GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 19, 2024

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

RE: License #: AS800384551
Investigation #: 2024A1031049
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
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800384551
Investigation #:	2024A1031049
Complaint Receipt Date:	07/26/2024
Investigation Initiation Date:	07/26/2024
Report Due Date:	09/24/2024
Licensee Name:	Our Haus, Inc.
Licensee Address:	30637 White Oak Drive Bangor, MI 49013
Licensee Telephone #:	(269) 214-8350
Administrator:	Heather Nadeau
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?
Resident A was pushed into a window by staff and suffered injuries.	No
Resident B took another resident's medications.	Yes

III. METHODOLOGY

07/26/2024	Special Investigation Intake 2024A1031049
07/26/2024	Special Investigation Initiated - Letter Email sent to Candice Kinzler.
07/26/2024	APS Referral
08/01/2024	Contact – Telephone Interview with Montiece Sanders and Heather Nadeau.
08/08/2024	Contact - Face to Face Interview with Steve Nadeau.
08/08/2024	Contact - Face to Face Interview with Resident A.
08/08/2024	Inspection Completed On-site
08/08/2024	Inspection Completed-BCAL Sub. Compliance
08/08/2024	Exit Conference held with Heather Nadeau.

ALLEGATION:

Resident A was pushed into a window by staff and suffered injuries.

INVESTIGATION:

On 7/26/24, I exchanged emails with Van Buren Recipient Rights Director Candice Kinzler. Ms. Kinzler reported she received an incident report stating that Resident A fell through a window. Ms. Kinzler reported she interviewed Resident A and he reported he did not fall through the window but that he had fallen into it and it broke. Ms. Kinzler reported Resident A reported to her that he got into an argument with

direct care worker (DCW) Montiece Sanders over cigarettes. Resident A reported Mr. Sanders pushed him with one hand in the chest and then Resident A pushed Mr. Sanders back. They did this back and forth causing Resident A to fall into the window and Resident A suffered superficial would on his arms and legs.

On 8/1/24, I interviewed licensee Heather Nadeau via telephone. Ms. Nadeau reported she was aware of an alleged incident between Resident A and Mr. Sanders but did not have any evidence to support the allegations. Ms. Nadeau did report the window was broken in the home.

On 8/1/24, Candice Kinzler and I interviewed Mr. Sanders via telephone. Mr. Sanders reported Resident A became verbally and physically aggressive towards him over cigarettes. Mr. Sanders reported Resident A requested a cigarette and Mr. Sanders denied the request due to it not being time for his next allotted cigarette per his behavior plan. Mr. Sanders reported the home has “house cigarettes” to provide residents if it is part of their behavior plan. Mr. Sanders reported Resident A pushed him lightly when he stood up. Resident A then pushed Mr. Sanders again with more strength and then tried to “bear hug” and pickup Mr. Sanders. Mr. Sanders reported he tried to twist and get away from Resident A and then they both stumbled and Resident A fell into the window. Mr. Sanders reported he attempted to utilize Gentle Teaching techniques and they were unsuccessful. Mr. Sanders reported he tried to assess Resident A’s physical wellbeing when he fell into the window, but Resident A started throwing broken glass at him. Mr. Sanders reported he then went outside and called another staff member Steve Nadeau for assistance.

On 8/8/24, I conducted a face-to-face interview with staff member Steve Nadeau. Mr. Nadeau reported Mr. Sanders did contact him and he went to the home to assist. Mr. Nadeau reported when he arrived to the home, Mr. Sanders and Resident A were sitting on the front porch and the incident appeared to be regulated.

On 8/8/24, I interviewed Resident A in the home. Resident A reported he was upset because Mr. Sanders would not give him a cigarette when he requested one. Resident A reported Mr. Sanders did not give him a cigarette because it was not time for one to be given to him per his behavior plan. Resident A reported he then pushed Mr. Sanders and called him “very bad names”. That he should not have called him. Resident A reported he believed Mr. Sanders used CPI but wasn’t sure because he was upset and cussing at him. Resident A reported he fell into the window and got some small cuts on his arm. Resident A reported he requested to not receive medical treatment because he was not hurt. Resident A admitted to being physically aggressive towards Mr. Sanders first and Mr. Sanders did not initiate the incident.

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 Resident A and staff, there was no evidence found to support that Mr. Sanders did not ensure Resident A's protection and safety. Although Resident A did fall into the window, Resident A admitted to physically assaulting Mr. Sanders which resulted in him falling.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B took another resident's medications.

INVESTIGATION:

Ms. Kinzler reported she received an incident report stating that Resident B had taken another resident's medications due to them being left unsupervised on the counter.

Ms. Nadeau reported Mr. Sanders did inform her that he left another resident's medications on the counter and Resident B consumed them. Ms. Nadeua reported Mr. Sanders was immediately provided with medication training and safe medication procedures were discussed with him.

Mr. Sanders admitted to leaving another resident's medications on the counter and Resident B consumed them. Mr. Sanders reported he immediately contacted poison control and they reported Resident B would not be impacted by the medications as he is currently prescribed the same or similar medications. Mr. Sanders reported Ms. Nadeau had a conversation with him about safe medication passing and he was required to take medication training again.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Mr. Sanders admitted to leaving medication unattended and Resident B consumed the medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

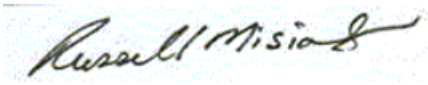
IV. RECOMMENDATION

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

8/15/24

Kristy Duda Date
Licensing Consultant

Approved By:



8/20/24

Russell B. Misiak Date
Area Manager