GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 27, 2026

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

RE: License #: AS800419102
Investigation #: 2026A1031032
Haus on Main

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 (616) 356-0100.

Sincerely,

KDuda

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AS800419102
Investigation #:	2026A1031032
Complaint Receipt Date:	08/09/2026
Investigation Initiation Date:	08/13/2026
Report Due Date:	10/08/2026
Licensee Name:	Our Haus, Inc.
Licensee Address:	30637 White Oak Drive Bangor, MI 49013
Licensee Telephone #:	(269) 214-8350
Licensee Designee:	Heather Nadeau
Name of Facility:	Haus on Main
Facility Address:	118 Main St Bangor, MI 49013
Facility Telephone #:	(269) 214-8350
Original Issuance Date:	04/08/2025
License Status:	REGULAR
Effective Date:	10/08/2025
Expiration Date:	10/07/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive prescribed medication.	Yes
Staff threatened Resident A.	No

III. METHODOLOGY

08/09/2026	Special Investigation Intake 2026A1031032
08/09/2026	APS Referral
08/13/2026	Special Investigation Initiated - Letter Email exchange with Kelsey Newsom.
08/14/2026	Contact – Document Sent – Email exchange with Victoria Stevens.
08/20/2026	Inspection Completed On-site
08/19/2026	Contact - Face to Face Resident A and Tasha Walker.
08/19/2026	Contact - Document Sent Email exchange with licensee Heather Nadeau.
08/19/2026	Contact - Document Received
08/21/2026	Contact – Documents Received
08/21/2026	Exit Conference held with licensee Heather Nadeau.

ALLEGATION:

Resident A did not receive prescribed medication.

INVESTIGATION:

On 8/9/26, I received an online complaint that read Resident A did not receive her prescribed birth control medication which caused suicidal ideations.

On 8/14/26, I exchanged emails with Victoria Stevens, Resident A's case manager through Van Buren Community Mental Health. Ms. Stevens reported Resident A has an extensive history of suicidal ideations without intent. Resident A has been regularly refusing her medications and insulin making it difficult for facility staff to manage her symptoms. To her knowledge, the facility is providing her with medications as prescribed and completes incident reports when she refuses her medications. In terms of her birth control, Resident A was upset with staff for providing her with the week of placebo pills. Resident A reported she previously skipped that week of pills and started a new pack. Staff reported to her there was no instruction or notes on the prescription that informed them of skipping the week of placebo medication. A medical appointment is scheduled with Resident A's primary care doctor to have the medication instructions updated to reflect that the week of placebo medication can be skipped if that is what the doctor feels necessary.

On 8/14/26, I received and reviewed Resident A's *Individual Plan of Service (IPOS)* dated 6/23/26. The IPOS read that staff are responsible for providing Resident A with her prescribed medications.

On 8/19/26, I conducted an unannounced visit to the facility and interviewed direct care worker (DCW) Tasha Walker and Resident A.

Ms. Walker reported Resident A has been refusing her medications although staff encourage her to take them. Ms. Walker showed me Resident A's medication and her birth control medication for July 2026 had multiple pills in the package.

Resident A reported she did not know if staff were not giving her medications to her or if she was refusing. Resident A expressed that she was upset that staff was giving her the week of placebo pills as she did not take them where she resided previously. Resident A reported she has a right to not take placebo medication if she does not want to.

On 8/19/26, I received an email from licensee Heather Nadeau. Ms. Nadeau provided copies of Resident A's medication administration record (MAR). Ms. Nadeau reported she reviewed the MAR and Resident A's birth control medication. Ms. Nadeau reported the MAR reflected the birth control medication was passed even though it was not as staff signed stating they passed her medication. Ms. Nadeau reported the medication was missed by staff six times on July 7, 10, 11, 17, 18, and 20. Ms. Nadeau reported she will be addressing this issue directly with staff and will be providing another medication administration training. The birth control pack is now attached to the bubble pack of Resident A's other medications to ensure that it is not missed.

On 8/19/26, I received and reviewed Resident A's MAR. The MAR does indicate that all medication was passed in July 2026. I observed the medications package and there were still pills in the pack for July 7, 10, 11, 17, 18, and 20.

On 8/21/26, I received and reviewed training records for medication administration for staff working at the facility. All staff completed necessary training to educate them on how to properly administer medications.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Interviews and the review of documentation along with medication revealed that Resident A did not receive her medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff threatened Resident A.

INVESTIGATION:

Ms. Stevens reported Resident A calls her almost daily expressing fear. Ms. Stevens attempts to prompt her to describe what is making her fearful and what actions staff are taking to make her scared. Resident A is not able to identify anything or explain what staff are doing to make her feel this way. She often answers by saying she does not know and has stated that she just does not like the staff. During her visits to the facility, there have been no visual sign of mistreatment and Resident A has not reported anything specific accusing staff.

Resident A reported there were no concerns regarding staff. Resident A reported a staff member just appeared to be in a bad mood one day and she did not like it. Resident A reported she was also upset with staff because they provided her with her placebo birth control medication which she did not like.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	There was no evidence found to support that staff did not treat Resident A with dignity and respect. Resident A reported she has not been mistreated by staff, but a staff member just appeared to be in a bad mood one day which she did not like and they tried to give her medication she did not want. Resident A reported she likes the staff working in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

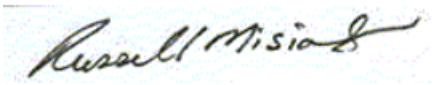
IV. RECOMMENDATION

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

8/21/26

Kristy Duda — Date
Licensing Consultant

Approved By:



8/25/26

Russell B. Misiak — Date
Area Manager