff LaTorsha Reddix was officially hired on 07/10/2025. Ms. Reddix did not have in her employee record a statement from a licensed physician attesting to her physical health within 30 days of hire.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

L. Reed

12/02/2025

LaShonda Reed
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

12/10/2025

Denise Y. Nunn
Area Manager

Date