GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Debra Young
Omega House, Inc.
2211 Maureen Ln., Houghton, MI 49930

August 12, 2026

RE: License #: AM310292818
Investigation #: 2026A0873014, Omega House

Dear Ms. Young:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(906) 250-9318
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM310292818
Investigation #:	2026A0873014
Complaint Receipt Date:	06/22/2026
Investigation Initiation Date:	06/23/2026
Report Due Date:	08/21/2026
Licensee Name:	Omega House, Inc.
Licensee Address:	2211 Maureen Ln. Houghton, MI 49930
Licensee Telephone #:	(906) 482-4438
Administrator:	Debra Young
Licensee Designee:	Debra Young
Name of Facility:	Omega House
Facility Address:	2211 Maureen Lane Houghton, MI 49931
Facility Telephone #:	(906) 482-4438
Original Issuance Date:	02/02/2009
License Status:	REGULAR
Effective Date:	08/02/2025
Expiration Date:	08/01/2027
Capacity:	8
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was given an increased dose of morphine without a doctor's order.	Yes
Resident B is receiving inadequate care at the facility.	No
Additional Findings	No

III. METHODOLOGY

06/22/2026	Special Investigation Intake 2026A0873014
06/23/2026	Special Investigation Initiated - Telephone Call to complainant
06/29/2026	APS Referral Referred to APS
07/08/2026	Inspection Completed On-site
07/08/2026	Contact - Face to Face Interviews with employees
07/08/2026	Contact - Document Received reviewed MAR
07/08/2026	Contact - Telephone call made Interview with Ms. Curtin, RN Aspirus
07/15/2026	Contact - Telephone call made Attempted contact Mr. Wagner
08/06/2026	Contact - Telephone call made Attempted contact Resident B
08/10/2026	Contact - Telephone call made Interview with Resident B
08/10/2026	Contact - Telephone call made Attempted contact Mr. Wagner

08/12/2026	Inspection Completed-BCAL Sub. Compliance
08/12/26	Exit Conference With licensee designee Debra Young

ALLEGATION:

Resident A was given an increased dose of morphine without a doctor's order.

INVESTIGATION:

On 6/22/26, I received a complaint that alleged Resident A, who was prescribed .25ml of morphine every two hours as needed, was given 3 doses within 45 minutes without doctor's orders.

On 6/23/26, I interviewed the complainant over the telephone. Aspirus hospice has a medical doctor that prescribes medication orders for residents at Omega. Earlier in the day on 5/28/26, Aspirus hospice registered nurse Alexis Curtin left that facility and reported Resident A was comfortable. At 1:55pm, Ms. Curtin received a text from Omega registered nurse Pamela Aho asking for an order to increase the morphine dose, reporting that Ms. Aho and Omega registered nurse Scott Wagner gave Resident A .25ml dose at 1:20pm and then a .5ml dose at 1:55pm. This equated to three doses of morphine within 35 minutes. The request to back-order a change in medication was denied.

On 7/8/26, I interviewed Ms. Curtin on the telephone. If Omega employees believed that a resident required a change in medication, they were unauthorized to make that change and must request the change through Aspirus hospice. After the incident, Ms. Curtin went back to Omega to assess the patient around 3:40pm and she seemed comfortable. Resident A died that evening at 7:50pm. Ms. Curtin does not believe the extra doses of morphine directly contributed to her death.

On 7/8/26, I interviewed Omega executive director Mike Lutz at the facility. Mr. Lutz was aware of the incident. Mr. Wagner told Ms. Aho to administer the extra doses of morphine because what she was prescribed was not enough. After the incident, when Mr. Lutz confronted Mr. Wagner about this, Mr. Wagner quit and walked out of the facility.

On 7/28/26, I interviewed Ms. Aho at the facility. Ms. Aho correctly explained the normal process for Omega to request a medication change through Aspirus hospice. Mr. Wagner used to work for Aspirus hospice and home health hospice and may be used to making those types of decisions on his own. He was not supposed to make those decisions in his capacity at Omega. Ms. Aho believed Mr. Wagner acted out of compassion for Resident A.

On 7/28/26, I reviewed Resident A's medication administration records which accurately reported the increased doses of morphine given that day.

After several attempts I was unsuccessful in reaching Mr. Wagner.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician, physician assistant, advanced practice nurse, or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any instructions regarding a resident's prescription medication.**
ANALYSIS:	Resident A was given three doses of morphine within 35 minutes even though she was prescribed one dose every 2 hours as needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION

Resident B is receiving inadequate care at the facility.

INVESTIGATION

During the course of this investigation I received a second complaint alleging that Resident B was upset because Mr. Lutz had complained to the resident and Aspirus hospice employees that Resident B has no personal hygiene and is destroying furniture with her bodily fluids by urinating wherever she wants and believes that this is their home.

On 8/10/26, I interviewed Resident B over the telephone. She was unsure why someone would make a complaint like that on her behalf. Although she had concerns about moving to a nursing home once her funds ran out at Omega, she reported that she is receiving a high level of care and feels safe and respected.

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:	After interviewing Resident B about the allegations made on her behalf, I have no evidence Resident B is not being treated with dignity and respect.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 8/12/26, I explained the findings of this report to licensee designee Debra Young. She told me they are working on strengthening their relationships with community partners and we discussed what would be required in the corrective action plan.

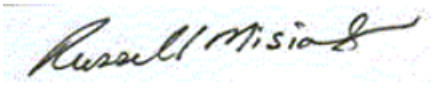
IV. RECOMMENDATION

Contingent upon receipt of an appropriate corrective action plan, I recommend no changes to the status of this license.

8/12/26

Garrett Peters Date
Licensing Consultant

Approved By:



8/17/26

Russell B. Misiak Date
Area Manager