GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2026

Changming Wang
Sheridan Living LLC
1768 Fireside Dr
Troy, MI 48098

RE: License #: AS810415752
Investigation #: 2026A0122021
Sheridan Living

Dear Mr. Wang:

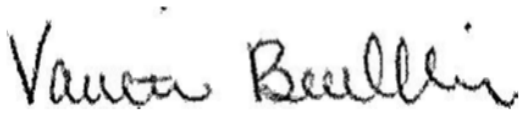
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9720.

Sincerely,



Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810415752
Investigation #:	2026A0122021
Complaint Receipt Date:	04/20/2026
Investigation Initiation Date:	04/21/2026
Report Due Date:	05/20/2026
Licensee Name:	Sheridan Living LLC
Licensee Address:	1768 Fireside Dr Troy, MI 48098
Licensee Telephone #:	(248) 404-7950
Administrator:	Changming Wang
Licensee Designee:	Changming Wang
Name of Facility:	Sheridan Living
Facility Address:	1718 Sheridan Dr Ann Arbor, MI 48104
Facility Telephone #:	(248) 404-7950
Original Issuance Date:	04/10/2023
License Status:	REGULAR
Effective Date:	04/10/2026
Expiration Date:	04/09/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is not clean; there is litter and food on the floors and the kitchen sink.	No
Resident A did not receive his morphine as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

04/20/2026	Special Investigation Intake 2026A0122021 APS Referral
04/21/2026	Special Investigation Initiated - On Site Observed the facility. Observed Residents A, B, C, and D. Requested the requested the files, they were not in the facility. Contacted licensee designee, Changming Wang.
04/22/2026	Inspection Completed On-site Reviewed resident files. Conducted interview with staff member, Simone Thomas.
04/23/2026	Contact – Telephone calls made Conducted interview with Relatives B1, D1, and staff member, Saleemah Hawkins. Left voice messages for Relatives A1 and C1.
05/05/2026	Contact – Telephone calls made Left voice messages for Relatives A1 and C1.
05/05/2026	Exit Conference Discussed findings with licensee designee, Changming Wang.

ALLEGATION: The facility is not clean; there is litter and food on the floors and the kitchen sink.

INVESTIGATION: On 04/21/2026 and 04/22/2026, I conducted onsite inspections. I observed the facility to be neat and clean. I observed the facility living room, kitchen, two bathrooms, and resident bedrooms. All common areas of the facility, living room, kitchen, and bathrooms were neat and organized. The residents' bedrooms were organized according to the personal preferences of each resident.

On 04/21/20265, I conducted separate interviews with Residents A, B, and C. All stated that the facility is neat and clean. All reported that they had not observed litter or food on the floor nor the kitchen sink. Resident D was unable to participate in an interview due to cognitive delays, and per his resident file he is diagnosed with dementia.

On 04/23/2026, I conducted separate interviews with Relatives B1 and D1. Both reported that they visited Residents B and D on a monthly basis, and both stated they have observed the facility to be clean and neat. They stated they had not observed litter or food in the kitchen sink. Relative D1 stated he has observed individuals smoking outside on the front porch but never inside of the facility.

On 04/23/2026, I conducted an interview with staff member, Saleemah Hawkins. Ms. Hawkins reported that she is no longer employed by licensee designee, Changming Wang, and her last day at the facility was 04/16/2026. Ms. Hawkins stated she has observed the facility to be dirty, with cigarette butts and alcohol bottles laying around. When I asked Ms. Hawkins, specifically where she had observed the items, she stated they were observed in the basement, where staff members sleep. Ms. Hawkins denied that she had observed the previous stated items on the main floor of the facility, where the residents live and have use of.

On 05/05/2026, I conducted an exit conference with licensee designee, Changming Wang, and discussed my findings with him. Mr. Wang agreed with my findings and had nothing further to add.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff member, Saleemah Hawkins, and Residents, A, B, and C and Relatives B1 and D1, and observations of the facility on 04/21/2026 and 04/22/2026, there is no evidence to substantiate the allegation that the facility is not clean; there was neither litter nor food on the floors and the kitchen sink. Therefore, the housekeeping standards presented were comfortable, clean, and orderly in appearance on 04/21/2026 and 04/22/2006.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A did not receive his morphine as prescribed.

INVESTIGATION: On 04/22/2026, I conducted an interview with staff member, Simone Thomas. Ms. Thomas reported that Resident A passed away approximately one month ago, he received medical care, including medication through his assigned hospice agency and was prescribed morphine through a representative of that hospice agency. Ms. Thomas stated that Relative A1 was present during the day of Resident A's passing. Per Ms. Thomas, on the evening of Resident A's passing, medication that was prescribed to Resident A by the hospice agency was delivered and arrived at the facility, which included morphine. Per Ms. Thomas, she accepted the package, gave it to Relative A1 for safekeeping as the hospice representative had not arrived at the facility yet.

Ms. Thomas stated she checked on the other residents and then went to her room for the evening. Ms. Thomas stated she was informed by Relative A1 that Resident A passed away approximately at 3:30 a.m. and the funeral home collected his body at approximately 7:00 a.m. Ms. Thompson stated that Resident A's morphine medication did not remain in her possession nor did she administer the medication to Resident A. Ms. Thomas stated that all of Resident A's medication and belongings were taken from the facility by Relative A1.

On 04/22/2026, I reviewed Resident A's file and reviewed his medication administration logs. All of his medication administration logs were completed appropriately documenting Resident A received all medications as directed. There were no medications of Resident A present in the facility, as they had been removed by Relative A1 the day after his passing as reported by staff member, Simone Thomas.

On 04/23/2026, I conducted an interview with staff member, Saleemah Hawkins. Ms. Hawkins reported that she is no longer employed by licensee designee, Changming Wang, and her last day at the facility was 04/16/2026. Ms. Hawkins confirmed that Resident A did reside at the Sheridan Living adult foster care facility, however,

Resident A had passed away. Ms. Hawkins reported that she had neither observed staff member, Simone Thomas, have possession of Resident A's morphine nor had she observed Ms. Thomas administer morphine to Resident A.

Ms. Hawkins stated that Relative A1 stated to her that there was a "hole" in Resident A's morphine bottle. Ms. Hawkins could give no other information regarding Resident A's morphine medication.

On 04/23/2026 and 05/05/2026, I left voice messages with Relative A1 requesting a return phone call to conduct an interview. As of 05/05/2026, I have received no contact from Relative A1.

On 05/05/2026, I conducted an exit conference with licensee designee, Changming Wang, and discussed my findings with him. Mr. Wang agreed with my findings and had nothing further to add.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, Simone Thomas and Saleemah Hawkins, and a review of pertinent information relevant to this investigation, I find no evidence to support the allegation that Resident A did not receive his morphine as prescribed. Therefore, Resident A's medication was given as prescribed by a licensed health care professional.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/21/2026, I conducted an onsite inspection and staff member, Simone Thomas, was present. I requested the resident files from Ms. Thomas so that I could review them. Ms. Thomas stated she did not know where the resident files were.

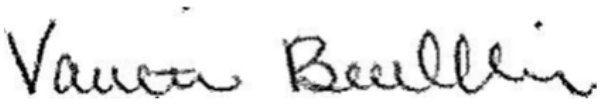
I contacted license designee, Changming Wang, and requested the resident files for my review. Mr. Wang stated the resident files were not present in the facility, but he would bring them to the facility for me to review them on 04/22/2026.

On 05/05/2026, I conducted an exit conference with licensee designee, Changming Wang, and discussed my findings with him. Mr. Wang agreed with my findings and had nothing further to add.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff member, Simone Thomas, and licensee designee, Changming Wang, and observation of the facility on 04/21/2026, there is enough evidence to substantiate the allegation that there were no resident records at the facility on 04/21/2026, as they were not made available as I requested on 04/21/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan, I recommend no change to the status of the license.



Vanita C. Bouldin
Licensing Consultant
Date: 05/05/2026

Approved By:

Ardra Hunter
Area Manager
Date: 05/14/2026