



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 09, 2023

Karen Conquest
11437 Runnells Dr.
Clio, MI 48420

RE: License #: AM730009474
Investigation #: 2024A0572003
Conquests AFC Home

Dear Ms. Conquest:

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) 643-7960.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The signature is written in a cursive style with a large, looping flourish at the end.

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM730009474
Investigation #:	2024A0572003
Complaint Receipt Date:	10/25/2023
Investigation Initiation Date:	10/27/2023
Report Due Date:	12/24/2023
Licensee Name:	Karen Conquest
Licensee Address:	11437 Runnells Dr. Clio, MI 48420
Licensee Telephone #:	(810) 397-3458
Administrator:	Karen Conquest
Licensee Designee:	N/A
Name of Facility:	Conquests AFC Home
Facility Address:	1914 N Bond Saginaw, MI 48602
Facility Telephone #:	(989) 752-5811
Original Issuance Date:	12/01/1997
License Status:	REGULAR
Effective Date:	07/19/2023
Expiration Date:	07/18/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents are sexually abusing each other, and sexual diseases are spreading.	No
Staff smokes marijuana at the facility back porch and blows the smoke in the resident's faces. Licensee, Karen Conquest, took the towels with urine on it and wiped it on Resident D.	No
Residents are having falls.	No
Staff are pushing pills to the residents.	No
Meds are being passed late to residents.	Yes
The facility is cold in the mornings, despite the staff saying that the heat is on.	No

III. METHODOLOGY

10/25/2023	Special Investigation Intake 2024A0572003
10/26/2023	Contact - Face to Face Two unsuccessful attempts to make contact during unannounced onsite.
10/27/2023	Special Investigation Initiated - On Site Resident A, Resident B, Resident C and Home Manager, Karen Conquest.
10/31/2023	Contact - Face to Face Resident B and C.
11/02/2023	Contact - Face to Face Resident B, C, D and Licensee, Karen Conquest.
11/02/2023	Exit Conference Licensee, Karen Conquest.
11/06/2023	APS Referral Licensing made referral.

11/06/2023	Contact - Document Received Incident Report.
11/09/2023	Contact - Face to Face Licensee, Karen Conquest.
11/09/2023	Contact - Document Received Resident A, B and C's, Assessment Plans and PCP.
11/09/2023	Contact - Telephone call made Staff, Lydia Bulgrien.
11/09/2023	Contact - Telephone call made Guardian 1

ALLEGATION:

Residents are sexually abusing each other, and sexual diseases are spreading.

INVESTIGATION:

On 10/25/2023, the local licensing office received a complaint for investigation. Adult Protective Services will be referred for further investigation.

On 10/26/2023, two unannounced onsite attempts were made. I will make another attempt within the week.

On 10/27/2023, I made another onsite at Conquests AFC Home located in Saginaw County. I interviewed Resident A, Resident B, Resident C and the Licensee, Karen Conquest.

On 10/27/2023, I interviewed Resident A regarding the allegation. Resident A denied being sexually abused at the home and does not know if anyone has been sexually abused at the home. Resident A has not had any sexual contact since her head injury 6 years ago. Resident A informed that Resident E is passing herpes to the other residents in the home. Resident A denied that Resident E is kissing or having sexual interactions with the other residents. When asked how Resident E was passing herpes to the other residents, she stated, "Because (Resident E) goes out into the community and contracts it and then she comes home afterwards."

On 10/27/2023, I interviewed Resident B regarding the allegation. Resident B denied that there is any sexual abuse going on at the facility. Resident B informed that no one is passing any sexual diseases to anyone.

On 10/27/2023, I interviewed Resident C regarding the allegation. Resident C denied that there is any sexual abuse at the facility and indicated that no one is passing any sexual diseases.

On 10/27/2023, I interviewed Licensee, Karen Conquest regarding the allegations. She denied that residents are sexually abusing each other and that any residents are passing any sexually transmitted diseases. Ms. Conquest informed that none of the residents have come to her to say that any of this was occurring.

On 11/09/2023, I made another onsite visit to Conquests AFC and reviewed Residents A, B and C's Assessment Plans and Person Center Plan (PCP). According to their Assessment Plans, Resident A, B and C are able to control their sexual behaviors. There also was no criminal sexual history reported in their PCP.

On 11/09/2023, I asked Licensee, Karen Conquest if she was aware if Resident A is sexually active or has any history of sexual abuse. Ms. Conquest denied that Resident A is sexually active and indicated that she is not aware of her having any sexual abuse history, but Resident A talks about being abused all the time.

APPLICABLE RULE	
R 400.14204	Direct care staff; qualifications and training.
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	Based on my investigation of the complaint, there is no evidence that residents are being sexually abused or that residents are passing sexually transmitted diseases. Everyone that were interviewed denied that residents are sexually abusing each other. Everyone, aside from Resident A also denies that a resident is passing sexually transmitted diseases. Resident A believes that Resident E is spreading herpes to other residents by going out into the community and returning home but denies that the resident is being sexually active with any of the residents. According to the Assessment Plan and PCP for Residents A, B and C, they are able to control sexual behaviors, and there is no sexual abuse history.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- Staff smokes marijuana at the facility back porch and blows the smoke in the resident's faces.
- Licensee, Karen Conquest, took the towels with urine on it and wiped it on Resident D.

INVESTIGATION:

On 10/27/2023, I interviewed Resident A regarding the first bulleted allegation. Resident A denied that staff smokes marijuana at the home. Resident E smokes in the backyard and she does not blow smoke in anyone's face.

On 10/27/2023, I interviewed Resident B regarding the first bulleted allegation. Resident B denied that any staff are smoking marijuana on the front porch and blowing it in their faces.

On 10/27/2023, I interviewed Resident C regarding the first bulleted allegation. Resident C informed that there is no one smoking marijuana at the home and blowing it in anyone's faces.

On 10/27/2023, I interviewed Licensee, Karen Conquest regarding the first bulleted allegation. Ms. Conquest stated, "Absolutely not. I do not have any staff smoking marijuana at my home and they are not blowing it in the residents faces.

On 11/02/2023, I interviewed Resident B regarding the second bulleted allegation. Resident B denied that Karen Conquest has wiped Resident D with a towel filled with urine on it.

On 11/02/2023, I interviewed Resident C regarding the second bulleted allegation. Resident C was informed that this has never happened.

On 11/02/2023, I interviewed Licensee, Karen Conquest regarding the second bulleted allegation. She stated, "Baloney. Absolutely not. That is horrible. That is so gross. I can't believe that someone would say such a thing."

On 11/02/2023, I observed Resident D, who is non-verbal. She appeared to be in good spirits. She is receiving adequate care and supervision and her well-being is appropriate.

On 11/02/2023, I was unable to interview Resident A regarding the second bulleted allegation as she is in the hospital due to mental health.

On 11/09/2023, I called Resident D's Guardian, Guardian 1; regarding the second bulleted allegation. Guardian 1 had not heard this allegation before and has not received any incident reports pertaining to this allegation. Guardian 1 has four clients in this home and informed that the facility typically takes very good care of the clients. Guardian 1 does not have any concerns for the health, safety, and wellbeing of any of the clients in the home.

APPLICABLE RULE	
R 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 on my investigation of the complaint, there is no evidence that staff are smoking marijuana and blowing it in the residents faces or that Ms. Karen Conquest has used a towel with urine to wipe Resident D. Everyone interviewed, aside from Resident A has denied both allegations. Resident A denied that staff smokes marijuana and blows the smoke in the residents faces, but informed that a resident has done this before, but it was 5 years ago. Resident A was in the hospital during my next two visits to the home and was not interviewed regarding the allegation that Ms. Conquest used a towel with urine to wipe Resident D with. Guardian 1 was not aware of the allegation and informed that the home takes very good care of the clients.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents are having falls.

INVESTIGATION:

On 10/27/2023, I interviewed Resident A regarding the allegation. Resident A informed that there has been falls, but staff are doing what they can to prevent them. Resident A indicated that she was falling at one point, but she was taken to see her doctor and they gave her a walker and now she is not falling anymore.

On 10/27/2023, I interviewed Resident B regarding the allegation. Resident B informed that there is one resident who is kind of stubborn who will try to walk without her walker, but staff will always remind her about safety and to use her walker. If a resident falls, staff makes sure that the resident is not hurt or has any broken bones. If they are in pain, Ms. Conquest will either transport them to the hospital or she will call for an ambulance if she is unable to leave the home.

On 10/27/2023, I interviewed Resident C regarding the allegation. Resident C informed that if a resident falls, staff will check to see if they are okay and then help them up. A couple residents that were falling, went into a nursing home because the home was unable to prevent the falls from happening.

On 10/27/2023, I interviewed Licensee, Karen Conquest regarding the allegation. Ms. Conquest informed that if a resident falls, staff will check to see if they are okay

and then send them to the hospital in case of an injury. Residents are always reminded to be careful or not to move so fast.

On 11/09/2023, I reviewed Resident A's Incident Report regarding a fall she had on 10/17/2023. Resident A slide off of her bed. Staff, Lydia Bulgrien helped Resident A up and asked if okay. Resident A was fine. Resident A then called the ambulance and said that her back hurts. The home has a record of residents falls and who has been contacted and what has been done to try to prevent the falls from reoccurring.

On 11/09/2023, I asked Licensee, Karen Conquest if Resident A had any other falls and she stated, "No." Resident A is not a fall risk and only fell the one time to her knowledge when she slid off the bed. Resident A has been using a walker for the past 3 years or longer.

On 11/09/2023, contact was made with Staff, Lydia Bulgrien. She informed that she was working when Resident A slid off of her bed. She checked to see if she was okay, and she said that she was fine. Resident A then called 911 because she claimed that her back was hurting. Resident A does not have any other falls.

APPLICABLE RULE	
R 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 on my investigation of the complaint, there is no evidence that the facility is in violation of any of the licensing rules. Residents falling in of itself is not a rule violation, however; I interviewed staff and residents to see what was the action steps if a resident was to fall. Everyone interviewed informed that if a resident falls, staff check to see if they are okay, they will assist them up off the floor and either Ms. Conquest will transport them to the hospital, or she will call for an ambulance. Staff informed that Resident A only had the one fall and is not a fall risk.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- Staff are pushing pills onto the residents.
- Meds are being passed late to residents.

INVESTIGATION:

On 10/27/2023, I interviewed Resident A regarding the allegations. Resident A denied that staff are making residents take medications that is not there's. Resident A has informed that staff has passed a medication, but it was not on time. The medication was supposed to be administered at noon, but it was passed at 3:30pm.

On 10/27/2023, I interviewed Resident B regarding the allegations. Resident B denied that residents are being given medications that does not belong to them. Resident B is not aware of if any medications were passed late. Resident B believes that everyone is getting their meds on time but is not for certain.

On 10/27/2023, I interviewed Resident C regarding the allegations. Resident C informed that they are only given medications that has their names on it. Resident C does not know if any medications were passed late to anyone. Resident C does not believe that anyone is getting their medications late. Resident C informed that staff do get bust sometimes but seems to still manage to pass their medications on time.

On 10/27/2023, I interviewed Licensee, Karen Conquest regarding the allegations. Ms. Conquest informed that only prescribed medications are given to the residents. Ms. Conquest indicated that approximately two weeks ago, there was a med pass that went about two hours late because the staff got busy and forgot about the med. This was the only med that was missed that day. The staff was counseled for it and an incident report was written.

On 10/27/2023, I reviewed Resident A's med sheet. It shows that the medication was administered as prescribed. There is nothing on the med sheet that indicates that the medication was passed late.

On 11/02/2023, I asked Ms. Karen Conquest to fax me the Incident Report regarding the medication error.

On 11/06/2023, I received the Incident Report regarding the medication error. It indicates that lunch pills were administered at 3pm instead of at noon. Staff will be more careful and prioritize when administering medications.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation, there is no evidence that residents are being made to take medications that are not prescribed to them. Everyone interviewed denied this allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	Resident medications.
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation, there is evidence that one of the residents was passed a medication late. Resident A informed that a staff member passed one of the residents' medications 3 and a half hours late. Ms. Karen Conquest also informed that there was a staff who passed a medication at least two hours late. The other residents interviewed were not aware of the late medication pass.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The facility is cold in the mornings, despite the staff saying that the heat is on.

INVESTIGATION:

On 10/27/2023, I interviewed Resident A regarding the allegation. Resident A informed that it is cold in the house and indicated that it is cold right now. Resident A was observed wearing a t-shirt, shorts, and no shoes on.

On 10/27/2023, I interviewed Resident B regarding the allegation. Resident B denies that the home is cold in the mornings. If it is, staff will turn up the heat.

On 10/27/2023, I interviewed Resident C regarding the allegation. Resident C informed that the heat stays on and that no one is in the home freezing.

On 10/27/2023, I interviewed Licensee, Karen Conquest regarding the allegation. Ms. Conquest indicated that the heat is on. She informed that Resident A will visit with another resident in her room. This resident is on oxygen and has a C-PAP, which creates a little bit of heat in her small room, so when Resident A leaves her room, she feels as if the entire house is cold.

On 10/27/2023, while conducting my interviews, I check the thermostat and it was on 68^o and the house temperature was at 72^o. I made two other visits to the home and the home was always at an appropriate temperature.

APPLICABLE RULE	
R 400.14406	Room temperature.
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit

	during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	Based on my investigation, there is no evidence that the home is cold. During all three of my unannounced visits to the home, the home was always warm. Residents were seen wearing shorts and t-shirts inside the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this medium sized group home, pending the receipt of an acceptable corrective action plan (Capacity 1-12).




11/09/2023

Anthony Humphrey
Licensing Consultant

Date

Approved By:



11/09/2023

Mary E. Holton
Area Manager

Date