



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 22, 2025

Sherman Taylor  
Taylor's Special Care Services, Inc.  
Ste 210  
23800 West Ten Mile Rd  
Southfield, MI 48034

RE: License #: AS630405301  
Investigation #: 2026A0602004  
Winchester Home

Dear Mr. Taylor:

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,

A handwritten signature in cursive script that reads "Cindy Berry". The signature is written in black ink and is positioned below the word "Sincerely,".

Cindy Berry, Licensing Consultant  
Bureau of Community and Health Systems  
3026 West Grand Blvd  
Cadillac Place, Ste 9-100  
Detroit, MI 48202  
(248) 860-4475

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630405301
<b>Investigation #:</b>	2026A0602004
<b>Complaint Receipt Date:</b>	11/18/2025
<b>Investigation Initiation Date:</b>	11/19/2025
<b>Report Due Date:</b>	01/17/2026
<b>LicenseeName:</b>	Taylor's Special Care Services, Inc.
<b>Licensee Address:</b>	Ste 210 23800 West Ten Mile Rd Southfield, MI 48034
<b>Licensee Telephone #:</b>	(248) 350-0357
<b>Administrator:</b>	Sherman Taylor
<b>Licensee Designee:</b>	Sherman Taylor
<b>Name of Facility:</b>	Winchester Home
<b>Facility Address:</b>	21001 Winchester Street Southfield, MI 48076
<b>Facility Telephone #:</b>	(248) 350-0357
<b>Original Issuance Date:</b>	01/26/2021
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	07/26/2025
<b>Expiration Date:</b>	07/25/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
<b>Resident A reported physical and emotional abuse, mistreatment by staff (including racism).</b>	No
<b>Unsafe and unsanitary living conditions.</b>	Yes
<b>Inadequate medical care for multiple health issues.</b>	No

**III. METHODOLOGY**

11/18/2025	Special Investigation Intake 2026A0602004
11/19/2025	Special Investigation Initiated - Telephone Call made to the home; Resident A is currently hospitalized for psychiatric treatment with an unknown discharge date.
11/19/2025	Contact – Telephone call made Call made to Resident A, no answer and unable to leave a message.
12/12/2025	Inspection Completed On-site I interviewed staff member, Tamisha Taylor and Resident A.
12/19/2025	Contact – Telephone call made Message left for the home manager, Roxanne Turner.
12/19/2025	Contact – Telephone call made Message left for Resident A's daughter.
12/22/2025	Exit Conference Message left for the licensee designee, Sherman Taylor.

**ALLEGATION:**

- **Resident A reported physical and emotional abuse, mistreatment by staff (including racism).**
- **Unsafe and unsanitary living conditions.**
- **Inadequate medical care for multiple health issues.**

## INVESTIGATION:

On 11/18/2025, a complaint was received and assigned for investigation alleging that Resident A reported physical and emotional abuse, mistreatment by staff (including racism), unsafe and unsanitary living conditions, and inadequate medical care for multiple health issues.

On 12/12/2025, I made an unannounced on-site investigation at which time I interviewed staff member Tamisha Taylor and Resident A. Ms. Taylor stated Resident A had a court hearing on 11/18/2025 regarding the status of her guardianship. Ms. Taylor was not exactly sure what took place during the court hearing but the judge had her petitioned into the psychiatric hospital. Resident A was admitted and remained hospitalized until 12/04/2025. According to Ms. Taylor, she has no knowledge of any staff member mistreating Resident A or being racist towards her. Resident A uses racial slurs towards the black staff members when she does not get her way. Ms. Taylor stated she had no knowledge of unsafe living conditions or that Resident A did not receive medical treatment when needed or when she asked for it. She went to state that she has personally assisted Resident A with cleaning her room, organizing her clothes and belongings but she does not maintain it as she is not the tidiest person. Ms. Taylor said Resident A has a history of going into the community, meeting random men and bringing them back to the home. According to Ms. Taylor, she had no knowledge of staff mistreating Resident A. She said Resident A becomes upset when staff try and talk to her about her risky behaviors while in the community and she may interpret that as mistreatment.

Resident A stated she recently went to court regarding guardianship and was petitioned into the hospital and admitted to Common Ground. Prior to her hospitalization, there was an issue with the toilet being stopped up. However, when she returned home, the toilet had been fixed. Resident A could not provide any examples of situations where staff had been physically, emotionally or racially abusive towards her. I asked Resident A if she had any health issues that were not being addressed by staff. She said she did have a sexually transmitted infection several months ago but the home manager took her to the doctor and she was provided with medication. She also reported having cracked heels due to her diabetes but has cream for her feet but does not always use it.

On 12/12/2025, I received and reviewed a copy of Resident A's individual plan of service (IPOS) completed by Easterseals and dated 11/26/2025. According to the plan, Resident A is diagnosed with schizoaffective disorder, major depressive disorder, alcohol use disorder, generalized anxiety disorder, and hoarding disorder. Her current medication regimen includes:

- Buspirone – 10mg (one 3 times daily)
- Hydroxyzine – 25mg (one capsule 3 times daily)
- Melatonin – 10mg (one tablet at bedtime)
- Olanzapine – 10mg (one tablet at bedtime)

Seroquel – 200 mg (one tablet 3 times daily)  
Zoloft – 100mg (once daily)

Resident A has a history of elopement from the home, going into the community meeting random men, providing them with her address and phone number, bringing them back to the home, participating in risky behaviors, and consuming alcohol. As a result, Resident A is now on a 5 phase program. The initial phase restricts unsupervised community access. As she successfully completes each phase, she will regain her independent community access.

On 12/12/2025, I inspected the home and observed the tub in the upstairs bathroom to be discolored and a black substance covering the caulking where the wall and tub meet. It appears that the tub glaze is wearing off. I also observed that the shower in Resident A's room contained a black substance on the shower walls and shower floor. There was also dirty wet underwear located on the shower floor. There were clothes strewn on the floor throughout the entire bedroom along with empty soda bottles and food wrappers. I did not observe any issues with any of the toilets in the home.

On 12/22/2025, I left a message for the licensee designee, Sherman Taylor informing him of the investigative findings and recommendation documented in this report.

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on the information obtained during the investigation, there is insufficient information to determine that staff mistreated Resident A.  According to Ms. Taylor, she had not knowledge of staff mistreating Resident A. She said Resident A becomes upset when staff try and talk to her about her risky behaviors while in the community and may interpret that mistreatment.  Resident A could not provide any information regarding when and how staff mistreated her.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.647</b>	<b>Safety and maintenance of premises.</b>
	<b>(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.</b>
<b>ANALYSIS:</b>	<p>Based on the information obtained during the investigation and my own observation, there is sufficient information to determine that the housekeeping standards (in regard to the bathrooms) do not present a comfortable, clean, and orderly appearance. On 12/12/2025, I observed the tub in the upstairs bathroom to be discolored and a black substance covering the caulking where the wall and tub meet. It appears that the tub glaze is wearing off.</p> <p>On 12/12/2025, I also observed that the shower in Resident A's room contained a black substance on the shower walls and shower floor. There was also dirty wet underwear located on the shower floor. There were clothes strewn on the floor throughout the entire bedroom along with empty soda bottles and food wrappers.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<p><b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</b></p> <p><b>(a) Be free from discrimination based on race, religion, color, national origin, sex, gender identity, age, physical or mental impairment, marital status, or source of payment in the provision of services and care.</b></p>
<b>ANALYSIS:</b>	<p>Based on the information obtained during the investigation, there is insufficient information to determine that Resident A was discriminated against. Ms. Taylor stated she has no knowledge of any staff member discriminating against Resident A. However, Resident A has called the black staff member racial slurs. When asked, Resident A was unable to provide any information that would support discrimination against her.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**IV. RECOMMENDATION**

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



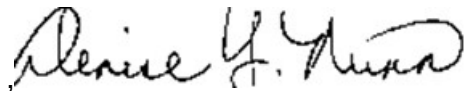
12/22/2025

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Cindy Berry  
Licensing Consultant

Date

Approved By:



12/22/2025

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Denise Y. Nunn  
Area Manager

Date