



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 11, 2025

Deidre Wheatley
D & D Senior Living, Inc.
14184 22 Mile Road
Shelby Twp., MI 48315

RE: License #: AS500364160
Investigation #: 2025A0617017
Shelby Manor 1

Dear Ms. Wheatley:

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 black ink, appearing to be 'EJ', written in a cursive style.

Eric Johnson, 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 #:	AS500364160
Investigation #:	2025A0617017
Complaint Receipt Date:	07/09/2025
Investigation Initiation Date:	07/10/2025
Report Due Date:	09/07/2025
Licensee Name:	D & D Senior Living, Inc.
Licensee Address:	14184 22 Mile Road Shelby Twp., MI 48315
Licensee Telephone #:	(586) 405-9623
Administrator:	Deidre Wheatley
Licensee Designee:	Deidre Wheatley
Name of Facility:	Shelby Manor 1
Facility Address:	14184 22 Mile Road Shelby Twp., MI 48315
Facility Telephone #:	(586) 532-9461
Original Issuance Date:	11/14/2014
License Status:	REGULAR
Effective Date:	05/14/2025
Expiration Date:	05/13/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has deep, oddly shaped arm cuts that raise doubts about claims she injured herself on her wheelchair.	Yes

III. METHODOLOGY

07/09/2025	Special Investigation Intake 2025A0617017
07/10/2025	Special Investigation Initiated - Face to Face Special Investigation initiated with unannounced onsite investigation
07/10/2025	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I interviewed licensee designee Deidre Wheatley, staff Nakiece Ross, staff supervisor Marissa Post, Resident A, Resident B, and Resident C.
07/10/2025	Contact - Telephone call made TC to Ms. Ashley Herrod
08/25/2025	Contact - Telephone call made I interviewed staff Ashley Herrod.
08/25/2025	Exit Conference I held an exit conference with licensee Deidre Wheatley. informing her of the findings of the investigation.

ALLEGATION:

Resident A has deep, oddly shaped arm cuts that raise doubts about claims she injured herself on her wheelchair.

INVESTIGATION:

On 07/07/25, I received a complaint on Shelby Manor 1. The complaint indicated that Resident A can be a combative resident. Apparently when Resident A was getting dressed in the morning by one of the staff, she swung her arms, and she hit her arm on

the wheelchair. Resident A has multiple cuts on her arm, and they all look very deep. One is even in the shape of a "M". It looks like someone dug something into her skin; complainant is worried that what they are saying is not true by the way it looks. Resident A has even gotten combative with the complainant before too while in her wheelchair and has never gotten any cuts, even if she hit her arm on the wheelchair.

On 07/10/25. I conducted an unannounced onsite investigation at the facility. I interviewed licensee designee Deidre Wheatley, staff Nakiece Ross, staff supervisor Marissa Post, Resident A, Resident B, and Resident C.

During the onsite investigation, I interviewed Ms. Wheatley. According to Ms. Wheatley, the incident took place on 07/01/25, but she was not present when the incident happened. Ms. Wheatley was informed by staff that Resident A was combative and hit her arm on the wheelchair. Ms. Wheatley stated that staff Ashley Herrod was the staff on shift at the time of the incident. Ms. Wheatley stated that an incident report was not completed for the incident.

I reviewed Resident A's file and according to the notes, on 07/01/25, Resident A was combative when staff attempted to change her briefs. The notes do not state that Resident A hit her arm or sustained any injuries. No incident report (IR) was found in the file.

During the onsite investigation, I interviewed staff Nakiece Ross. According to Ms. Ross, she was not present when the incident occurred. However, Ms. Ross stated that staff Ashley Herrod told her what happened. Ms. Herrod told Ms. Ross that Resident A was very combative and she swung her arms trying to hit Ms. Herrod. Resident A hit her arm on her wheelchair or the bedrails on her bed. When Ms. Ross arrived at the facility, she observed Resident A with bandages on her arm.

During the onsite investigation, I interviewed staff supervisor Marissa Post. According to Ms. Post, Ms. Herrod told her that Resident A was extremely combative when Ms. Herrod was getting her changed and out of bed. Once Ms. Herrod got Resident A into her wheelchair, she noticed that Resident A had a skin tear on her forearm. Ms. Post isn't sure exactly what Resident A hit her arm on but believes it was the wheelchair. Ms. Post notified Resident A's guardian.

During the onsite investigation, I attempted to interview Resident A. Resident A appeared to be confused and could not give consistent coherent answers. Resident A did state that one of the staff bit her and "battled" her. She stated that she is in pain. I observed Resident A's arm heavily bandaged. I observed Ms. Post unbandage Resident A's arm and clean the wound. I observed Resident A with a large skin tear and a large scratch on her arm. I took pictures. I observed Resident A in extreme physical pain when the bandage was being changed.

During the onsite investigation, I interviewed Resident B. According to Resident B, she loves living in the facility. She has no concerns to report and stated that she did not witness anything with regards to the incident with Resident A.

During the onsite investigation, I interviewed Resident C. According to Resident C, she loves living in the facility. She has no concerns to report and stated that she did not witness anything with regards to the incident with Resident A.

On 08/25/25, I interviewed staff Ashley Herrod. According to Ms. Herrod she was getting Resident A up for her morning brief change when Resident A was being very combative. Resident A swung her arms and acted out of character. Ms. Herrod believes the change in her behavior was due to a Urinary Tract infection (UTI). Once Ms. Herrod got Resident A into her wheelchair, she noticed that Resident A had a skin tear on her forearm. Ms. Herrod stated that she cleaned and applied first aid care to the wound. Ms. Herrod stated that Resident A must have hit her arm on her wheelchair or bedrails.

On 08/25/25, I held an exit conference with licensee Deidre Wheatley informing her of the findings of the investigation. Ms. Wheatley stated that the reason Resident A was not sent to the hospital was because the guardian didn't want Resident A to be sent but as part of her corrective action plan, she has instructed staff to send residents out for care when an incident occurs. Ms. Wheatley stated that she will review the report and submit a corrective action plan.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, the facility failed to protect and properly care for Resident A. Resident A sustained several injuries to her forearm. Resident A stated that she is in pain. I observed Resident A's arm heavily bandaged. I observed Ms. Post unbandage Resident A's arm and cleaned the wound. I observed Resident A with a large skin tear and a large scratch on her arm. During the onsite, I observed Resident A in extreme physical pain when the bandage was being changed. Resident A was not protected and properly cared for while in care of this licensee.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14311	Incident notification, incident records.
	(2) If an elopement occurs, staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the elopement occurred, staff shall contact law enforcement.
ANALYSIS:	During the onsite investigation, I reviewed Resident A's file and an Incident Report was not completed for this incident. Ms. Wheatley stated that an IR was not completed.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14310	Resident health care.
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A sustained a severe skin tear and cut on her forearm and was not sent out for professional medical treatment. The facility provided first aid care to Resident A, which was not sufficient due to her being in extreme visible pain during the onsite investigation, 9 days after the incident occurred. According to Ms. Wheatley, Resident A was not sent to the hospital was because the guardian didn't want Resident A to be sent.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

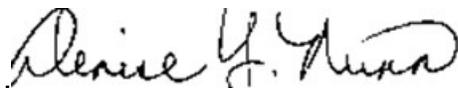


08/26/25

Eric Johnson
Licensing Consultant

Date

Approved By:



09/11/2025

Denise Y. Nunn
Area Manager

Date