GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2025

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

RE: License #: AL820313042
Investigation #: 2025A0116015
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) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820313042
Investigation #:	2025A0116015
Complaint Receipt Date:	02/21/2025
Investigation Initiation Date:	02/24/2025
Report Due Date:	04/22/2025
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:	Jennifer Ward
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

II. ALLEGATION(S)

	Violation Established?
Staff, Tiffany Jennings, punched Resident A in the arm twice, after her and Resident A had a verbal altercation while she was showering him. The incident was witnessed by another staff.	Yes

III. METHODOLOGY

02/21/2025	Special Investigation Intake 2025A0116015
02/21/2025	Contact - Telephone call made Interviewed licensee designee, Jennifer Ward.
02/24/2025	Special Investigation Initiated - Telephone Interviewed Guardian A1.
02/26/2025	Inspection Completed On-site Interviewed Resident A along with assigned APS investigator, Jodi Nicoletti. Spoke with licensee designee, Jennifer Ward.
03/03/2025	Contact - Telephone call made Interviewed staff, Milan Stefani.
03/03/2025	Contact - Telephone call made Left a message for staff, Tiffany Jennings, requesting a return call.
03/04/2025	Inspection Completed-BCAL Sub. Compliance
03/04/2025	Exit Conference With licensee designee, Jennifer Ward.

ALLEGATION:

Staff, Tiffany Jennings, punched Resident A in the arm twice, after her and Resident A had a verbal altercation while she was showering him. The incident was witnessed by another staff.

INVESTIGATION:

On 02/21/25, I interviewed licensee designee, Jennifer Ward, after receiving an incident report documenting that staff, Tiffany Jennings, punched Resident A in his arm during his shower and popped him in the mouth. Ms. Ward reported that the incident occurred on 02/19/25, and staff, Milan Stefani, witnessed the incident and reported it to facility nurse, Amber Furlong, on 02/20/25. Ms. Ward reported that she has conducted an internal investigation and determined that the incident happened, and she has suspended, staff, Tiffany Jennings, pending the external investigations. Ms. Ward reported that she observed two bruises on the top portion of Resident A's right arm. Ms. Ward denied observing any marks/bruises/cuts to Resident A's mouth/lip.

Ms. Ward reported she has a meeting scheduled with Ms. Jennings Monday 02/24/25 at 2:00 p.m. to hear her side of the story and make a final decision as to her employment status. Ms. Ward reported that she would be filing an APS complaint as well. Ms. Ward provided the contact information for Resident A's guardian and reported that he visits with his guardian every Sunday and returns on Wednesday.

On 02/24/25, I interviewed Guardian A1, and she reported that Ms. Ward informed her of the incident with Resident A and she reported, "I am sick to my stomach at the thought of someone hurting (Resident A)." Guardian A1 reported that this is the first time anything like this has happened since Resident A has lived in the facility and reported she has not had any concerns in the past about the care provided. Guardian A1 reported that she is undecided now about Resident A returning to the facility. Guardian A1 reported that she knows for certain if the staff, who hit Resident A remains employed there, she will not return him. Guardian A1 reported that Resident A is at her home and reported that he has bruises on his right arm and a cut on his lip. Guardian A1 reported that if she decides to return Resident A to the facility, she will have him there Wednesday 02/26/25, by 3:00 p.m. Guardian A1 also reported that due to Resident A's brain injury and cognitive delays he will not be able to recall or verbalize what happened to him.

On 02/26/25, I conducted a scheduled onsite inspection and interviewed Resident A. Assigned APS investigator, Jodi Nicoletti, was present at the facility so a joint interview was conducted. Resident A was not able to recall or verbalize what happened and does not remember being hit. Resident A no longer had visible bruises on his right arm, or the cut on his lip.

I spoke with licensee designee, Jennifer Ward, and she reported that staff, Tiffany Jennings, was a no show for the scheduled meeting on 02/24/25, and has since been terminated. Ms. Ward reported that Ms. Jennings had been employed at the facility since 03/04/24, and reported there has not been any previous incidents or concerns regarding resident care. Ms. Ward reported that Ms. Jennings was fully trained and passed all required background checks. I reviewed the training transcript

of Ms. Jennings and confirmed that she was fully trained in all required areas and had been working in this field since 2007. Ms. Ward also showed me and APS investigator, Ms. Nicoletti, pictures of the two bruises on Resident A's right upper arm, that were taken on 02/20/25, a day after the incident.

On 03/03/25, I interviewed staff, Milan Stefani, and she reported that she has been employed at the facility for a little over a month. Ms. Stefani reported that on 02/19/25, she was assisting staff, Tiffany Jennings, shower Resident A, when he began to get upset because he did not like the way Ms. Jennings was washing him. Ms. Stefani reported that Resident A likes the washcloth to be fully open and wants to be washed a certain way or he will get frustrated. Ms. Stefani reported that Resident A began to yell at Ms. Jennings and then pushed her, Ms. Stefani reported that Ms. Jennings became frustrated and told Resident A not to do that again. Ms. Stefani reported that Resident A hit her again and Ms. Jennings with a closed hand punched Resident A twice in the right upper arm area and then popped him in the mouth with an open hand because he was yelling and screaming at her. Ms. Stefani reported that she was very uncomfortable and shocked to see staff hit a Resident. Ms. Stefani reported she did not know what to do initially but remembered her training and knew that reporting it was the right thing to do. Ms. Stefani reported that the following day she reported the incident to Amber Furlong, once of the nurses at the facility. Ms. Stefani reported that no one deserves to be treated that way. Ms. Stefani was very emotional during the interview.

On 03/04/25, I conducted the exit conference with licensee designee, Jennifer Ward and informed her of the findings of the investigation. Ms. Ward reported an understanding and stated that she would submit an acceptable corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based on the findings of the investigation, which included interviews of licensee designee, Jennifer Ward, Guardian A1, and staff, Milan Stefani, I am able to corroborate the allegation. Ms. Ward reported being made aware of the incident by facility nurse, Amber Furlong, and observing the bruises to Resident A's upper right arm area. Guardian A1 reported that she was contacted by Jennifer Ward and was told that a staff had punched Resident A twice in the upper right arm and popped in the mouth, while being showered. Guardian A1 reported that she observed the bruises on Resident A's arm and observed a cut to his lip. Staff, Milan Stefani, reported that she was assisting staff, Tiffany Jennings, with Resident A's shower and witnessed her get frustrated with Resident A, after he yelled at her for not washing him the way he wanted to be washed. Ms. Stefani reported Ms. Jennings punched Resident A with a closed hand/fist twice in the right upper arm and popped him in the mouth because he was yelling and screaming at her.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/06/25

Pandrea Robinson
Licensing Consultant

Date

Approved By:

03/06/25

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Ardra Hunter
Area Manager

Date