GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 30, 2025

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

RE: License #: AS800417728
Investigation #: 2025A1031025
Haus on Monroe

Dear Licensee Designee:
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) 356-0100.

Sincerely,

KDuda

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

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

I. IDENTIFYING INFORMATION

License #:	AS800417728
Investigation #:	2025A1031025
Complaint Receipt Date:	03/25/2025
Investigation Initiation Date:	03/25/2025
Report Due Date:	05/24/2025
Licensee Name:	Our Haus, Inc.
Licensee Address:	30637 White Oak Drive Bangor, MI 49013
Licensee Telephone #:	(269) 214-8350
Licensee Designee/Administrator:	Heather Nadeau
Name of Facility:	Haus on Monroe
Facility Address:	807 W. Monroe Bangor, MI 49013
Facility Telephone #:	(269) 214-8350
Original Issuance Date:	12/06/2023
License Status:	REGULAR
Effective Date:	06/06/2024
Expiration Date:	06/05/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff slapped Resident A.	Yes

III. METHODOLOGY

03/25/2025	Special Investigation Intake 2025A1031025
03/25/2025	Special Investigation Initiated - Letter Email sent to Allison Krindler.
03/25/2025	APS Referral
03/25/2025	Contact – Document Received from Allison Krindler.
03/25/2025	Contact - Telephone call received from Heather Nadeau.
03/25/25	Contact – Voicemail left with Chad Brimlee.
04/04/2025	Inspection Completed On-site
04/04/2025	Contact - Face to Face Interview with Phillip Salinas, Resident A, and Resident B.
04/29/2025	Inspection Completed-BCAL Sub. Compliance
04/30/2025	Exit Conference held with Heather Nadeau.

ALLEGATION:

Staff slapped Resident A.

INVESTIGATION:

On 3/25/25, I exchanged emails with Resident A's recipient rights officer Allison Krindler. Ms. Krindler reported she received an incident report from the facility that read Resident A was slapped on the face by direct care worker (DCW) Chad Brimlee. Ms. Krindler reported DCW Dywanna Pettway witnessed Mr. Brimlee slap Resident A and provided a written statement. Ms. Krindler reported that the facility informed her that Mr. Brimlee was terminated from employment immediately following the incident.

On 3/25/25, I received an incident report, written statements, and interview notes from Ms. Krindler. The incident report dated 3/24/25 read that Resident A reported staff slapped him across the face. The incident report included supplemental information that included written statements completed by Dywanna Pettway and Mr. Brimlee. Ms. Pettway's written statement dated 3/25/25 read that Resident A threatened to hit Mr. Brimlee and then Mr. Brimlee made threats to press charges on Resident A. Mr. Brimlee provoked Resident A by telling Resident A to hit him. Mr. Brimlee made comments about Resident A's mother and his appearance. Resident A walked up to Mr. Brimlee and then Mr. Brimlee smacked Resident A across his face. Ms. Pettway noted that Mr. Brimlee did not handle the situation appropriately.

Mr. Brimlee's statement read that Resident A threaten to get a gun and stab him with colored pencils. Mr. Brimlee offered Resident A a PRN medication which he took but he did not calm down. Resident A was loud and disruptive as he was ripping up books and making marks on the table with a rock. Resident A was yelling and cussing at staff then started yelling that saying he smacked Resident A.

I reviewed the interview notes received from Ms. Krindler related to her investigation. Ms. Krindler's notes read that Ms. Pettway reported witnessing Mr. Brimlee slap Resident A and Mr. Brimlee denied slapping Resident A.

On 3/25/25, I received a call from licensee designee Heather Nadeau. Ms. Nadeau reported she was informed that Mr. Brimlee had slapped Resident A which was witnessed by Ms. Pettway. Ms. Nadeau reported Mr. Brimlee denied the allegations, but she terminated his employment due to Resident A and Ms. Pettway reporting the incident. Ms. Nadeau reported the facility has a zero-tolerance policy for this type of behavior.

On 4/4/25, I conducted an unannounced visit to the facility and independently interviewed the facility manager Phillip Salinas, Resident A, and Resident B.

Mr. Salinas reported he was not working when the incident occurred, but it was report to him immediately. Ms. Salinas reported Mr. Brimlee was terminated from employment following the incident.

Resident A reported he was arguing with Mr. Brimlee and Mr. Brimlee "was talking crap" to him. Resident A reported he asked Mr. Brimlee to leave him alone because he was making him upset. Resident A and Mr. Brimlee continued to argue and then Mr. Brimlee threatened to beat him up. Resident A reported Mr. Brimlee kept making threats towards him so he got into Mr. Brimlee's face. Resident A said that is when Mr. Brimlee slapped him. Resident A reported he called the police and pressed charges on Mr. Brimlee.

Resident B reported Mr. Brimlee was not being nice to Resident A. Resident B reported Mr. Brimlee instigated the entire incident as he kept yelling at Resident A

and told Resident A to hit him. Resident B reported she told Mr. Brimlee just to leave Resident A alone and to give him some space. Resident B walked out of the room and heard a “smack”. Resident B reported she did not witness the incident but heard a noise that made her go back into the room where Mr. Brimlee and Resident A were. Resident B reported that is when Resident A started yelling that Mr. Brimlee had slapped him.

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 interviews with staff and residents along with the review of written statements, there is sufficient evidence found to support that Mr. Brimlee intentionally exposed Resident A to physical and emotional harm. The facility handled the situation appropriately by immediately terminating Mr. Brimlee’s employment following the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

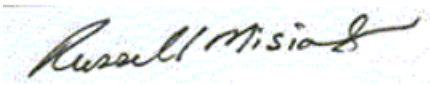
IV. RECOMMENDATION

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

4/29/25

Kristy Duda Date
Licensing Consultant

Approved By:



4/30/25

Russell B. Misiak Date
Area Manager