GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2025

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

RE: License #: AS800403925
Investigation #: 2025A1031024
Robert Riemer Haus

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) 356-0183.

Sincerely,

KDuda

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

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS800403925 |
| | |
| **Investigation #:** | 2025A1031024 |
| | |
| **Complaint Receipt Date:** | 02/19/2025 |
| | |
| **Investigation Initiation Date:** | 02/19/2025 |
| | |
| **Report Due Date:** | 04/20/2025 |
| | |
| **Licensee Name:** | Our Haus, Inc. |
| | |
| **Licensee Address:** | 30637 White Oak Drive<br>Bangor, MI 49013 |
| | |
| **Licensee Telephone #:** | (269) 214-8350 |
| | |
| **Administrator/Licensee Designee:** | Heather Nadeau |
| | |
| **Name of Facility:** | Robert Riemer Haus |
| | |
| **Facility Address:** | 408 Division St.<br>Bangor, MI 49013 |
| | |
| **Facility Telephone #:** | (269) 214-8350 |
| | |
| **Original Issuance Date:** | 08/12/2020 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 02/12/2025 |
| | |
| **Expiration Date:** | 02/11/2027 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff did not ensure Resident A's safety. | Yes |
| Staff withheld Resident A's walker. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 02/19/2025 | Special Investigation Intake<br>2025A1031024 |
| 02/19/2025 | APS Referral |
| 02/19/2025 | Special Investigation Initiated - Letter<br>Email Exchange with Candice Kinzler. |
| 03/11/2025 | Inspection Completed On-site |
| 03/11/2025 | Contact - Face to Face Heather Nadeau, Roshanda Buford, and Resident A. |
| 04/02/2025 | Contact - Telephone Interview with Shawn Heinze. |
| 04/10/2025 | Contact - Telephone Interview held with Cheryl Klein. |
| 04/10/2025 | Contact - Document Requested and Reviewed. |
| 04/10/2025 | Contact – Telephone Interview |
| 04/10/2025 | Exit Conference held with Licensee. |

**ALLEGATION:**

**Staff did not ensure Resident A's safety.**

**INVESTIGATION:**

On 2/19/25, I received an email from Van Buren Recipient Rights Director Candice Kinzler. Ms. Kinzler provided an incident report regarding a complaint she received involving Resident A.

On 2/19/25, I reviewed the incident report dated 2/17/25 provided by Ms. Kinzler. The incident report read a bus driver reported that she and another driver are worried about the way Resident A is being treated. The caregiver was mean to Resident A while speaking to him.

On 3/11/25, I interviewed Resident A at the facility. Resident A was not able to fully engage in the interview process. Resident A reported Ms. Heinze is mean to him. Resident A reported Ms. Heinze tried to trip him. Resident A reported he does not know why she does this.

On 3/11/25, I interviewed direct care worker (DCW) Roshanda Buford at the facility. Ms. Buford was talking to Ms. Heinze on the telephone prior to being interviewed. I overheard Ms. Buford state “it’s not like [Resident A] can talk anyway”. She then ended the telephone conversation when I asked to speak with her. Ms. Heinze reported she has never observed Ms. Heinze treat Resident A poorly. Ms. Buford reported she felt Resident A is treated well at the facility by staff.

On 4/2/25, I interviewed Ms. Heinze via telephone. Ms. Heinze reported she did not speak to Resident A in a negative manner. Ms. Heinze reported the only thing she said to him was “you need to watch what you are doing and not worry about anyone else”.

On 4/10/25, I interviewed Cheryl Klein. Ms. Klein reported she is a bus driver for Star Transportation and was responsible for transporting Resident A to his day program in the morning. Ms. Klein reported she was his bus driver for a longtime and witnessed Ms. Heinze mistreat Resident A multiple times as she would raise her voice at him and demand him not to do things. Ms. Klein reported Ms. Heinze was not near him to assist as she stayed on the front porch with his walker while he walked down independently. Ms. Klein reported it was evident that Resident A was uncomfortable walking down the ramp independently as he tried to hold on to the rails but was directed not to touch them. Ms. Klein reported other staff at the facility treated him well. Ms. Klein reported Resident A is a very sweet individual and it bothered her how Resident A was being treated.

On 4/10/25, I received and reviewed Resident A’s *Assessment for AFC Residents* dated 12/18/24. The assessment read that Resident A requires staff support within the community. For walking and mobility, it read that Resident A is “very unsure of walking and needs staff support and encouragement” and he has a walker to use if needed.

On 4/10/25, I interviewed Nolan Welch. Mr. Welch. Mr. Welch reported that he is a bus driver for Star Transportation and was responsible for transporting Resident A to his residence after attending his day program. Mr. Welch reported he witnessed two incidents that were concerning to him. Mr. Welch reported on one occasion Resident A fell while getting onto the ramp to enter the bus. Mr. Welch assisted Resident A with getting him into the bus and into his seat. Mr. Welch reported Ms. Heinze came

to the bus and told him that Resident A pretends to fall all the time. Mr. Welch reported Resident A had a significant fall which prompted him to complete an incident report. Mr. Welch reported Ms. Heinze dismissed his concern with Resident A falling. Mr. Welch reported he witnessed a second occasion involving Ms. Heinze and Resident A that was concerning. Mr. Welch reported it was a snowy and icy day when he dropped off Resident A at the facility. Resident A went to walk up to the facility to use the ramp and Ms. Heinze took his walker away when he tried to use it. Mr. Welch reported he noticed Resident A to have an unsteady gate, and he would have benefited from using his walker. Mr. Welch reported that staff do not walk with Resident A from the bus and stand by the front door of the facility. Mr. Welch reported it would be helpful if staff could walk with him to and from the bus to provide additional assistance if needed based on his observations of Resident A.

| **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 and the review of documentation, it has been determined that Resident A was not treated with dignity and staff did not ensure his protection and safety. I heard Ms. Buford make a negative statement about Resident A while he was in a nearby room. Resident A expressed that he did not feel that Ms. Heinze treats him well. Service providers witnessed Ms. Heinze raise her voice at Resident A and not aid him when he felt unsafe walking while minimizing his need for assistance. Ms. Heinze failed to provide support and encouragement when needed by Resident A. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Staff withheld Resident A's walker.**

**INVESTIGATION:**

The incident reported read that Resident A's caregiver was witnessed by the driver to withhold his walker while he was walking down the ramp. Resident A was instructed by the caregiver to not hold on to the rails on the ramp. Resident A appeared to be afraid to walk without his walker.

On 3/11/25, I conducted a face-to-face interview with licensee Heather Nadeau at her office. Ms. Nadeau reported Resident A injured his hip a while ago and has been skittish ever since walking down the ramp. Ms. Nadeau reported the facility manager Shawn Heinze thought that Resident A would go down the ramp easier without his walker. Ms. Nadeau reported Resident A can become anxious especially after he broke his hip.

Resident A reported Ms. Heinze is mean to him, and she does not let him use his walker. While at the facility, Resident A sitting in a chair in his bedroom and was observed to not have his walker near him.

Ms. Heinze reported Resident A does not like using his walker when walking down the ramp. Ms. Heinze reported she will provide Resident A with his walker when he gets to the bottom of the ramp. Ms. Heinze reported she did set his walker to the side because she was afraid he would fall while using his walker. Ms. Heinze reported Resident A will hand her his walker because he wants her to hold it for him. Ms. Heinze reported Resident A moves throughout the facility independently and only uses his walker while he is at his day program.

Ms. Klein reported she witnessed Ms. Heinze take away Resident A's walker while he was walking down the ramp. Ms. Heinze left the walker by the front door and told him to walk without it. Ms. Klein reported Ms. Heinze was not near him to assist as she stayed on the front porch with his walker while he walked down independently. Ms. Klein reported when Resident A got down to the bottom of the ramp, he tried to steady himself by putting his hand on a car in the driveway. Ms. Heinze then yelled at Resident A instructing him not to touch the car. Ms. Klein reported she has heard Ms. Heinze yell at Resident A on multiple occasions and not assist him with walking down the ramp. Ms. Klein reported she noticed Ms. Heinze providing Resident A with his walker and assisting him down the ramp after she made the complaint.

The assessment read that Resident A requires staff support within the community. For walking and mobility, it read that Resident A is "very unsure of walking and needs staff support and encouragement" and he has a walker to use if needed.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14306** | **Use of assistive devices.** |
| | **(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.** |

| | |
|---|---|
| **ANALYSIS:** | Resident A has access to a walker to use when he feels it is needed. Staff withheld Resident A's walker as they were afraid he would fall without it despite Resident A wanting to use his walker to ensure his own personal comfort and safety. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 4/10/25, I conducted an exit interview with Ms. Nadeau. Ms. Nadeau reported she understood the reasoning for the findings. Ms. Nadeau reported she had Ms. Buford retake recipient rights training on 4/9/25 due to concerns I shared with her about the comments she made about Resident A during the onsite inspection. Ms. Nadeau expressed that she takes these concerns seriously and will immediately address it with the staff involved.

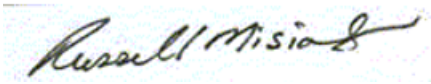
## IV. RECOMMENDATION

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

4/10/24

Kristy Duda Date
Licensing Consultant

Approved By:



4/24/25

Russell B. Misiak Date
Area Manager