GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2025

Jennifer Ward
Special Tree Neuro Care Center Ltd.
Suite 2
10909 Hannan Road
Romulus, MI 48174

RE: License #: AL820313042
Investigation #: 2025A0992023
NeuroCare Center South

Dear Ms. Ward:

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) 456-0439.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820313042
Investigation #:	2025A0992023
Complaint Receipt Date:	04/09/2025
Investigation Initiation Date:	04/10/2025
Report Due Date:	06/08/2025
Licensee Name:	Special Tree Neuro Care Center Ltd.
Licensee Address:	39010 Chase Road Romulus, MI 48174
Licensee Telephone #:	(734) 239-1937
Administrator:	Jennifer Ward
Licensee Designee:	Megen McDonough
Name of Facility:	NeuroCare Center South
Facility Address:	39000 Chase Road Romulus, MI 48174
Facility Telephone #:	(734) 893-1000
Original Issuance Date:	08/07/2012
License **Status:**	REGULAR
Effective Date:	06/10/2024
Expiration Date:	06/09/2026
Capacity:	15

Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

ALLEGATION:

	Violation Established?
There are concerns Resident A was leaking spinal fluid for a substantial amount of time and he did not receive medical treatment. Resident A was neglected, and the staff did not provide adequate care. Resident A passed away.	No

II. METHODOLOGY

04/09/2025	Special Investigation Intake 2025A0992023
04/10/2025	Special Investigation Initiated – Telephone call made to Complainant
04/14/2025	Inspection Completed On-site- Licensee designee, Jennifer Ward and administrator Megan McDonough
05/01/2025	Contact - Telephone call made- Registered nurse, Amber Nagy, with Special Tree NeuroCare Center South.
05/01/2025	Contact - Telephone call made- Physician assistant, Kelly Long, with Special Tree NeuroCare Center South.
05/01/2025	Contact - Telephone call made- Internal case manager, Matt Stein, with Special Tree NeuroCare Center South.
05/05/2025	Contact - Telephone call received from Mr. Stein
05/19/2025	Contact - Telephone call made- Physician, Dr. Miriam Berri, consultant with Special Tree NeuroCare Center South. Dr. Berri was not available, message left.
05/21/2025	Contact - Telephone call made to Dr. Berri
05/21/2025	Contact - Document Sent- Dr. Berri's Administrative Assistant, Tiffany Miller.
06/04/2025	Contact - Telephone call received from Dr. Berri

06/06/2025	Contact - Telephone call received from Complainant
06/06/2025	Exit Conference with licensee Ms. Ward.

ALLEGATION: There are concerns Resident A was leaking spinal fluid for a substantial amount of time and he did not receive medical treatment. Resident A was neglected, and the staff did not provide adequate care. Resident A passed away.

INVESTIGATION: On 04/10/2025, I completed a telephone interview with Complainant. Complainant stated while visiting with Resident A she observed an excessive amount of fluid leaking from his nose. She stated Resident A was leaking fluid for 15 days, which was concerning. Complainant stated she expressed her concerns to the registered nurse, Amber Nagy. Complainant stated nurse Nagy performed a "napkin test". Complainant stated nurse Nagy explained that the "napkin test," is an unofficial test to determine if the fluid is spinal fluid or not. Complainant stated an official test was never performed and Resident A's physician was not notified. Complainant identified Resident A's physician as Dr. Miriam Berri with The University of Michigan. Complainant stated on the morning of 1/25/2024, the staff found Resident A in his room in distress; 911 was called and he was transported to Corewell Wayne Hospital. Complainant stated Resident A was immediately transferred to University of Michigan hospital and required emergency surgery, a shunt revision. Complainant stated it was later determined that the staff on shift failed to follow Resident A's plan of care and did not check on Resident A throughout the night. Complainant stated the staff were terminated. Complainant stated Resident A was neglected and not provided adequate care. Complainant stated after six weeks in the intensive care unit; Resident A passed away.

On 04/14/2025, I completed an unannounced onsite investigation and interviewed licensee designee, Jennifer Ward and administrator Megan McDonough regarding the allegation. Ms. Ward stated since a significant amount of time has lapsed, she would need to retrieve Resident A's records to address the allegation. Ms. Ward reviewed the records and confirmed Resident A was a former resident that was discharged on 2/24/2024, after a 30-day hospitalization. Ms. Ward stated Resident A did have postnasal drip, which was not concerning because he had a history of postnasal drip. However, she stated Relative A expressed concerns and the physician assistant (PA), Kelly Long, with Special Tree NeuroCare Center South and physician, Dr. Miriam Berri, consultant with Special Tree NeuroCare Center South were notified. Ms. Ward stated the "napkin test," is called a halo test. She stated a halo test is an unofficial test that nurses performed to determine if the fluid is spinal fluid. Ms. Ward stated she was not sure if any additional test were completed, and suggested I speak with Dr. Berri for more information. She stated there was a point when Resident A was prescribed allergy medication to address the postnasal drip

and after several doses, Relative A1 stated she noticed a difference. Ms. Ward stated on the morning of 1/25/2024, Resident A was found in his bedroom seizing. She stated the staff was unable to control the seizure and called 911. Ms. Ward stated Resident A was transported by the emergency medical services (EMS) to Corewell Wayne hospital and remained hospitalized. She stated after being hospitalized for several weeks; Resident A passed away. Ms. Ward stated the allegation resulted in a legal matter and an internal investigation was conducted. She stated during the investigation it was determined that the Staff 1, which was assigned to Resident A did not toilet Resident A between 1:00 a.m. to 2:00 a.m. as outlined in his service plan. She stated Staff 1 was terminated. Ms. Ward stated Resident A did not require hourly checks or any specific supervision requirements. She stated Resident A was provided quality care and he was seen by his physician as required and his medical team from the University of Michigan were actively involved in his care.

Megan McDonough provided statements consistent with the statements Ms. Ward provided during her interview. She stated Resident A had an extensive medical history and a medical team that was very involved in his care. She stated the postnasal drip was brought to the attention of PA Long and Dr. Berri. She stated once it was determined that the fluid was not spinal fluid, he was prescribed allergy medicine to treat the postnasal drip, and it seemed to work. Ms. McDonough explained that the allegation resulted in a legal matter and an internal investigation was conducted. She stated during the investigation it was discovered that Staff 1 was assigned to Resident A and did not fulfill her duties of toileting Resident A between 1:00 a.m. to 2:00 a.m. as outlined in his service plan. She stated as a result Staff 1 was terminated. However, Ms. McDonough stated Resident A's service plan does not include nightly checks such as every half hour or every hour. She stated on 1/25/2024, Resident A had a seizure and staff called 911. She stated Resident A remained hospitalized and was eventually discharged from the facility. Ms. McDonough stated it should be noted that at the time Resident A experienced a seizure he had been totally weaned off his seizure medication (Keppra) as recommended by Relative A1 and authorized by his neurosurgeon. She stated prior to Resident A being weaned off Keppra, he had not experienced a seizure.

On 05/01/2025, I interviewed registered nurse, Amber Nagy, with Special Tree NeuroCare Center South regarding the allegation. Nurse Nagy stated Resident A has always had chronic postnasal drip and hypersalivation since she came onboard in 10/2023. She stated Relative A1 did express concerns regarding Resident A's postnasal drip and a halo test was performed. She stated she is not sure if any additional testing was performed, but PA Long was notified. She stated to her knowledge the fluid was normal because she recalls Resident A being prescribed Claritin to treat the issue and Relative A1 stating it helped. Nurse Nagy stated she does not recall postnasal drip being an ongoing concern after the Claritin was prescribed. Nurse Nagy stated on 1/25/2024, Resident A had a seizure and was transported to the hospital. She stated she was totally caught off guard because the day before Resident A was active. She stated she had given him a task to complete

which he successfully completed, and he went to fitness. She stated there were no obvious signs or indicators that he was not feeling well or was going to have a seizure. As far as the staff being terminated, it was discovered that Staff 1 did not toilet Resident A as outlined in his service plan. She stated Staff 1's termination did not have anything to do with Resident A's medical needs. She stated Resident A had a medical team that was actively involved in his care, and he was often seen by his neurologist.

On 05/01/2025, I interviewed physician assistant, Kelly Long, with Special Tree NeuroCare Center South regarding the allegation. PA Long stated that Resident A had a catastrophic brain injury and multiple medical professionals were involved with his care. As it pertains to Resident A's chronic postnasal drip, she stated an official test was not performed in the facility, and the concern was deferred to the neurologist and Dr. Berri. She stated the official testing required is outside the scope of the facility. PA Long stated hydrocephalus is a buildup of fluid which is why a shunt is placed to assist with drainage which contradicts him having postnasal drip. PA Long stated Resident A experienced a seizure on 1/25/2024 and required a shunt revision; she stated he coded during the procedure. Relative A1 insisted Resident A's Keppra was discontinued and either his neurologist or Dr. Berri supported the decision. She stated she is aware Staff 1 failed to toilet Resident A, but that had nothing to do with Resident A's medical needs. PA Long explained that unfortunately individuals with traumatic brain injury (TBI) have an abundance of other health issues that may result in he/she is expiring.

On 05/05/2025, I interviewed Resident A's internal case manager, Matt Stein, with Special Tree NeuroCare Center South regarding the allegation. Mr. Stein stated as it pertains to postnasal drip, he is aware that a computerized tomography (CT) scan was completed on 12/12/2023 but was unsure of the outcome. He stated Dr. Berri or Neurosurgeon, Dr. Jacob Rahul Joseph would be able to provide additional information.

On 05/21/2025, I contacted Dr. Miriam Berri, consultant with Special Tree NeuroCare Center South regarding the allegation. Dr. Berri stated she was unable to address the allegation at this time. She suggested I contact her administrative assistant, Tiffany Miller to schedule a formal appointment to review Resident A's medical file and address the allegation.

On 05/21/2025, I contacted Ms. Miller, and an interview was schedule for 6/4/2025 to review Resident A's medical file and address the allegation with Dr. Berri.

On 06/04/2025, I received a call from Dr. Berri, and I interviewed her regarding the allegation. Dr. Berri stated Resident A had chronic postnasal drip. She stated every time someone's nose run, it is not spinal fluid. However, she stated she is not a neurosurgeon, so this matter was deferred to the neurosurgeon. She stated Resident A had a team of medical professionals involved in his care. Dr. Berri stated a test was done and CT scans were completed on multiple occasions as a part of his

care. Dr. Berri reviewed Resident A's medical history from 5/25/2023 to 1/25/2024. She provided an outline of his care and appointments with her and his neurology team. Dr. Berri stated the following:

> 5/25/2023 - A sample was collected from Resident A, which was normal. No medication prescribed.
>
> 7/20/2023 – Visit with Dr. Samuel Terman for seizure activity including tremors. Recommended weaning off Keppra. Keppra medication was changed.
>
> 8/17/2023 – Visit with Dr. Berri at facility. Resident A experiencing small tremors. No agitation. Continue seizure precautions and monitor.
>
> 9/12/2023 - Visit with Dr. Berri at facility. No agitation. No medication changes. Continue seizure precautions and monitor.
>
> 11/2/2023 - Visit with Dr. Berri at facility. Experiencing laughing spells. No agitation. Keppra discontinued per neurologist recommendation.
>
> 12/5/2023 – Visit with neurologist. Experiencing laughing spells. Right side of mouth hypersalivation. Discussed Parkinson's features. No medication changes.
>
> 12/7/2025- Visit with Dr. Berri at facility. No changes. Continue seizure precautions and monitor.
>
> 12/12/2023 - Visit with neurologist. CT scan completed. Discussion regarding cranial reconstruction, defects and risk. Stable. Follow-up in a year.
>
> 1/18/2024 - Visit with Dr. Berri at facility. Vitals stable. No changes. Plan to go home in the Spring. Follow-up in a year with neurologist.
>
> 1/25/2024 – Emergency department due to altered mental state. Found in his room shaking, was intubated due to rapid breathing. High White blood count. Transferred to the University of Michigan hospital. Seizure and fever. CT scan completed. Experience shunt failure. Examined by neurology. Shunt revision surgery. Administered Keppra. No infection noted. Transferred to intensive care unit (ICU).

Dr. Berri stated Resident A had multiple doctor appointments and the medical team were very involved in his care. She stated the facility did not neglect their duties as it pertains to his care. She stated any time the pressure in the brain change, it can cause a seizure. She stated Resident A experienced a shunt malfunction, which is a

physical problem. She stated individuals with shunts are susceptible to such complications.

On 6/6/2025, I reviewed Resident A's adult foster assessment plan and service plan. The assessment plan and service plan does not include specific language as it pertains to supervision. As far as toileting the assessment plan states, "staff will assist" and the service plan states, "Client (Resident A) should be taken to the bathroom between 1-2 am." Resident A was not toileted between 1-2 am as outlined in his service plan.

On 06/06/2025, I contacted Complainant and explained that based on the investigative findings, I am unable to determine that the direct care staff neglected Resident A as it pertains to his medical needs. I explained that based on the investigative findings, both PA Long and Dr. Berri confirmed they were aware of postnasal drip concerns. There were a team of medical professionals involved in Resident A's treatment and CT scans were completed. As it pertains to the staff not following Resident A's assessment plan and service plan, there is evidence to support the allegation that Staff 1 failed to toilet Resident A between 1:00-2:00 a.m. as outlined in his service plan.

On 06/06/2025, I completed an exit conference Ms. Ward. I explained that based on the investigative findings, I am unable to determine that Resident A personal needs, including protection and safety were not attended to. Based on the investigative findings, that PA Long was notified and Dr. Berri regarding the concerns of the chronic postnasal drip. There were a team of medical professionals involved in Resident A's treatment and CT scans were completed. As it pertains to Staff 1 not following Resident A's assessment and/or service plan, there is sufficient evidence to support the allegation.

APPLICABLE RULE	
R 400.15305	**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 upon my investigation, which consisted of multiple interviews with facility members and a review of pertinent documentation relevant to this investigation, there is not enough evidence to substantiate the allegation that Resident A's personal needs, including protection and safety, shall be attended to at all times. Dr. Berri and PA Long indicated that Resident A had a catastrophic brain injury and although multiple medical professionals were involved with his care Resident A, experienced a shunt malfunction. The allegation is not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	It has been established that direct care worker did not provide Resident A with personal care as specified in his service plan. I reviewed Resident A's adult foster assessment plan and service plan. The assessment plan or service plan does not include specific language as it pertains to supervision. As far as toileting the assessment plan states, "staff will assist" and the service plan states, "Client (Resident A) should be taken to the bathroom between 1-2 am." Resident A was not toileted as outlined in his service plan. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of the license remain unchanged

6/09/2025

Denasha Walker Date
Licensing Consultant

Approved By:

06/12/2025

Dawn Timm Date
Area Manager