GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 25, 2022

Dornita Elder
Time of Refreshing LLC
27660 Vermont
Southfield, MI 48076

RE: License #: AS630306304
Investigation #: 2022A0991023
Time of Refreshing

Dear Ms. Elder:

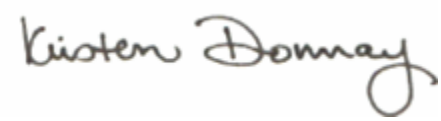
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630306304
Investigation #:	2022A0991023
Complaint Receipt Date:	04/06/2022
Investigation Initiation Date:	04/07/2022
Report Due Date:	06/05/2022
Licensee Name:	Time of Refreshing LLC
Licensee Address:	27660 Vermont Southfield, MI 48076
Licensee Telephone #:	(313) 220-1117
Licensee Designee:	Dornita Elder
Name of Facility:	Time of Refreshing
Facility Address:	27660 Vermont Southfield, MI 48076
Facility Telephone #:	(313) 220-1117
Original Issuance Date:	04/26/2010
License Status:	REGULAR
Effective Date:	03/01/2021
Expiration Date:	02/28/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is being verbally abused at the home. Staff are cruel and rude, and Resident A feels staff want to kill her.	No
Resident A's money was stolen.	No
Additional Findings	Yes

III. METHODOLOGY

04/06/2022	Special Investigation Intake 2022A0991023
04/06/2022	APS Referral Received referral from Adult Protective Services (APS) - denied for investigation
04/07/2022	Special Investigation Initiated - Telephone Call to licensee designee, Dornita Elder
04/11/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed staff, licensee designee, and Resident A
04/11/2022	Contact- Document Received Copies of Resident A’s cash accounting record
04/11/2022	Contact- Telephone call made Left message for Resident A’s relative
05/24/2022	Exit Conference Via telephone with licensee designee, Dornita Elder

ALLEGATION:

Resident A is being verbally abused at the home. Staff are cruel and rude, and Resident A feels staff want to kill her.

INVESTIGATION:

On 04/06/22, I received a complaint from Adult Protective Services (APS) alleging that staff at Time of Refreshing are verbally abusive towards Resident A and that Resident A feels staff want to kill her. The complaint indicated that direct care worker, Yolanda, is cruel and rude to Resident A. APS denied the complaint for investigation. Allegations about staff, Yolanda and Gail, being verbally abusive towards Resident A were previously investigated in SIR #: 2021A0991023 and were not substantiated.

I initiated my investigation on 04/07/22, by contacting the licensee designee, Dornita Elder, via telephone. Ms. Elder stated that Resident A has been unstable lately. Resident A takes several medications and has recently been going to the store and buying caffeine pills. Ms. Elder stated that she noticed that Resident A was shaking very badly, and she discovered that Resident A had been hiding caffeine pills in her bra and in band aid boxes in her bedroom after returning from the store. Resident A is her own guardian and has community access. Ms. Elder stated that she took Resident A to the doctor, and the doctor explained that the caffeine pills are working against Resident A's medications. Ms. Elder stated that Resident A has a history of making up allegations and gets upset when staff try to set boundaries. She did not have any concerns about any staff being verbally aggressive towards Resident A. Ms. Elder stated that staff, Yolanda, no longer works in the home.

On 04/11/22, I conducted an unannounced onsite inspection at Time of Refreshing. I interviewed Resident A. Resident A stated that she feels emotionally abused. She stated that "life isn't appreciated in the home." She feels insulted and unappreciated, and staff are rude to her. She stated that Gail tells her that she is not staff, she is just a resident. Resident A stated that staff tell her that she is making too much noise or to get her elbows off the table. It feels like staff want to kill her because they make a big deal about nothing. Staff put forks and napkins on the table and say, "Don't touch that." Resident A reported that staff, Yolanda, left in May 2021 and no longer works in the home. Resident A reported that she is her own guardian. She stated that she takes her medications, but they make her sleepy, so she bought caffeine pills.

On 04/11/22, I interviewed direct care worker, Tyiasha Carswell. Ms. Carswell indicated that she started working at Time of Refreshing one month ago and is still being trained. She stated that never heard anyone being rude or disrespectful towards Resident A. She has a good relationship with Resident A, but Resident A likes to talk non-stop. She stated that she redirects Resident A by asking her to take a seat and be quiet. Ms. Carswell stated that Resident A never reported to her that she felt like staff wanted to kill her. She did not have any concerns about any of the staff in the home.

On 04/11/22, I interviewed Delois Foster. Ms. Foster indicated that she is not a direct care worker in the home, but she helps the licensee designee, Dornita Elder, and will come sit with the residents if Ms. Elder needs to run errands or go to the store. Ms. Foster stated that Ms. Elder is usually in the home, but she fills in whenever she is needed. Ms. Foster stated that she never heard anyone being disrespectful to Resident

A or say that they want to kill her. She stated that staff are not verbally aggressive towards Resident A. Ms. Foster stated that she tries to listen to Resident A, but Resident A's mood changes frequently. Ms. Foster stated that she did not have any concerns about anyone in the home.

On 04/11/22, I interviewed the licensee designee, Dornita Elder. Ms. Elder reiterated that Resident A has been unstable lately due to secretly taking caffeine pills. According to the doctor, these pills were counteracting Resident A's medications. Ms. Elder stated that she did not have any concerns about staff being verbally abusive or suggesting that they want to kill Resident A. Ms. Elder stated that if staff made these types of comments, they would not be allowed to work in her home. She stated that Resident A is very preoccupied with death. Resident A also rants and rages whenever anybody tries to set boundaries.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A is being verbally abused or subjected to mental or emotional cruelty. The licensee designee and staff who were interviewed had no knowledge of staff being verbally abusive towards Resident A. The licensee designee indicated that Resident A was recently taking caffeine pills in secret, which was counteracting her prescribed medications and causing Resident A to be unstable. Resident A stated that it feels like staff want to kill her or are being emotionally abusive; however, the examples that she provided were in line with staff redirecting her or asking her not to do something.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A's money was stolen.

INVESTIGATION:

On 04/11/22, I conducted an unannounced onsite inspection at Time of Refreshing. I interviewed Resident A. Resident A stated that she is her own guardian. Her sister controls her money and gives money to Resident A to spend. Resident A stated that staff took $80 from her. Resident A reported that on 03/09/22, she had $925. On 03/10/22, she only had $845. Resident A reported that $80 was missing and she did not spend it. She stated that she had $500 in her black purse that was in her book bag. Resident A indicated that she knew staff took her money because she was $80 short. Delois was working on the day her money went missing. Resident A stated that on 04/05/22, she went to the bank and got around $100. On 04/10/22, she counted her money and had $893. During the onsite inspection, Resident A counted her money. She had $500 in cash that was in a black zipper pouch. She had $380 in an envelope and $13 in a wallet, which added up to $893. Resident A stated that she keeps track of her money. She showed the back of two receipts where she was writing dates and amounts of money; however, it did not list her expenses or deposits. There were no entries for March 2022 until 03/20/22, at which time she had $867.

On 04/11/22, I interviewed the licensee designee, Dornita Elder. Ms. Elder stated that Resident A manages her own money. Staff do not manage any of Resident A’s funds or cash on hand. Ms. Elder stated that Resident A gets money from her sister. Ms. Elder has been telling Resident A’s sister for years that Resident A does not need that much money. Resident A is her own guardian and has access to the community. She goes out and shops and brings stuff back to the home. Resident A reported to Ms. Elder that she was missing $60. She later reported that it was $80 that was missing. Ms. Elder stated that Resident A keeps her money in different envelopes. She told Resident A to put all of her money in one spot, but Resident A chooses not to do this. Ms. Elder stated that she did not take any money from Resident A and she does not believe that any staff person took money from Resident A. Ms. Elder stated that none of the other residents in the home would have the ability to steal money from Resident A.

On 04/11/22, I interviewed direct care worker, Tyiasha Carswell. Ms. Carswell stated that she did not know anything about Resident A’s missing money. Resident A did not tell her that she was missing money. She stated that she did not know that Resident A even had money. She has never seen Resident A with money. She does not take Resident A shopping or handle any of her cash. Resident A goes out on her own.

On 04/11/22, I interviewed Delois Foster. Ms. Foster stated that Resident A recently reported to her that some of her money was missing. She told her that $60 or $80 was missing. Ms. Foster stated that she had no idea what happened to Resident A’s money. She did not take any money from Resident A. She never handles Resident A’s cash. Resident A goes out shopping and spends her own money.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff took money from Resident A. The licensee designee and staff who were interviewed denied taking any money from Resident A. They do not handle any of Resident A's cash. Resident A manages her own money and has community access, so she often goes shopping on her own. Resident A claimed that $80 was missing, but this information could not be verified, as Resident A was storing her money in different envelopes, purses, and wallets. Resident A was tracking her money on the back of receipts, but her accounting record did not clearly show her expenditures or deposits.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/11/22, I conducted an unannounced onsite inspection. When I arrived at the home, Tyiasha Carswell and Delois Foster were present. Ms. Carswell indicated that she began working in the home earlier this month. She stated that she is still in the process of being trained and always works with another staff person. Ms. Foster indicated that she is not a staff person in the home. She volunteers and comes to the home to sit with the residents if the licensee designee, Dornita Elder, needs to go to the store or run errands. Ms. Foster stated that she had completed some training and was fingerprinted. She stated that Ms. Elder is usually at the home, but she fills in whenever she is needed. During the onsite inspection, Ms. Elder arrived at the home. She stated that most of the time she is at the home, but Ms. Foster is a volunteer and will fill in if she needs to go out for a few minutes. She did not have a staff file for Ms. Foster.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(3) Any individual, including a volunteer, shall not be considered in determining the ratio of direct care staff to residents unless the individual meets the qualifications of a direct care staff member.
ANALYSIS:	Based on the information gathered during my investigation, there is sufficient information to conclude that on 04/11/22 Tyiasha Carswell and Delois Foster were alone with the residents for a period of time before the licensee designee returned to the home. Ms. Carswell is a new employee who was not fully trained at the time of the onsite inspection. Ms. Foster indicated that she is a volunteer and sits with the residents when the licensee designee needs to run errands. There was no staff file for Ms. Foster and it could not be determined if she met all of the qualifications of a direct care staff member.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection, I observed a stair lift installed on the staircase leading to the second floor. The licensee designee, Dornita Elder, indicated that she had the stair lift installed when Resident B moved into the home about four months ago, after she closed another facility where Resident B had been residing. Resident B uses a wheelchair full time. I observed Resident B sitting at the kitchen table in her wheelchair during the onsite inspection. The facility is not wheelchair accessible. There is a step down into the living room area and the egress doors are not equipped with ramps. Ms. Elder indicated that they have portable ramps for egress. Resident B's bedroom is located on the second floor of the home. Ms. Elder stated that Resident B has a wheelchair that they keep upstairs as well.

On 05/24/22, I conducted an exit conference via telephone with the licensee designee, Dornita Elder. Ms. Elder indicated that she would submit a corrective action plan to address the violations. She stated that Resident B had been in her care for eight years, but she would contact Resident B's relatives about locating another placement for her. Ms. Elder also stated that she spoke with Resident A's relative about limiting the amount of cash that she receives each month. I provided technical assistance to Ms. Elder regarding training and qualifications for staff or volunteers. I informed Ms. Elder that any staff person or volunteer must be fully trained and meet all staff qualifications if they are going to be left alone with the residents.

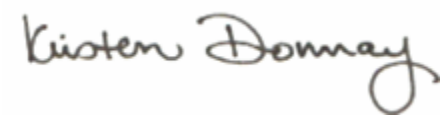
APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the physical accommodations to meet Resident B's needs were not available in the home. The facility is not equipped for residents who utilize wheelchairs, as the bedrooms are located on the second floor, there is a step down into the living room area, and the means of egress are not equipped with ramps.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14405	**Living space.**
	(3) Living, dining, bathroom, and sleeping areas used by residents who have impaired mobility shall be accessible and located on the street floor level of the home that contains the required means of egress.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the living, bathing, and sleeping areas were not accessible to Resident B who has impaired mobility and uses a wheelchair. The sleeping area for Resident B was located above the street floor, and the licensee designee installed a chair lift for Resident B to access the second floor of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14509	**Means of egress; wheelchairs.**
	(1) Small group homes that accommodate residents who regularly require wheelchairs shall be equipped with ramps that are located at 2 approved means of egress from the first floor.
ANALYSIS:	During the onsite inspection, I observed that Resident B was using a wheelchair and the facility was not equipped with ramps at the two approved means of egress from the first floor. The licensee designee indicated that they have portable ramps that they can use for Resident B if she needs to leave the home; however, the ramps were not permanently installed at the means of egress.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

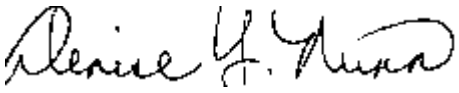


05/24/2022

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



05/25/2022

_____

Denise Y. Nunn Date
Area Manager