STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS

In the matter of

License #: AF130305310
SIR #: 2018A0783044

Bobbi Greenwood-Easter

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ORDER OF SUMMARY SUSPENSION
AND NOTICE OF INTENT TO REVOKE LICENSE

The Michigan Department of Licensing and Regulatory Affairs, by Jay Calewarts, Division Director, Adult Foster Care and Camps Licensing Division, Bureau of Community and Health Systems, orders the summary suspension and provides notice of the intent to revoke the license of Licensee, Bobbi Greenwood-Easter, to operate an adult foster care family home pursuant to the authority of the Adult Foster Care Facility Licensing Act, 1979 PA 218, as amended, MCL 400.701 et seq., for the following reasons:

1. On or about January 7, 2010, Licensee was issued a license to operate an adult foster care family home with a licensed capacity of six at 11303 West Drive North, Bellevue, Michigan 49021.
2. Prior to the issuance of the license, and during subsequent modifications of the statutes and rules, Licensee received copies of the Adult Foster Care Facility Licensing Act and the licensing rule book for

adult foster care family homes. The Act and rule book are posted and available for download at www.michigan.gov/lara.

Previous Licensing Violations

3. On December 7, 2017, Licensing Consultant Stephanie Gonzalez initiated *Special Investigation #2018A0465008* after the Bureau received a licensing-related complaint and cited Licensee, in part, for failing to destroy or dispose of discontinued resident medication, as required by Rule 400.1418(7). During an on-site investigation on December 19, 2017, Ms. Gonzalez observed a resident's prescription for nystatin that was not listed on the resident's medication record. Licensee acknowledged that the resident was no longer prescribed nystatin but that she was keeping the medication in case she was prescribed it again in the future.
4. On February 9, 2018, Ms. Gonzalez issued *Special Investigation Report #2018A0465008* recommending the issuance of a six-month, first provisional license upon receipt of an acceptable written corrective action plan. Licensee accepted a first provisional license, which was issued effective February 28, 2018.

Current Allegations

5. Licensee lacks the good moral character to operate an adult foster care home in a fair, honest, and open manner, as demonstrated by the following:

Incident Involving Resident J and $6,100

a. On June 15, 2018, Resident J was admitted to Licensee's home. On June 16, 2018, Resident J gave Licensee a check for $3,350 to provide one month of care from June 16, 2018, until July 16, 2018.

b. On or about June 16, 2018, shortly after Resident J was admitted to the home, Licensee asked Resident J for a loan of $6,000 so she could pay employees. Resident J agreed to loan Licensee the money for a few weeks.

c. On or about June 20, 2018, Licensee came into Resident J's room during the night with a check from Resident J's checkbook that Licensee completed herself in the amount of $6,100. Resident J signed the check, and Licensee received the money. Licensee later told him that it the money was not a loan but rather for two additional months of respite care at the home, which Resident J did not want.

d. On August 1, 2018, during an interview with Ms. Barner, Licensee denied borrowing money from Resident J and stated that Resident J wrote her a check for $6,100 for two months of respite care.

e. On July 13, 2018, Resident J left Licensee's home.

f. On July 15, 2018, Resident J called Licensee who agreed to refund him the fee for one of the two months for which he unwillingly paid in advance. Licensee did not refund any portion of the $6,100 that she claimed was for respite care.

g. On July 20, 2018, during an interview with Ms. Barner, Licensee stated she had not refunded any of the money back to Resident J because

she believes that he will be returning to the home at some point. Licensee stated that she normally does not issue refunds but that she would in this case.

h. On August 1, 2018, Ms. Barner contacted Licensee who reported that Resident J had not returned to the home but she had not heard directly from him.

i. On August 2, 2018, Resident J telephoned Licensee and informed her that he would not be returning to the home and requested a refund as previously agreed. Licensee hung up on Resident J after he requested the refund.

Incident Involving Resident F and Black SUV

j. In February 2018, Licensee obtained power of attorney for Resident F. The *Power of Attorney Not Affected By Disability* document was signed and notarized on February 22, 2012. At the bottom of the last page of the document, a second signature was added for Resident F on January 6, 2018, indicating that it was reaffirming the document.

k. In or around June 2018, Licensee obtained financing and purchased a black SUV from Caron Chevrolet in Resident F's name. Licensee obtained a car loan for $33,263.44 with an interest rate of 4.14 percent from Chemical Bank in Resident F's name.

l. Licensee purchased the black SUV solely for her own personal use and without Resident F's knowledge, as evidenced by the following:

i. Resident F does not have a driver's license and is unable to drive a vehicle. Resident F uses a walker to ambulate and can only be transported in a "handi-van," or a wheelchair transport van.

ii. After purchasing the vehicle, Licensee added lettering decals to the vehicle advertising Main Street Eatery in Bellevue, a business owned by the Licensee.

m. On August 1, 2018, Ms. Gonzalez conducted an on-site investigation at the home and interviewed Resident F. Resident F stated that Licensee did not manage her finances, responding, "Bobbi does not manage my money. She tried to once but I told her no, and the bank said they wouldn't let that happen." When Ms. Gonzalez showed her the power of attorney document, Resident F stated that she did not remember signing it and again denied giving Licensee permission to access and manage her finances. Resident F stated that she does not own a vehicle and denied signing any paperwork agreeing to purchase a vehicle.

n. On August 1, 2018, during an interview, Licensee identified the black SUV as her vehicle to Ms. Gonzalez. She stated that the vehicle is in Resident F's name but that it is "both of ours." Licensee stated that the vehicle loan with the bank was only in Resident F's name, and that she used the vehicle to transport Resident F to her appointments and to go shopping, despite Resident F stating that she is unable to be

transported in a regular vehicle. Licensee told Ms. Gonzalez that she pays the monthly payment on the loan but provided no documentation or evidence showing how the payments are made.

6. Licensee failed to return residents' funds and valuables to the residents within five days of his or her discharge from the home, as evidenced by the following:
    a. On or about June 16, 2018, shortly after Resident J was admitted to the home, Licensee offered to buy Resident J's portable air conditioner for $200 due to the air conditioner at the home not working properly. Resident J never received the $200 from Licensee.
    b. On July 13, 2018, Resident J was discharged from the home. Licensee did not give Resident J the $200 for the air conditioner and did not return his portable air conditioner to him.
    c. On July 20, 2018, during an on-site inspection, Ms. Barner observed Resident J's portable air conditioner in the basement of the home. Licensee acknowledged that the unit belonged to Resident J and stated that she would return it to him later that day.
    d. On August 1, 2018, during another on-site inspection, Ms. Barner observed Resident J's air conditioner still in the basement of the home.
7. Licensee borrowed money from Resident J and did not pay him, as evidenced by the following:
    a. On or about June 16, 2018, shortly after Resident J was admitted to the home, Licensee asked Resident J for a loan of $6,000 so she could

pay employees. Resident J agreed to loan Licensee the money for a few weeks.

b. On or about June 20, 2018, Licensee came into Resident J's room during the night with a check from Resident J's checkbook that Licensee completed herself in the amount of $6,100 and a contract for Resident J to receive care in the home for 90 days at a cost totaling $9,450. Resident J signed the check and the contract, unbeknownst that it was an agreement to pay for 90 days of care at the home. Licensee later told Resident J that the money was not a loan but rather for two additional months of respite care at the home, which Resident J did not want.

c. On August 1, 2018, during an interview with Ms. Barner, Licensee denied borrowing money from Resident J and stated that Resident J wrote her a check for $6,100 for two months of respite care.

8. Licensee admitted Resident J to her adult foster care home even though she was unable to adequately provide for his supervision, protection, and personal care, as demonstrated by the following:

a. On or about June 15, 2018, Resident J was admitted to Licensee's adult foster care home. According to Resident J's written assessment plan and health appraisal, [redacted]. Resident J uses a wheelchair and a walker and is unable to climb stairs.

b. Upon admission to the home, Licensee placed Resident J in a bedroom in the basement of the home. There was no elevator in the home and no way for Resident J to ambulate from his bedroom to the main level of the home. Resident J asked Licensee to move him to a bedroom on the main level of the home as he was confined to his bedroom in the basement. Licensee told him that there were no other bedrooms available on the main level of the home.

c. On July 20, 2018, Ms. Barner conducted an on-site inspection at the home and observed Resident J's bedroom in the basement. There was no living or dining space in the basement, and the hallway outside Resident J's bedroom was filled with furniture, preventing Resident J from using his wheel chair to leave his room.

d. During an interview on July 20, 2018, Licensee acknowledged that even with assistance, Resident J is unable to navigate the stairs to the main level of the home. Licensee stated that Resident J eats all his meals and receives all of his services in his room.

9. Licensee failed to dispose or destroy discontinued resident medications, as evidenced by the following:

a. On June 8, 2018, Ms. Gonzalez conducted an on-site investigation at the home and observed medications that were no longer prescribed for residents:

i. There was a bottle of nystatin prescribed to Resident B that was not listed on Resident B's medication record. The prescription expired on March 29, 2018.

ii. There was a bottle of losartan 50 mg prescribed to Resident F with "Dc'd" written on the cap. This medication was not listed as a prescribed medication on the pharmacy medication record for Resident F.

iii. There was a bottle of ciprofloxacin 500mg and a bottle of atorvastatin calcium 20mg prescribed to Resident I on-site at the home. According to the resident register, Resident I passed away on February 14, 2018.

iv. There was a bottle of bisacodyl 100mg and a bottle of cephalexin 250mg prescribed to Resident K at the home. According to the resident register, Resident K is deceased.

v. There was a bottle of melatonin 3mg prescribed to Resident L at the home. According to the resident register, Resident L moved out of the home on June 1, 2018.

vi. There was a bottle of levofloxacin 250mg prescribed to Resident M at the home. According to the resident register on the day of the inspection, Resident M no longer resided at the home.

b. On August 1, 2018, during an on-site investigation, Ms. Gonzalez asked Licensee to observe the contents of the safe in the home. The safe contained medications no longer prescribed to residents:

i. There were bottles of acetaminophen/hydrocodone 325mg, alprazolam 0.25mg, and three boxes of fentanyl patches 12 MCG/HR, all previously prescribed to Resident B. None of these medications were listed as current medications on Resident B's medication records.

ii. There was a bottle of Levsin 0.125mg and a bottle of morphine sulfate 10mg/5mg solution, both prescribed to Resident C. Licensee informed Ms. Gonzalez that Resident C no longer resides at the home.

iii. There was a box of fentanyl 25MCG/HR patches and a bottle of morphine sulfate oral solution 100mg/5ml, both prescribed to Resident D. Licensee informed Ms. Gonzalez that Resident D no longer resides at the home.

iv. There were two boxes of acetaminophen suppositories 650mg prescribed to Resident E. Licensee informed Ms. Gonzalez that Resident E no longer resides at the home.

v. There was a bottle of acetaminophen 325mg prescribed to Resident G that was not listed on Resident G's medication log.

vi. There was a bottle of acetaminophen/hydrocodone 325mg prescribed to a previous occupant of the home. Licensee told Ms. Gonzalez that the occupant no longer resided in the home.

c. During the on-site investigation on August 1, 2018, Licensee acknowledged that the medications in the safe were either

discontinued or belong to a resident who no longer resides at the home. Licensee stated that she was "holding the medication" and intended to "burn the medication and bottles" but had not had time to do it.

10. Licensee failed to administer medication to residents pursuant to label instructions, as evidenced by the following:

    a. Licensee did not administer temazepam 30mg and escitalopram 20mg to Resident H from June 8, 2018, until June 11 and 12, 2018. During an on-site inspection on June 8, 2018, Ms. Gonzalez observed Resident H's prescription bottles for temazepam 30mg and escitalopram 20mg were both empty. Twin Valley Pharmacy confirmed to Ms. Gonzalez that Resident H's temazepam was not delivered to the home until June 11, 2018, and the escitalopram was not delivered to the home until June 12, 2018.

    b. Licensee did not administer pravastatin sodium 20mg to Resident B from July 20, 2018, until July 27, 2018. During on on-site inspection on July 20, 2018, Resident B's pravastatin sodium medication was missing. Twin Valley Pharmacy confirmed to Ms. Gonzalez that Resident B's pravastatin sodium was delivered to the home on July 27, 2018, leaving Resident B without his medication for seven days.

11. Licensee left residents alone with a staff person who does not meet the minimum licensing requirements:

a. On July 30, 2018, Licensee left the residents with Mackenzie Hillsburg as the only responsible person in the home.

b. On August 1, 2018, Ms. Gonzalez conducted an on-site inspection at the home. When asked about Ms. Hillsburg's role in the home, Licensee initially claimed that Ms. Hillsburg was only a volunteer, not an employee, and that she never leaves her alone with residents. She indicated that Ms. Hillsburg does not provide unsupervised care to residents and was not being paid for her time at the home.

c. During a later interview with Ms. Gonzalez, Licensee admitted to leaving Ms. Hillsburg alone with residents on July 30, 2018, and to paying Ms. Hillsburg a "stipend." Licensee admitted that she did not have an employee file for Ms. Hillsburg and did not have verification of TB testing, a health care appraisal, or a criminal background fingerprint check on file.

COUNT I

The conduct of Licensee, as set forth in paragraphs 7(a) through 7(c) above, evidences a willful and substantial violation of:

R 400.1421

(8) A licensee, responsible person, and members of the licensee's or responsible person's family shall not borrow money or valuable from a resident, with or without the consent of the resident. A licensee shall further take reasonable precautions to assure the prohibition of financial transactions between a resident and other occupants of the home.

COUNT II

The conduct of Licensee, as set forth in paragraphs 5(a) through 5(n) above, evidences a willful and substantial violation of:

R 400.1404

(3) A licensee or responsible person shall possess all of the following qualifications:

(a) Be of good moral character to provide for the care and welfare of the residents.

NOTE:
MCL 338.41

(1) The phrase "good moral character", or words of similar import, when used as a requirement for an occupational or professional license or when used as a requirement to establish or operate an organization or facility regulated by this state in the Michigan Compiled Laws or administrative rules promulgated under those laws shall be construed to mean the propensity on the part of the person to serve the public in the licensed area in a fair, honest, and open manner.

COUNT III

The conduct of Licensee, as set forth in paragraphs 8(a) through 8(d) above, evidences a willful and substantial violation of:

Rule 400.1407

(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions:

(a) The amount of personal care, supervision, and protection required by the resident is available in the home.

COUNT IV

The conduct of Licensee, as set forth in paragraphs 9(a) through 9(c) above, evidences a willful and substantial violation of:

R 400.1418

(7) Prescription medication which is no longer required by a resident shall be destroyed after consultation with a physician or a pharmacist.

COUNT V

The conduct of Licensee, as set forth in paragraphs 5(j) through 5(n) above, evidences a willful and substantial violation of:

R 400.1421

(7) A resident's account shall be individual to the resident. A licensee shall be prohibited from having any ownership interest in a resident's account and shall verify such in a written statement to the resident or the resident's designated representative.

COUNT VI

The conduct of Licensee, as set forth in paragraphs 10(a) and 10(b) above, evidences a willful and substantial violation of:

R 400.1418

(2) Medication shall be given pursuant to label instructions.

COUNT VII

The conduct of Licensee, as set forth in paragraphs 6(a) through 6(d) above, evidences a willful and substantial violation of:

R 400.1421

(12) A licensee shall return the full amount of funds and valuables remaining in the account to the resident or his or her designated representative not later than 5 banking days following the request or date of discharge.

COUNT VIII

The conduct of Licensee, as set forth in paragraph 11 above, evidences a willful and substantial violation of:

R 400.1405

(3) A licensee shall provide the department with written evidence that he or she and each responsible person in the home is free from communicable tuberculosis. Verification shall be within the 3-year period before employment and verification shall occur every 3 years thereafter.

DUE TO THE serious nature of the above violations and the potential risk they represents to vulnerable adults in Licensee's care, emergency action is required. Therefore the provision of MCL 24.292 of the Administrative Procedures Act of 1969, as amended, is invoked. Licensee is hereby notified that the license to operate an adult foster care family home is summarily suspended.

EFFECTIVE 6:00 PM, on August 17, 2018, Licensee is ordered not to operate an adult foster care family home at 11303 West Drive North, Bellevue, Michigan 49021 or at any other location or address. Licensee is not to receive adults for care after that

time or date. Licensee is responsible for informing case managers or guardians of adults in care that the license has been suspended and that Licensee can no longer provide care.

HOWEVER, BECAUSE THE Department has summarily suspended the license, an administrative hearing will be promptly scheduled before an administrative law judge. Licensee MUST NOTIFY the Department and the Michigan Administrative Hearings System (MAHS) in writing within seven calendar days after receipt of this Notice if Licensee wishes to appeal the summary suspension and attend the administrative hearing. The written request must be submitted via MAIL or FAX to:

Michigan Administrative Hearings System
611 West Ottawa Street, 2nd Floor
P.O. Box 30695
Lansing, Michigan 48909
Phone: 517-335-2484
FAX: 517-335-6088

MCL 24.272 of the Administrative Procedures Act of 1969 permits the Department to proceed with the hearing even if Licensee does not appear. Licensee may be represented by an attorney at the hearing at his or her own expense.

DATED: 8-17-18

Jay Calewarts, Division Director
Adult Foster Care and Camps Licensing Division
Bureau of Community and Health Systems

This is the last and final page of the ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT in the matter of Bobbi Greenwood-Easter, AF130305310, consisting of 16 pages, this page included.

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