GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 8, 2025

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

RE: License #: AS800384551
Investigation #: 2025A1031046
Mills 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AS800384551
Investigation #:	2025A1031046
Complaint Receipt Date:	07/23/2025
Investigation Initiation Date:	07/23/2025
Report Due Date:	09/21/2025
Licensee Name:	Our Haus, Inc.
LicenseeAddress:	30637 White Oak Drive Bangor, MI 49013
Licensee Telephone #:	(269) 214-8350
Licensee Designee/Administrator:	Heather Nadeau
Name of Facility:	Mills Haus
Facility Address:	303 Cemetery Road Bangor, MI 49013
Facility Telephone #:	(269) 214-8350
Original Issuance Date:	10/19/2016
License Status:	REGULAR
Effective Date:	04/19/2025
Expiration Date:	04/18/2027
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff consumed alcohol while transporting residents.	Yes
Staff assaulted Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/23/2025	Special Investigation Intake 2025A1031046
07/23/2025	Special Investigation Initiated - On Site
07/23/2025	Contact – Telephone Interview with Candice Kinzler.
07/23/2025	Contact - Face to Face Candice Kinzler, Resident A, Resident B, Resident C and Heather Nadeau.
07/23/2025	Inspection Completed-BCAL Sub. Compliance
08/06/2025	APS Referral
08/06/2025	Contact - Document Sent Requested training documentation, disciplinary records, and incident report.
08/092025	Contact – Documents Received.
08/18/2025	Contact – Telephone Interview with Jorden Grigs and Cameron Watkins.
08/19/2025	Contact - Voicemail left with Cameron Watkins.
08/21/2025	Contact – Email Exchange with Mike Hartman.
09/08/2025	Contact – Exit Conference held with Heather Nadeau.

ALLEGATION:

Staff consumed alcohol while transporting residents.

INVESTIGATION:

On 7/23/25, I received a telephone call from Van Buren County recipient rights director Candice Kinzler. Ms. Kinzler reported she was informed of an alleged incident that occurred at the facility that involved a direct care worker (DCW) consuming alcohol and transporting the residents that reside at the facility.

On 7/23/25, Ms. Kinzler and I conducted an unannounced visit to the facility and independently interviewed Resident A, Resident B, Resident C, DCW Jerome Johnson, and licensee Heather Nadeau.

Resident A reported he and the other residents went for a drive to South Haven with DCW Cameron Watkins. Mr. Watkins stopped at a liquor store and bought beer and drank beer while driving. Mr. Watkins took the residents to his friends' house located in South Haven. Resident A reported Mr. Watkins left the residents in the van while he talked with his friend and drank beer. Resident A reported Mr. Watkins consumed at least five beers while talking with his friend. Resident A reported Mr. Watkins' friend left and went to the store to get "wraps" for marijuana. When his friend returned, Mr. Watkins and his friend smoked marijuana together. Mr. Watkins reported he and the other residents remained in the vehicle for a long time as Mr. Watkins had put the child locks on so they could not exit the vehicle. Resident A could not remember if the air conditioning was on but reported the window was open. Resident A reported he climbed through the driver's side window to get out of the vehicle due to it being hot inside and he wanted to ask Mr. Watkins for a cigarette. Resident A reported after they left Mr. Watkins' friend's house, they went to McDonald's to get Mr. Watkins food. While at McDonald's, Mr. Watkins fell asleep in the drive-through lane and a McDonald's employee came out to wake him up. After this occurred, Mr. Watkins transported the residents back to the facility and worked the remainder of his shift.

Resident B reported he and the other residents went on a van ride with Mr. Watkins and they drove to South Haven. Resident B reported they went to Mr. Watkins friend's house and Mr. Watkins consumed alcohol while driving after they stopped at a store to purchase alcohol. Resident B reported Mr. Watkins drank with his friend when they arrived at his friend's house. Resident B reported he got very sweaty in the van because it was very hot although the air conditioning was on. Resident B reported he did not see Mr. Watkins smoking anything. Resident B reported Mr. Watkins drove to McDonald's to get himself food. Mr. Watkins fell asleep while ordering food and a person behind them started honking their horn. An employee

from McDonald's came outside to wake up Mr. Watkins and then Mr. Watkins drove the residents back to the facility.

Resident C reported that Mr. Watkins got drunk and drove the residents to South Haven. Mr. Watkins stopped at a liquor store on the way to his friends' house and bought himself a case of beer and the residents' sodas. When they arrived at Mr. Watkins' friend's house, Mr. Watkins got out of the vehicle and started talking with his friend. Resident C reported they were drinking alcohol and smoking marijuana. Resident C reported they waited in the van for a long time before leaving. Resident C reported it got hot in the van although the air conditioning was running. Resident C reported Mr. Watkins did let them out of the van to smoke a cigarette. Resident C reported Mr. Watkins was swerving all over the road while driving and coming up close to other car bumpers, which was scary. Resident C reported he told Mr. Watkins to "hold up" because he was not driving right. Resident C reported after they left Mr. Watkins' friend's house, they stopped at McDonalds because Mr. Watkins wanted food for himself. Resident C reported while they were sitting in line, Mr. Watkins fell asleep. A McDonald's employee came outside to wake up Mr. Watkins and kept saying "hello, hello, are you alright?". After Mr. Watkins woke up, he drove the residents back to the facility.

Mr. Johnson reported he did not have any information regarding the allegations. Mr. Johnson reported he typically works in a different facility and was covering a shift.

Ms. Nadeau reported Resident A informed her of the incident that occurred with Mr. Watkins later in the evening. Ms. Nadeau reported she spoke with the residents about the incident, and they were all consistent in reporting that Mr. Watkins consumed alcohol, transported all the residents in a vehicle, and fell asleep at McDonald's. Ms. Nadeau reported she looked in a garbage can located outside of the facility and found an empty alcohol can. Ms. Nadeau reported Mr. Watkins was spoken to about the incident and immediately terminated from employment at the facility.

On 8/9/25, I received and reviewed Mr. Watkins training records. Mr. Watkins completed the required training through the facility.

On 8/18/25, I interviewed the facility manager Jorden Grigs via telephone. Mr. Grigs reported he was not working when the incident occurred but had heard about what happened. Mr. Grigs reported the residents previously reported to him that Mr. Watkins had consumed alcohol while working at the facility. Mr. Grigs reported he informed the licensee but there was no evidence found to prove that he was consuming alcohol while working aside from resident reports.

On 8/18 and 8/19, I left a voicemail with Mr. Watkins requesting a return telephone call. As of 8/21/25, I have not received a return telephone call.

On 8/21/25, I conducted a workforce background clearance check and Mr. Watkins was determined to be eligible for employment on 10/22/24.

On 8/21/25, I exchanged emails with adult protective services worker Mike Hartman. Mr. Hartman found a preponderance of evidence to support that the residents were neglected as Mr. Watkins consumed alcohol and possibly marijuana while transporting the residents and fell asleep at McDonald's,

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 interviews with staff, residents, APS, and the licensee, it has been determined that Mr. Watkins was not suitable to meet the needs of the residents. There were consistent reports that Mr. Watkins consumed alcohol while transporting the residents in a vehicle and he also fell asleep while operating the vehicle. There was also an alcohol can located by the licensee in a garbage can located outside of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff assaulted Resident A.

INVESTIGATION:

Ms. Kinzler reported she received a complaint that alleged Mr. Watkins hit Resident A with a marker holder.

Resident A reported he and Mr. Watkins got into an argument that led to a physical altercation between the two of them. Resident A reported Mr. Watkins took a marker holder from a whiteboard that was on the wall and hit him across the leg with it. Resident A took the marker holder away from Mr. Watkins and threw it on the floor. Resident A reported Mr. Grigs was present when the alleged incident occurred and told Mr. Watkins he should not have done that to Resident A.

Resident B reported he did not witness Mr. Watkins assault Resident A.

Resident C reported Resident A and Mr. Watkins were mad at each other and got into an argument. Resident C reported Mr. Watkins hit Resident A with a marker holder but he could not recall exactly where it was. Resident C stood up and reenacted what he witnessed and acted as Mr. Watkins swinging an object and then pointed to his thigh area where he believed the object hit Resident A. Resident C reported Resident A took the object away from Mr. Watkins and threw it.

Mr. Johnson reported he did not have any information regarding the allegations. Mr. Johnson reported he typically works in a different facility and was covering a shift. I reviewed Mr. Watkins behavior intervention training which he successfully completed on 4/26/25.

Mr. Grigs reported he recalled the incident as Resident A was upset with Mr. Watkins. Mr. Grigs reported Resident A ripped the marked holder off the wall when he was upset and got into a physical altercation with Mr. Watkins. Mr. Grigs reported Resident A also hit him in the back of the head with a blender, and he walked out of the kitchen to regroup himself. Mr. Grigs reported he did not witness Mr. Watkins hit Resident A with the marker holder. Mr. Grigs reported when he walked back into the kitchen, Resident A had the marker holder in his hand. Mr. Grigs reported the next day, he overheard Resident A on the telephone telling a relative that that Mr. Watkins had hit him.

On 8/18 and 8/19, I left a voicemail with Mr. Watkins requesting a return telephone call. As of 8/21/25, I have not received a return telephone call.

Mr. Hartman reported he did not find a preponderance of evidence to support that Resident A was abused.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	There was enough found to support that Resident A was mistreated by Mr. Watkins as Mr. Watkins hit Resident A with a marker holder which was an intentional action to cause physical and emotional harm. Resident A and Resident B were interviewed separately, and both consistently reported the same incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/23/25, I conducted an unannounced visit to the facility. While in the kitchen, I noticed the menus for June and July 2025 were not completed. There were 14 days in June and 5 days in July that did not have anything documented for breakfast, lunch and dinner. The rest of the menu for June and July were missing multiple meals per day. The meals that were documented were minimal and did not include daily food items necessary to meet nutritional dietary allowances. For example, some of the dinners documented were “pizza”, “burgers”, “tacos”, “pork chops”. It is unclear what other nutritional items were served to the residents.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.
ANALYSIS:	Based on incomplete or partially completed menus, it does not appear that residents are receiving nutritional daily dietary allowances as required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Menus were observed to be incomplete or partially incomplete for June and July 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

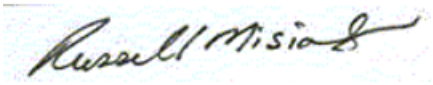
IV. RECOMMENDATION

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

8/20/25

Kristy Duda Date
Licensing Consultant

Approved By:



8/21/25

Russell B. Misiak Date
Area Manager