GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 11, 2024

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

RE: License #: AS800384551
Investigation #: 2024A1031020
Mills Haus

Dear Licensee:

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 (616) 356-0183.

Sincerely,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800384551
Investigation #:	2024A1031020
Complaint Receipt Date:	01/03/2024
Investigation Initiation Date:	01/03/2024
Report Due Date:	03/03/2024
Licensee Name:	Our Haus, Inc.
Licensee Address:	30637 White Oak Drive Bangor, MI 49013
Licensee Telephone #:	(269) 214-8350
Administrator/Licensee Designee:	Heather Nadeau
Name of Facility:	Mills Haus
Facility Address:	303 Cemetery Road Bangor, MI 49013
Facility Telephone #:	(269) 427-1084
Original Issuance Date:	10/19/2016
License Status:	REGULAR
Effective Date:	04/19/2023
Expiration Date:	04/18/2025
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff left their personal medication on a shelf and Resident A consumed the medication.	Yes

III. METHODOLOGY

01/03/2024	Special Investigation Intake 2024A1031020
01/03/2024	Special Investigation Initiated – Telephone Interview with Candice Kinzler.
01/03/2024	Contact - Telephone Interview with Alex Ely.
01/04/2024	Inspection Completed On-site
01/04/2024	Inspection Completed-BCAL Sub. Compliance
01/04/2024	Contact - Face to Face Interview with Alex Ely and Dennis Wooten.
01/04/2024	Contact - Telephone Interview with Austin Bowman.
01/11/2024	Exit Conference held with Heather Nadeau.

ALLEGATION:

Staff left their personal medication on a shelf and Resident A consumed the medication.

INVESTIGATION:

On 1/3/24, I interviewed Recipient Rights Director Candice Kinzler via telephone. Ms. Kinzler reported she was informed that a direct care worker (DCW) had left their Tylenol and Ibuprofen on a shelf in the kitchen and Resident A consumed the medications. Resident A was in the hospital and being treated and monitored.

On 1/3/24, Ms. Kinzler and I interviewed the home manager Alex Ely via telephone. Mr. Ely reported DCW Austin Bowman left a bag of pills on a shelf in the kitchen. Mr. Ely reported DCW Dennis Wooten said he seen the bag of pills on the shelf but did not know what it was, so he left it alone. Mr. Ely reported Resident A informed him

that he had consumed the medications directly after he took them. Mr. Ely reported Resident A was taken to the hospital for treatment and monitoring. Mr. Ely reported Resident A received a drug test and there was no indication that drugs were taken. Mr. Ely reported Resident A's Tylenol levels were increasing and required continued monitoring. Mr. Ely reported Mr. Bowman reported he accidently left his Tylenol and Ibuprofen on the shelf and felt terrible about making this mistake. Mr. Ely reported Mr. Bowman was suspended and will be receiving additional training when he returns to the home to work.

On 1/4/24, I conducted a face-to-face interview with Mr. Ely at the home. Mr. Ely showed me where the medications were found which was on a shelf located in the kitchen. Mr. Ely reported staff can lock personal belongings in the staff office and medications should have not been left out. Mr. Ely reported Resident A is doing well overall and there was no significant impact as a result of consuming the medication.

On 1/4/24, I interviewed Mr. Wooten in the home. Mr. Wooten reported he did see the medications on the shelf prior to Resident A consuming them. Mr. Wooten reported he did not know what they were, so he did not touch it. Mr. Wooten reported he was going to talk to Mr. Ely about the medications but got busy caring for the residents in the home. Mr. Wooten was reminded that medications, whether it is the staff or resident's, should not be left out and accessible to residents at any time.

On 1/4/24, I interviewed Mr. Bowman via telephone. Mr. Bowman reported he recently had dental work done and brought Tylenol and Ibuprofen in a baggie to work. Mr. Bowman reported he took the baggie out of his pocket and set it on the shelf and forgot to put them back in his pocket. Mr. Bowman reported this incident was a honest accident and he felt terrible that Resident A consumed the medication. Mr. Bowman acknowledged that he should have locked up his personal medication in the staff office.

On 1/11/24, I completed an exit conference with licensee Heather Nadeau via telephone. Ms. Nadeua reported she was aware of the incident and immediately held a staff meeting to discuss locking up personal belongings while working in the home and residents not having access to any medications. Ms. Nadeau agreed with the findings as Resident A did have access to Mr. Bowman's medications and consumed them.

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:	Staff in the home did not ensure the protection and safety of the residents in the home as they left their personal medication on a shelf that was accessible to residents. Resident A's protection and safety was jeopardized as he consumed medications that were not prescribed to him.
CONCLUSION:	**VIOLATION ESTABLISHED**

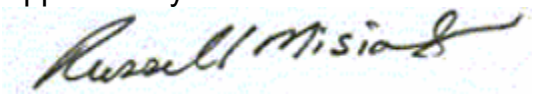
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

1/11/24

Kristy Duda Date
Licensing Consultant

Approved By:



1/11/24

Russell B. Misiak Date
Area Manager