



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 1, 2026

LaTosha Agee
Carson's Adult Foster Care Inc
23650 Beech
Southfield, MI 48033

RE: License #: AM820009861
Investigation #: 2026A0993012
Carson AFC #2

Dear Ms. Agee:

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 (313) 456-0380.

Sincerely,

A handwritten signature in cursive script that reads "DaShawnda Lindsey". The signature is written in a dark ink and is positioned above the printed name and address.

DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM820009861
Investigation #:	2026A0993012
Complaint Receipt Date:	05/07/2026
Investigation Initiation Date:	05/07/2026
Report Due Date:	07/06/2026
Licensee Name:	Carson's Adult Foster Care Inc
Licensee Address:	23650 Beech Rd. Southfield, MI 48033
Licensee Telephone #:	Unknown
Administrator:	LaTosha Agee
Licensee Designee:	LaTosha Agee
Name of Facility:	Carson AFC #2
Facility Address:	5825 Livernois Detroit, MI 48210
Facility Telephone #:	(248) 974-7988
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	05/24/2025
Expiration Date:	05/23/2027
Capacity:	11
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was jumped on and beat up by a male staff.	Yes

III. METHODOLOGY

05/07/2026	Special Investigation Intake 2026A0993012
05/07/2026	APS Referral Received allegations to Adult Protective Services (APS)
05/07/2026	Referral - Recipient Rights Forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
05/07/2026	Special Investigation Initiated - Telephone Telephone call made to APS specialist Charmaine Parks
05/07/2026	Inspection Completed On-site Conducted an unannounced onsite investigation. I interviewed home manager Lajuana Davis and Resident A
05/14/2026	Contact - Telephone call made Telephone call made to staff Kimberly Lewis
05/14/2026	Contact - Telephone call made Telephone call made to former staff TreVon Davis. Left a message.
05/14/2026	Contact - Telephone call made Telephone call made to Relative A1
05/14/2026	Contact - Telephone call made Telephone call made to DWIHN recipient rights officer Dominique Moore
05/15/2026	Contact - Telephone call made Telephone call made to former staff TreVon Davis. Left a message.
05/19/2026	Contact - Telephone call made Telephone call made to former staff TreVon Davis

05/19/2026	Exit Conference Held with licensee designee LaTosha Agee
05/20/2026	Contact - Telephone call made Telephone call made to case manager A1. Left a message.
05/21/2026	Contact - Telephone call made Telephone call made to case manager A1. Left a message.
05/26/2026	Contact - Telephone call made Telephone call made to case manager A1. Left a message.
05/27/2026	Contact - Telephone call made Telephone call made to case manager A1. Left a message.
05/29/2026	Contact - Telephone call made Telephone call made to case manager A1. She was unavailable.
05/29/2026	Exit Conference Held with licensee designee LaTosha Agee

ALLEGATION:

Resident A was jumped on and beat up by a male staff.

INVESTIGATION:

On 05/07/2026, I received allegations from Adult Protective Services (APS).

On 05/07/2026, I forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights.

On 05/07/2026, I conducted a telephone interview with APS specialist Charmaine Parks. She stated she substantiated the allegations.

On 05/07/2026, I conducted an unannounced onsite investigation. I interviewed home manager Lajuana Davis and Resident A,

Ms. Davis stated she was not present in the facility when the alleged incident occurred. However, she was informed that former staff TreVon Davis grabbed Resident A's jacket. She did not know what led to Mr. Davis grabbing Resident A's jacket as she did not get the entire story. Per Ms. Davis, Mr. Davis did not jump on Resident A or beat him up. Ms. Davis stated Mr. Davis was terminated after the incident.

Resident A denied that he was beaten up or jumped on by Mr. Davis or any other staff in the facility. Per Resident A, Mr. Davis grabbed his jacket or hoodie. Resident A could not recall what he was wearing that day. Resident A stated Mr. Davis was trying to show him something or explain something that Resident A had done. Resident A could not recall all the details surrounding the incident, but he stated Mr. Davis was mad when he grabbed his jacket or hoodie.

On 05/14/2026, I conducted a telephone interview with staff Kimberly Lewis. Ms. Lewis stated that when she arrived at the facility, Resident A asked her to use the telephone. While talking to a relative, Resident A informed his relative that Mr. Davis grabbed his shirt and hemmed him up. Resident A did not state what led to the incident. Ms. Lewis could not recall the name of the relative Resident A was talking to. Ms. Lewis denied ever witnessing Mr. Davis or anyone else in the facility beating up or jumping on Resident A.

On 05/14/2026, I attempted to conduct a telephone interview with Relative A1 with no success. Relative A1 did not wish to provide her last name or provide any information about Resident A and his living circumstances.

On 05/14/2026, I conducted a telephone interview with DWIHN recipient rights officer Dominique Moore. She stated her investigation is pending.

On 05/19/2026, I conducted a telephone interview with former staff TreVon Davis. Mr. Davis denied ever jumping on or beating up Resident A. Per Mr. Davis, he tried to show Resident A something, grabbed his arm, pulling him to “come on.” Mr. Davis denied being upset or mad when the incident occurred.

On 05/19/2026, I contacted licensee designee LaTosha Agee and conducted an exit conference. She denied that Mr. Davis jumped on or beat up Resident A. However, she confirmed she was notified that Mr. Davis collared or grabbed Resident A. As a result, Mr. Davis was terminated. I informed her of the findings. She agreed to submit a corrective action plan.

On 05/29/2026 as well as on 05/20/2026, 05/21/2026, 05/26/2026, and 05/27/2026, I attempted to speak with case manager A1 with no success. I left several messages for a returned call.

On 05/29/2026, I conducted a follow-up exit conference with licensee designee LaTosha Agee. I informed her there are no changes with the department’s recommendation.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes

	any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Mr. Davis grabbed Resident A's jacket or hoodie. Resident A stated Mr. Davis was mad when he grabbed his jacket or hoodie. As a result, he was terminated. Evidence supports Mr. Davis mistreated Resident A. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



05/29/2026

DaShawnda Lindsey
Licensing Consultant

Date

Approved By:



06/01/2026

Ardra Hunter
Area Manager

Date