GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2025

Timotei Pecura
11469 N Haggery Rd
Plymouth, MI 48170

RE: License #: AS820418173
Investigation #: 2025A0122014
SERENE UNITY HOME CARE

Dear Mr. Pecura:

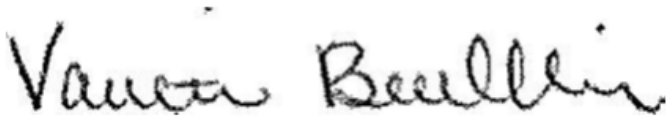
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS820418173
Investigation #:	2025A0122014
Complaint Receipt Date:	01/20/2025
Investigation Initiation Date:	01/22/2025
Report Due Date:	02/19/2025
Licensee Name:	Timotei Pecura
Licensee Address:	11469 N Haggery Rd Plymouth, MI 48170
Licensee Telephone #:	(312) 202-2552
Administrator:	N/A
Licensee Designee:	Timotei Pecura
Name of Facility:	SERENE UNITY HOME CARE
Facility Address:	11469 N Haggerty Rd. Plymouth, MI 48170
Facility Telephone #:	(312) 202-2552
Original Issuance Date:	11/19/2024
License Status:	TEMPORARY
Effective Date:	11/19/2024
Expiration Date:	05/18/2025
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide personal care to Resident A.	No
Staff did not follow physician directions for Resident A's wound care.	Yes

III. METHODOLOGY

01/20/2025	Special Investigation Intake 2025A0122014
01/22/2025	Special Investigation Initiated - On Site Reviewed Resident A's file.
01/23/2025	Contact – Telephone call made Completed interview with Complainant 1. Completed interview with Corpore Sano Home Health nurse, Liz Smith.
01/23/2025	Contact – Document sent Sent email requesting information from Complainant 1.
01/26/2025	Contact – Document received Email – statement received from Complainant 1.
01/27/2025	Contact – Telephone call made Completed interview with licensee designee, Tim Pecura. Requested documentation from licensee designee, Tim Pecura.
01/28/2025 01/31/2025	Contact – Document sent Email to Home Health Agency, Corpore Sano – requesting information.

02/03/2025	APS Referral
02/03/2025	Exit Conference Discussed findings with licensee designee, Tim Pecura.

ALLEGATION: Staff failed to provide personal care to Resident A.

INVESTIGATION: On 01/22/2025, I completed interviews with licensee designee, Tom Pecura, and staff, Rachel Pecura. Ms. Pecura confirmed that she completed personal care for Resident A. Ms. Pecura stated Resident A received two showers per week and daily sponge baths. Ms. Pecura reported that Resident A was compliant with her hygiene tasks and denied that she failed to provide Resident A with personal care. Tom Pecura reported the same.

On 01/22/2025, I completed an on-site inspection. I observed three residents in the facility living room and 1 resident in her bedroom visiting with a relative. I observed all residents to be clean, appropriately dressed for the weather, showing no signs of discomfort or distress. There were no odors coming from the residents or the facility which would suggest that residents personal care tasks are not being attended to.

On 01/23/2025, I completed an interview with Complainant 1. Complainant 1 reported the following, staff failed to bathe Resident A regularly and she was often left sitting in soiled diapers for extended periods of time. Complainant 1 gave no dates nor times of his observations of Resident A in this alleged condition.

Complainant 1 reported that Resident A is deceased and therefore I was unable to interview her.

On 02/03/2025, I completed an exit conference with licensee designee, Tom Pecura, and discussed my findings. Mr. Pecura stated he understood my findings.

APPLICABLE RULE	
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 upon my investigation, which consisted of interviews with staff member, Rachel Pecura, licensee designee, Tim Pecura, and Complainant 1 and onsite inspection there is insufficient evidence to substantiate the allegations that staff failed to provide personal care to Resident A. On 01/22/2025, I observed the residents as being clean, appropriately dressed for the weather, showing no signs of discomfort or distress. Both residents and the facility were free from odors which confirmed that residents' personal needs are being attended to.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff did not follow physician directions for Resident A's wound care.

INVESTIGATION: On 01/22/2025, I reviewed Resident A's file, including physician orders and medication administration sheets. Resident A was admitted on 08/26/2024, and the following wound care order was documented on Resident A's Wellbridge of Novi LLC Order Summary Report dated 08/26/2024, "Wound care bilateral buttock pressure ulcer, cleanse with soap and water, pat dry. Apply barrier cream every shift."

On 01/22/2025, I reviewed Resident A's medication administration records for August 2024 and September 2024, my review disclosed no documentation that Resident A's wound care had been provided. My review showed no documentation of a barrier cream listed, no staff initials to verify administration of prescribed barrier cream, nor does the records list staff initials to document the wound was cleansed every shift.

On 01/23/2025, I contacted Corpore Sano Home Health nurse, Liz Smith. Ms. Smith confirmed that she worked with Resident A providing skilled nursing services only but denied assessing or providing wound care to Resident A.

On 01/23/2025, I completed an interview with Complainant 1. Complainant 1 stated that Resident A's wounds developed while she was living in the facility, but could not report what physician instructions were given to Rachel or Tom Pecura to provide wound care to Resident A.

On 01/27/2025, I completed an interview with licensee designee, Tim Pecura. Mr. Pecura confirmed that Resident A was admitted on 08/26/2024 and that he used Resident A's Wellbridge of Novi LLC Order Summary Report dated 08/26/2024 to determine Resident A's medication orders. Mr. Pecura stated that Resident A did not have a wound on her buttocks at the time of admission, a barrier cream was not listed under her prescribed medication orders, and he did not receive all of Resident A's medications from Wellbridge of Novi.

Mr. Pecura reported that he had a physician from Corpore Sano Home Health Care, Inc. complete an assessment on Resident A, so that prescription orders for Resident A's missing medication could be obtained. I requested a copy of the physician assessment. Mr. Pecura stated he did not have a copy of the physician assessment in Resident A's file but that one could be obtained from Corpore Sano Home Health Care, Inc. As of 02/03/2025, Mr. Pecura has not submitted a physician assessment completed by a representative of Corpore Sano Home Health Care, Inc.

On 01/28/2025 and 01/31/2025, I sent an email to Corpore Sano Home Health Care, Inc. requesting a copy of an initial physician assessment/initial contact note completed by a representative of Corpore Sano Home Health Care, Inc. for Resident A. As of 02/03/2025, I have had no contact from a representative nor have I received the requested information from a representative of Corpore Sano Home Health Care, Inc.

During my review of Resident A's file, I observed no documentation of a verbal/written order from medical personnel stating Resident A did not have wounds on her buttocks nor were there an order from medical personnel discontinuing the wound care orders written on 08/26/2024.

On 02/03/2025, I completed an exit conference with licensee designee, Tim Pecura, and discussed my findings. Mr. Pecura stated he understood my findings and would submit a corrective action plan to address the rule violation found.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based upon my investigation, which consisted of interviews with staff member, Rachel Pecura, licensee designee, Tim Pecura, and Complainant 1, and review of pertinent documentation relevant to this investigation, there is sufficient evidence to substantiate the allegation that staff did not follow physician directions for Resident A's wound care. After reviewing Resident A's Wellbridge of Novi LLC Order Summary Report dated 08/26/2024, medication administration records dated August and September 2024, there is no evidence to document staff applied barrier cream to her bilateral buttock pressure ulcer every shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Vanita C. Bouldin
Licensing Consultant
Date: 02/04/2025

Approved By:

Ardra Hunter
Area Manager
Date: 02/04/2025