



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

June 15, 2021

Heather Nadeau  
Our Haus, Inc.  
PO Box 10  
Bangor, MI 49013

RE: License #: AS800384554  
Investigation #: 2021A0581037  
Katy Haus

Dear Ms. Nadeau:

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) 284-9730.

Sincerely,

A handwritten signature in black ink that reads "Cathy Cushman". The signature is written in a cursive, flowing style.

Cathy Cushman, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(269) 615-5190

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS800384554
<b>Investigation #:</b>	2021A0581037
<b>Complaint Receipt Date:</b>	05/17/2021
<b>Investigation Initiation Date:</b>	05/18/2021
<b>Report Due Date:</b>	07/16/2021
<b>Licensee Name:</b>	Our Haus, Inc.
<b>Licensee Address:</b>	30637 White Oak Drive Bangor, MI 49013
<b>Licensee Telephone #:</b>	(269) 214-8350
<b>Administrator:</b>	Heather Nadeau
<b>Licensee Designee:</b>	Heather Nadeau
<b>Name of Facility:</b>	Katy Haus
<b>Facility Address:</b>	209 Park Road Bangor, MI 49013
<b>Facility Telephone #:</b>	(269) 427-1084
<b>Original Issuance Date:</b>	10/19/2016
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/20/2021
<b>Expiration Date:</b>	04/19/2023
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
The facility staff are not allowing Resident A to voice grievances and when he does, they abuse him.	No
The facility is taking advantage of Resident A by taking his money.	No
Additional finding:	Yes

**III. METHODOLOGY**

05/17/2021	Special Investigation Intake 2021A0581037
05/17/2021	APS Referral APS also received the allegations. No referral is necessary.
05/18/2021	Special Investigation Initiated - Telephone Interview with Van Buren County Adult Protective Services specialist, Lenny Weston.
05/26/2021	Inspection Completed On-site Interviewed direct care staff, licensee designee, and residents. Reviewed resident documentation.
06/03/2021	Contact – Telephone call made Interview with Guardian A1
06/03/2021	Contact – Telephone call made Interview with Allegan Community Mental Health case worker, Laura Fury.
06/03/2021	Exit conference with Administrator/Licensee Designee, Heather Nadeau.

**ALLEGATION:**

**The facility staff are not allowing Resident A to voice grievances and when he does, they abuse him.**

**INVESTIGATION:**

On 05/17/2021, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system as a referral from Adult Protective Services (APS). The complaint alleged the facility retaliates against Resident A when he makes complaints to the Recipient Rights Office, for example, staff hit or beat him up; however, the complaint indicated Resident A does not currently have any injuries and Resident A was unable to indicate when the alleged abuse occurred. The complaint also alleged the facility shreds the reports Resident A makes.

On 05/18/2021, I interviewed APS specialist, Lenny Weston, via telephone. Mr. Weston confirmed what was written in the complaint. Mr. Weston stated Resident A did not have specific instances when he had filed a complaint but alleged these reports were not given to recipient rights.

On 05/26/2021, I conducted an unannounced on-site inspection at the facility, as part of my investigation. I interviewed direct care staff, Madison Kuery, the Administrator/Licensee Designee, Heather Nadeau, Resident A and Resident B.

Ms. Keury and Ms. Nadeau both stated all the residents can make complaints and/or grievances, if they have them, including Resident A. They both stated they would also assist Resident A in completing a recipient rights complaint if he had one. While I was at the facility, Ms. Nadeau showed me where the information to make a recipient rights complaint was located. This area, which was in the facility's living and was accessible to all the residents, included contact information like phone numbers, faxes, and mailing addresses. Additionally, Ms. Nadeau provided blank complaint forms for residents as well. Both Ms. Keury and Ms. Nadeau denied being physically or verbally assaultive towards Resident A, even after he makes complaints. Contrarily, Ms. Nadeau stated Resident A has a history of being the aggressor.

Resident A stated he has a personal cell phone and can make calls when he wants to. He stated he also knows how to call the Recipient Rights (RR) office and make complaints, but stated he thought he had written complaints out and did not believe these complaints made it to the RR office. Resident A stated he has "memory issues" and was unable to recall a specific time he had made a complaint and did not think the complaint made it to the rights office. Resident A could also not recall a time when he was assaulted after making a complaint. I observed Resident A during the on-site and did not see any marks, bruises, or injuries on him.

I interviewed Resident B during the on-site, who identified himself as Resident A's roommate. Resident B stated he could make complaints and grievances, if he wanted to and did not feel he would be retaliated against. Resident B stated he had not seen Resident A be assaulted or treated differently within the facility by any direct care staff.

On 06/03/2021, I interviewed Guardian A1. Guardian A1 stated Resident A has resided at the facility for approximately one year. She stated Resident A is “very high functioning”, but exhibits a lot of behaviors, including, but not limited to being threatening and assaultive towards staff and police. Guardian A1 stated that despite Resident A’s behaviors, the facility seems to work with him well.

Guardian A1 stated Resident A has been involved with Allegan Community Mental Health (CMH) for several years and is aware of how to make and/or file complaints so people and agencies are aware if anything is happening to him. Guardian A1 stated Resident A complains “all the time”, almost daily and most, if not all, his complaints are invalid. Guardian A1 stated Resident A will lie and say people are being physically assaultive or aggressive with him when it is actually Resident A who is aggressive or physically and/or verbally assaultive. Guardian A1 stated she is confident Resident A would report to all the necessary parties/agencies if he was being abused in any way, shape, or form. She stated prior to December 2020 she was visiting with him every couple of week and never saw any marks or bruises on him even when he said he had been assaulted. Guardian A1 stated she observed Resident A a few weeks ago and he did not have any marks or bruises at that time either.

On 06/03/2021, I interviewed Resident A’s Allegan Community Mental Health (CMH) case manager, Laura Fury. She stated she had been working with Resident A since February 2021. She stated Resident A experiences delusions and will often report he has made or will make complaints to various agencies like the FBI and recipient rights. She stated Resident A can sound “articulate” and believable; however, he often makes false allegations. Ms. Fury did not have any concerns with the facility destroying complaints. She stated the facility does keep her abreast of incidences with Resident A occurring at the facility. She acknowledged receiving incident reports from the facility.

<b>APPLICABLE RULE</b>	
<b>R 400.14304</b>	<b>Resident rights; licensee responsibilities.</b>
	<p><b>(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:</b></p> <p><b>(f) The right to voice grievances and present recommendations pertaining to the policies, services, and house rules of the home without fear of retaliation.</b></p> <p><b>(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.</b></p>

<b>ANALYSIS:</b>	Based on my investigation, which included interviews with direct care staff, Guardian A1, APS specialist, Lenny Weston, Allegan CMH case manager, Laura Fury, Resident A and Resident B, there is no evidence indicating facility staff or the facility's Administrator/Licensee Designee is preventing Resident A from filing grievances, contacting Recipient Rights to file complaints, or retaliating against him if complaints are made.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**The facility is taking advantage of Resident A and taking his money.**

**INVESTIGATION:**

The complaint alleged the facility is taking advantage of Resident A by taking his money. The complaint alleged the licensee is telling Resident A he owes them \$600 every two weeks when he only makes \$300 every two weeks from working at Walmart. The complaint indicated Resident A's Social Security Income (SSI) was cut due to him working and alleged the licensee was taking all his paychecks from working and they were also getting his disability checks.

Adult Protective Services specialist, Mr. Weston, stated Resident A had a job at Walmart for a few months; therefore, his SSI income was decreased. He stated Resident A used to get approximately \$900 in SSI, but in May it was cut to \$630, and in July it would go down to \$340. Mr. Weston stated Guardian A1 had reported having enough money to cover the decrease in SSI funds, but Resident A needed to use some of his paycheck funds to cover the remaining monthly fee to reside at the facility. Mr. Weston stated Resident A did not want to use his job money to pay the facility. Mr. Weston stated Guardian A1 reported to him Resident A spends his paychecks on food and miscellaneous things rather than contributing to his monthly fee to live at the facility.

Direct care staff, Ms. Keury, was not familiar with Resident A's finances or how much he paid to live at the facility. She stated he did get paid to work at Walmart; however, this money was deposited onto a debit card that only Resident A held onto and managed. She stated facility staff did not manage or hold any of Resident A's personal funds.

Ms. Nadeau's statement to me was consistent with Mr. Weston's and Ms. Keury's statements to me. She stated she charges Resident A the standard AFC rate of \$907.50 per month. She stated Resident A worked approximately three months at Walmart and for the last couple of months his SSI has decreased. She stated Guardian A1 has always paid Resident A's monthly rate, but discussions had been

had with Resident A about providing additional funds from his biweekly paychecks from Walmart to cover the portion of SSI funds he was no longer receiving. Ms. Nadeau stated Resident A was receiving approximately \$300-\$400 biweekly for working at Walmart but he managed the funds himself on a debit card provided by Walmart. Ms. Nadeau stated that despite the decreased SSI funds, Guardian A1 has continued covering the lost funds to ensure Resident A maintains his placement. Ms. Nadeau stated Resident A's SSI should increase back to the original amount since he is no longer working and she is willing to work with Guardian A1 until his SSI increases again.

Resident A confirmed having a job at Walmart and receiving paychecks via a debit card. He confirmed he was the only person who had access to this debit card and the only person who managed the funds on it. He stated no one at the facility told him how he could spend his personal money. He stated he also had a bank account that only he and Guardian A1 had access to. He stated Guardian A1 would put money in that account for him as well. He stated he was aware of his SSI funds decreasing. He also acknowledged it costing him approximately \$907 a month to reside at the facility. He stated Guardian A1 was responsible for paying that fee every month.

I reviewed Resident A's *Resident Care Agreement*, dated 06/05/2020, which indicated Resident A is charged \$896.50 per month to reside at the facility. I also reviewed Resident A's *Resident Funds II* form documenting the AFC payment received by the facility. According to this form, the facility accepted \$896.50 a month (SSI deposit) from 07/01/2021 through 03/01/2021 then beginning 04/01/2021 through 05/01/2021 the facility was accepting \$907.50 a month in SSI as the payment for AFC services.

Guardian A1 stated she is Resident A's payee for his SSI and pays the facility for Resident A to reside there. She stated she currently pays them \$907.50 a month. Guardian A1 stated Resident A did have a job at Walmart; however, was recently let go. She stated while he worked at Walmart, his SSI was reduced. She stated she tried to manage his paychecks from Walmart; however, discovered she was unable to as she was not the payee for his estate. She stated as a result, Resident A was able to access these paychecks via a debit card. Guardian A1 stated due to Resident A's SSI being decreased, he technically was responsible for paying the facility part of his paychecks to cover the remaining rent he owed; however, he refused. She stated she was able to pay the remaining balances despite not receiving the full SSI payment. Guardian A1 stated she had no issues with the facility and felt they were really working with her to ensure Resident A can continue to reside in the facility. Guardian A1 stated she did not feel she was being charged more for Resident A to live at the facility than what was agreed upon.

Resident A's CMH case manager, Ms. Fury, stated Resident A had expressed he was being over charged at the facility; however, she stated Guardian A1 is responsible for paying the AFC fee. She stated Guardian A1 had talked to Resident



A about how when he had got a job his SSI would decrease and that he would need to cover some of his monthly fee to the facility out of his own paychecks.

<b>APPLICABLE RULE</b>	
<b>R 400.14315</b>	<b>Handling of resident funds and valuables.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on my investigation, there is no evidence the facility staff, the licensee designee, or the administrator are taking advantage of Resident A by taking his personal funds as indicated in the complaint.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.14315</b>	<b>Handling of resident funds and valuables.</b>
	<b>(12) Charges against the resident's account shall not exceed the agreed price for the services rendered and goods furnished or made available by the home to the resident.</b>
<b>ANALYSIS:</b>	Based on my investigation, there is evidence the facility is accepting more funds for Resident A's Adult Foster Care payment than what was agreed upon as indicated in Resident A's <i>Resident Care Agreement</i> . Resident A's <i>Resident Care Agreement</i> , dated 06/05/2020, did not reflect the increased AFC payment of \$907.50 as indicated on his <i>Resident Funds II</i> form, as required.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 06/03/2021, I conducted my exit conference with the licensee designee, Heather Nadeau, via telephone. I explained to Ms. Nadeau my findings. She stated she was only updating the RCA once a year; however, she stated she would now update the RCA whenever there was an increase or decrease in the AFC payment from Social Security Administration.

**IV. RECOMMENDATION**

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

*Cathy Cushman*

06/03/2021

---

Cathy Cushman  
Licensing Consultant

Date

Approved By:

*Dawn Timm*

06/15/2021

---

Dawn N. Timm  
Area Manager

Date