GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2026

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

RE: License #: AS820281136
Investigation #: 2026A0901041
Kean Home

Dear Louis Hill:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820281136
Investigation #:	2026A0901041
Complaint Receipt Date:	06/18/2026
Investigation Initiation Date:	06/24/2026
Report Due Date:	08/17/2026
Licensee Name:	Hill's Support Services Inc
Licensee Address:	PO Box 648 Inkster, MI 48141
Licensee Telephone #:	(313) 671-8188
Administrator:	Louis Hill
Licensee Designee:	Louis Hill
Name of Facility:	Kean Home
Facility Address:	26645 Kean Street Inkster, MI 48141
Facility Telephone #:	(313) 633-9153
Original Issuance Date:	04/13/2006
License Status:	REGULAR
Effective Date:	12/16/2025
Expiration Date:	12/15/2027
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff, Lashaunna Modock, refused to give Resident A his juice packet and told him he had to drink water first.	Yes
Resident A was physically assaulted by staff, Lashaunna Modock.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/18/2026	Special Investigation Intake 2026A0901041
06/18/2026	Adult Protective Services Referral (APS)
06/24/2026	Special Investigation Initiated - Telephone APS
06/24/2026	Referral - Recipient Rights
06/24/2026	Inspection Completed On-site Staff, Nukeisha Carr Residents A & B
06/26/2026	Contact - Telephone call made Licensee designee, Louis Hill
06/26/2026	Contact - Telephone call made Home manager, Tracy Hill
06/26/2026	Contact - Telephone call made Staff, Lashaunna Modock
06/26/2026	Contact - Telephone call made Resident C
06/27/2026	Contact - Document Received Individual Plan of Service

06/29/2026	Contact - Telephone call made Case manager, Eva Chahrour
06/29/2026	Contact - Telephone call made Guardian, Damon Watkins
07/01/2026	Contact - Telephone call made Staff, Joy Roby
07/16/2026	Inspection Completed On-site Resident C
07/16/2026	Inspection Completed-BCAL Sub. Compliance
08/12/2026	Exit Conference Licensee designee, Louis Hill

ALLEGATION:

Staff, Lashaunna Modock, refused to give Resident A his juice packet and told him he had to drink water first.

INVESTIGATION:

On 06/24/2026, I made a telephone call to Charmaine Parks, from APS. She stated Resident A remains at the facility, but staff, Lashaunna Modock, was no longer employed there.

On 06/24/2026 I conducted an onsite inspection at the facility. Staff, Nukeisha Carr, was interviewed. She stated the incident occurred on 05/30/2026. She indicated when she arrived at work that morning, Resident A was upset and stated he had an altercation with Lashaunna which initiated because he wanted his flavored water. Nukeisha explained that Resident A does not like plain water, so they have flavor packets available for him to add to his water. She said Resident A told her Lashaunna refused to give him a flavor packet and told him he had to drink the plain water first. She further said staff, JoyRoby, and Residents B and C were also present. I reviewed an incident report that was dated 05/30/2026 and was written by Lashaunna. It documented that Resident A wanted juice instead of water and she told him to drink the water first.

During the onsite inspection on 06/24/2026, I interviewed Resident A. He stated Lashaunna argued with him and tried to make him drink plain water. He stated

everyone knows he does not like plain water, so he asked for one of his flavor packets and she refused to give it to him.

During the onsite inspection on 06/24/2026, I interviewed Resident B. She stated Resident A and staff were arguing because the staff tried to make Resident A drink water and he did not want it. Resident B could not remember the name of the staff person.

Resident C was not interviewed during this onsite inspection due to not being home.

On 06/26/2026, I made a telephone call to the licensee designee Louis Hill, to inform him of the complaint. He suggested I contact the home manager, Tracy Hill.

On 06/26/2026, I made a telephone call to Tracy. She said Resident A told her the same as he reported to me. She also stated Lashaunna no longer worked at the facility.

On 06/26/2026, I made a telephone call to Lashaunna. She explained that Resident A was upset because he wanted a juice packet. She said she refused to give it to him because he does not drink enough water and has dark urine. Instead, she gave him plain water and told him she would give him a juice packet after he drunk the cup of water.

On 06/27/2026, I received an email from Tracy that consisted of Resident A's IPOS from PsyGenics. It did not indicate that he had to drink water before being given flavored beverages.

On 06/29/026, I made a telephone call to Resident A's case manager, Eva Chahrour. She stated Resident A told her the same information he reported to me. She also stated she did not understand why he was not given the flavored water and that there was nothing in his IPOS preventing him from having it.

On 06/29/2026, I made a telephone call to Resident A's guardian, Damon Watkins, from Faith Connections. He stated Resident A should not have been restricted from having the beverage he requested because there is nothing in writing authorizing staff to limit his beverage consumption or requiring him to drink more water.

On 07/01/2026, I made a telephone call to staff, Joy Roby. She stated Resident A wanted his Crystal Light and Lashaunna refused to give it to him. She gave him water and told him he had to drink it first. Resident A said he would drink the water after he had his Crystal Light, but Lashaunna still refused to give it to him.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information I obtained during this investigation, the personal care provided to Resident A was not in accordance with his IPOS. Lashaunna refused to give him the flavored beverage he requested because she personally felt he needed to drink more water. However, his IPOS did not authorize staff to limit his beverage intake and his case manger, and guardian also indicated that there were no restrictions in place that prevented Resident A from having the beverage of his choice.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was physically assaulted by staff, Lashaunna Modock.

INVESTIGATION:

On 06/24/2026, I made a telephone call to Charmaine Parks, from APS. She stated her complaint was substantiated.

On 06/24/2026 I conducted an onsite inspection at the facility. Staff, Nukeisha Carr, was interviewed. She stated the incident occurred on 05/30/2026. She explained that when she arrived at work that morning Resident A was visibly upset and complaining about his back hurting. He said he had an altercation with Lashaunna and that she punched him in the face and dragged him out of his wheelchair, due to him wanting flavored water.

During the onsite inspection on 06/24/2026, I reviewed two incident reports. Both were dated 05/30/2026. The report written by Lashaunna indicated the incident happened at breakfast. Resident A wanted juice instead of water and she told him to drink the water first. He wanted another staff to assist him. When he saw the other staff (the incident report did not indicate who the other staff was), he began snapping at Lashaunna, yelling and cursing at her, and talking about her son. He

was moving his arms around so she pulled him back from the table so he would not hit the other residents. As she was pulling him back, he punched her in the mouth. She let his wheelchair go and he grabbed her arm and bit her. As she was still trying to pull away from Resident A, he grabbed her jacket and pulled himself up, holding on to her and would not let go. She was finally able to release herself because he was on the floor and she was holding him down. When she released him, he called her more names. Her and the other staff called management. The other incident report was written by staff, Joy Roby. It stated Resident A was taken to the hospital to make sure nothing was wrong. His vitals were checked at the hospital, and the doctor checked his back and body for bruises and marks. He was discharged and given Tylenol and a muscle relaxer shot.

During the onsite inspection on 06/24/2026, I interviewed Resident A, who is wheelchair bound. He stated he punched Lashaunna and she pulled him out of his chair and hit him in the face and on his chest. He said she also dragged him out of his chair through the house on the floor. He crawled to his chair to pull himself up and she pushed him back down. Resident A stated she has not been back to the facility, and he feels safe there as long as she is not there.

During the onsite inspection on 06/24/2026, I interviewed Resident B. She stated Resident A and staff were arguing and screaming at each other. He bit staff and she hit him and knocked his chair over. Resident A was on the floor and was trying to get up.

Resident C was not interviewed during this onsite inspection due to not being present.

On 06/26/2026, I made a telephone call to the licensee designee, Louis Hill, to inform him of the complaint. He suggested I contact the home manager, Tracy Hill.

On 06/26/2026, I made a telephone call to Tracy. She said Resident A told her the same as he reported to me and that Lashaunna’s account of what happened was different. Tracy said Lashaunna denied assaulting Resident A and stated he latched on to her and fell out his chair. She stated staff, Joy Roby, was also present. She further said Lashaunna no longer worked at the facility.

On 06/26/2026, I made a telephone call to Lashaunna. She stated the incident happened in the dining room during breakfast. He wanted a juice pack, and she told him to drink his water first. When Joy entered the dining room, he started swinging his arms and was angry at Lashaunna for not giving him the juice pack. She pulled him away from the table to keep him from hitting the other residents and got hit in the mouth. He bit her on the arm and as she was trying to walk away, he grabbed her jacket and was trying to lift himself up. Each time she pulled her arm away he grabbed the other arm, so she grabbed his shoulders and with both arms pushed him away. She denied pushing him out of his wheelchair but said Resident A fell on the floor when he grabbed on to her as she was trying to pull away from him.

Lashaunna said because she was upset about the inappropriate things he was saying and the fact that he punched her in the mouth, she said some inappropriate things to him out of anger. When he was calling her names, she replied, “Yo momma” and called him “handicapped”. She further said Joy and Residents B and C witnessed everything.

On 06/26/2026 I made a telephone call to the facility to interview Resident C but he was in the hospital.

On 06/27/2026, I received an email from Tracy that consisted of Resident A’s IPOS from PsyGenics. One of his goals pertained to his aggressive behavior and indicated, “Staff will help him recognize his triggers, redirect to appropriate coping methods, and ignore attention seeking behavior. If his behavior begins to escalate, staff will remove nearby objects that can be thrown, redirect other staff and home members away from him, and call 911 if he becomes physically aggressive.”

On 06/29/2026 I made a telephone call to Resident A’s case manager from PsyGenics, Eva Chahrour. She stated she was aware of the incident and that Resident A can be aggressive at times, but this is addressed in his IPOS, and staff should adhere to it when dealing with him.

On 06/29/2026, I made a telephone call to Resident A’s guardian, Damon Watkins, from Faith Connections. He stated Resident A has the tendency to be aggressive at times but managing this behavior is addressed in his IPOS.

On 07/01/2026, I made a telephone call to Joy. She said everyone was at the table for breakfast. Lashaunna refused to give Resident A his Crystal Light and he got upset. As Lashaunna walked pass him, Resident A tried to hit her and missed. She walked back over to him and said, “Do it”. He hit her and she pulled him out of his wheelchair by both arms and dragged him around the floor in a circle. She dragged him back to his chair and pushed his face in it. She also hit him in the face and kicked him in the torso area. Lashaunna left him on the floor and told him he was a mistake. Joy also said she had a video of her calling him “handicap.”

On 07/01/2026, I received a picture and video from Joy. The picture was of Resident A lying on the floor next to his wheelchair. The video only showed the ceiling, but a female’s voice could be heard saying, “Aint nobody scared of you handicap. You think you can get somebody in trouble. You can get yourself in trouble.” According to Joy, this voice was Lashaunna.

On 07/16/2026, I conducted another onsite at the facility and interviewed Resident C. He said he could not remember everything that happened but said Resident A and a staff were arguing about water. The staff pulled Resident A out of his wheelchair onto the floor and hit him. He did not remember the staff person’s name.

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:	Based on the information I obtained during this investigation, Resident A was not treated with dignity and respect, and his safety and protection was not attended to. Although Lashaunna denied the allegations, Resident A and the other witnesses, Joy and Residents B and C, reported he was. In addition to this, Resident A was verbally abused by Lashaunna as well. She admitted to talking about his mother and calling him handicapped, which was also recorded. As well, Joy reported hearing Lashaunna tell Resident A he was a mistake.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/26/2026, I made a telephone call to Lashaunna. During her explanation of the incident that occurred on 05/30/2026, she indicated that she held Resident A down on the floor. She also documented this in the incident report she wrote on 05/30/2026.

On 06/29/2026 I made a telephone call to Resident A's case manager from PsyGenics, Eva Chahrour. She stated Resident A can be aggressive at times, but this is addressed in his IPOS and staff are not allowed to physically restrain him.

On 06/29/2026, I made a telephone call to Resident A's guardian, Damon Watkins, from Faith Connections. He also stated Resident A has the tendency to be aggressive, but staff should be adhering to his IPOS and they are not allowed to restrain him.

On 08/12/2026, I made a telephone call to the licensee designee, Louis Hill, for an exit conference. I informed him of my investigative findings, which he conveyed he understood and that Lashaunna remains unemployed with them.

APPLICABLE RULE	
R 400.641(6)	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(c) Restrain a resident's movement for the purpose of immobilizing the resident.**
ANALYSIS:	Based on the information I obtained during this investigation, Resident A was retrained for the purpose of immobilization. Lashaunna admitted to holding him down on the floor and documented this in the incident report she wrote. As indicated by Resident A's guardian and case manager, staff are not unauthorized to physically restrain him.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

08/13/2026

Regina Buchanan — Date
Licensing Consultant

Approved By:

08/19/2026

Ardra Hunter — Date
Area Manager