GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 9, 2022

Harry Gross
Nova Vida Inc
Box 92
1693 N Otto Road
Charlotte, MI 48813

RE: License #: AS230016074
Investigation #: 2022A0462024
Nova Vida

Dear Mr. Gross:

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 (517) 284-9730.

Sincerely,

Michele Streeter

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230016074
Investigation #:	2022A0462024
Complaint Receipt Date:	03/17/2022
Investigation Initiation Date:	03/17/2022
Report Due Date:	05/16/2022
Licensee Name:	Nova Vida Inc
Licensee Address:	Box 92 1693 N Otto Road Charlotte, MI 48813
Licensee Telephone #:	(517) 204-6216
Administrator:	Elijah Bush
Licensee Designee:	Harry Gross
Name of Facility:	Nova Vida
Facility Address:	1693 N. Otto Road Charlotte, MI 48813
Facility Telephone #:	(517) 204-6216
Original Issuance Date:	12/27/1995
License Status:	REGULAR
Effective Date:	05/09/2021
Expiration Date:	05/08/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A experienced rapid and extreme weight loss because he was not provided with adequate nutrition at the facility.	No
Facility staff members delayed seeking medical treatment for Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

03/17/2022	Special Investigation Intake 2022A0462024 Special investigation initiated- email to APS Specialist Carol Stahl.
03/21/2022	Unannounced investigation onsite. Face to face interviews with administrator Elijah Bush and home manager Allison Bush. Observation of Resident A. Requested and received documentation.
03/22/2022	Contact- Telephone interview with APS Specialist Carol Stahl.
04/25/2022	Contact- Requested and received documentation. Contact- Telephone interview with home manager Allison Gross. Exit Conference- with home manager Allison Bush via telephone.
05/02/2022	Left a voicemail message for licensee designee Harry Gross regarding an exit conference.

ALLEGATIONS:

- **Resident A experienced rapid and extreme weight loss because he was not provided with adequate nutrition at the facility.**

- **Facility staff members delayed seeking medical treatment for Resident A.**

INVESTIGATION: On 03/17/2022 Adult Protective Services (APS) forwarded the above allegations to the Bureau of Community and Health Systems (BCHS), via a written complaint. According to the written complaint, Resident A is a 65 year old

male who suffered a traumatic brain injury at the age of nine. Subsequently, Resident A was developmentally disabled, non-verbal and diagnosed with encephalopathy and seizures. The written complain indicated that in January 2022, Resident A was admitted to the hospital for increased seizure activity. Resident A had also been displaying “behavioral changes”, including throwing himself from his wheelchair and feeding difficulty. On 03/07, Resident A was re-admitted to the hospital with a “stated” weight of 148 lbs. While at the hospital, Resident A received a percutaneous endoscopic gastrostomy (peg-tube) for feeding. According to the written complaint, Resident A’s ability to eat improved prior to his discharge back to the facility and he no longer required feedings via peg-tube. However, on 03/12 Resident A returned to the hospital weighing only 100 lbs. The written complaint indicated that due to Resident A’s drastic weight loss there was concern Resident A had not received adequate nutrition at the facility. The facility’s home manager “Allison”, last name unknown, reported providing Resident A with protein powder from Sam's Club, which was not adequate intake for him. According to the written complaint, it was unknown what else may have been done to assist Resident A with his feeding issues. The written complaint indicated Resident A had another peg-tube surgically inserted because he removed the last one himself. Resident A would resume feeding via peg-tube and be ready for discharge 03/17 or 03/18 once his insurance agreed to cover the cost of the prescription formula required for him to receive adequate nutrition at the facility via tube feedings. According to the written complaint, facility staff members “delayed” seeking medical treatment for Resident A. The written complaint did not specify how Resident A’s treatment was delayed.

Via email, I notified APS Specialist Carol Stahl I was assigned to investigate these allegations. Via this email exchange, Ms. Stahl informed me she would be visiting Resident A at the facility tomorrow (03/18).

On 03/21 I conducted an unannounced investigation at the facility and interviewed administrator Eli Bush and home manager Allison Bush, who stated they were a married couple who resided at the facility. Mr. and Mrs. Bush denied both allegations, as well as the timeline of events as indicated in the written complaint. According to Mr. and Mrs. Bush, Resident A resided at the facility for almost 30 years. Resident A had a history of challenging behaviors associated with his diagnosis, which included feeding challenges. As a result, Resident A was fed via a peg-tube in the past. However, up until recently Resident A followed an oral dysphagia and “thickened liquid” diet at the facility and had no recent history of aspiration. Mr. and Mrs. Bush confirmed that starting in January 2022 and into early February 2022, Resident A began displaying behavioral challenges brought on by increased seizure activity, including throwing himself from his wheelchair and feeding difficulties. On 02/3, they called 911 and requested Resident A be transported to the emergency room (ER) after he refused to eat for almost 24 hours. Mrs. Bush stated Resident A was admitted to Sparrow Hospital on 02/03 and not sometime in January, as indicated in the written complaint. According to Mr. and Mrs. Bush, while hospitalized Resident A aspirated. Subsequently, hospital medical staff place a peg-tube in Resident A for feedings at this time, and not on 03/07 as

indicated in the written complaint. Sometime around 02/19, Mrs. and Mrs. Bush were informed Resident A would be discharged back to the facility with the peg-tube inserted, which according to Mr. and Mrs. Bush, they were both familiar and comfortable with. However, Mr. and Mrs. Bush stated they were then informed Resident A had improved and could return to following his oral dysphagia and thicken liquids diet. Mrs. Bush stated that her and Mr. Bush later learned that prior to Resident A's discharge on 02/19, hospital staff were ran into challenges regarding Resident A's medical insurance covering the cost of the prescription formula used for feedings via peg-tube. Subsequently, while the peg-tube remained in place, Resident A's hospital discharge paperwork did not include a prescription for this special formula. Mr. and Mrs. Bush stated there was also no documentation on Resident A's hospital discharge paperwork indicating what Resident A currently weighed and/or if he had been weighed at all during this hospitalization.

Mr. and Mrs. Bush provided me with medical records from Resident A's hospitalization at Sparrow hospital on 02/03 to 02/19, which confirmed Resident A was hospitalized at this time. These medical records confirmed that while in the hospital Resident A had a peg-tube inserted and received "*tube feedings.*" Documentation on the medical records provided read, "*formula was likely non-covered.*" According to these medical records, "*enteral formula feeding has been discontinued.*" Documentation on these medical records indicated that Resident A was ordered to continue dysphagia 4:4 diet per SLP (speech-language pathologist), PO (by mouth) supplement Boost Pudding provided TID (230cal, 7gm protein each) and continue free water flushes: 150mL q hours (600mL) for hydration. Neither an order for prescription formula for peg-tube feedings nor Resident A's current weight at that time were indicated in the medical records provided to me.

Mr. and Mrs. Bush stated that following Resident A's discharge back to the facility on 02/19, they did provide him with protein shakes, as indicated in the written complaint. According to Mr. and Mrs. Bush, this was because they were ordered to do so. Mr. and Mrs. Bush explained that upon his hospital discharge, Resident A was provided with a referral to the local home healthcare agency Elara Caring, who provided supplemental services to Resident A at the facility. According to Mrs. Bush, she asked Elara Caring registered nurse Glenda Horner for further direction regarding what to feed Resident A via peg-tube, if necessary. According to Mrs. Bush, Ms. Horner consulted with the gastrologist who treated Resident A in the hospital on 02/03 to 02/19. According to Ms. Bush, the gastrologist provided Ms. Horner with verbal instructions to continue oral feedings with thicken liquids, as well as provide Resident A with three Boost puddings orally a day, and three Boost or Premiere Protein shakes via peg-tube daily. Mr. and Mrs. Bush stated Resident A was mostly cooperative with this order, except for on days when he experienced increased seizure activity. According to Mrs. Bush, Elara Caring did not provide the facility with Resident A's diet order in writing. However, she has since requested a written copy of this order for his record.

Mr. and Mrs. Bush provided me with a form utilized by Elara Caring called, "*Elara Caring Vital Signs Log"*, which confirmed Resident A was seen in the facility by medical staff members from Elara Caring on 02/24, 02/25, 03/01, 03/03, 03/08, and 03/11.

Mrs. Bush stated the last time Resident A was weighed in the facility was in December 2021. According to Mrs. Bush, the facility had a standard floor scale and was not equipped with a wheelchair scale. Therefore, facility staff members had to assist Resident A in standing on the standard floor scale to be weighed. For this reason, Resident A's facility recorded weights were not accurate and were merely estimates. Mr. and Mrs. Bush denied Resident A was readmitted to the hospital on 03/07, as indicated in the written complaint. According to Mr. and Mrs. Bush, on 03/07 Resident A had a follow-up visit with his primary care physician Dr. Marl. Mrs. Bush stated Dr. Marl also had no way of weighing Resident A in his office. Therefore, during medical appointments with Dr. Marls, medical staff members asked facility staff members how much Resident A weighed and subsequently recorded the number facility staff members provided them. According to Ms. Bush, on 03/07 a medical staff member at Dr. Marl's office was provided with the facility's last recorded weight for Resident A (December 2021), which was 148 lbs. Mrs. Bush stated she did not believe this was Resident A's correct weight in December of 2021 or on 03/07 when provided to Dr. Marl.

Mr. and Mrs. Bush provided me with a facility form called, "*Medical Visit Form*" which indicated Resident A was seen at Dr. Marl's office on 03/07 for a "follow up from hospital stay". Documentation on this form confirmed Resident A was not hospitalized on 03/07, as indicated in the written complaint.

Mr. and Mrs. Bush provided me with Resident A's weight record. Documentation on Resident A's weight record indicated that on 03/10/2021 Resident A weighed 162 pounds. From April 2021 to August 2021, Resident lost a total of three lbs. and weighed 159 lbs. There was no record of Resident A's weight for the month of September 2021. According to documentation on Resident A's weight record, from October 2021 to December 2021, Resident A lost a total of 11 lbs. and in December 2021, Resident A weighed 148 lbs. Documentation on Resident A's weight record read, "*these weights are estimates only. (Resident A) has difficulty standing on the scale*."

Mr. and Mrs. Bush provided me with a facility form titled, "*Meals*" for the month of February and March. Documentation on these forms indicated that aside from the days Resident A was hospitalized, Resident A consumed a combination of his dysphagia/thicken liquids diet, water, high protein pudding, and Boost shakes. Mrs. Bush stated facility staff members fed the documented food items to Resident A both orally and via his peg-tube. Documentation of the *Meals* form for March stated that in the week leading up to 03/12, Resident A experienced increased seizure activity and began refusing meals.

Mr. and Mrs. Bush stated that on 03/12, after experiencing increased seizure activity, refusing to eat, and eventually pulling his peg-tube out, Resident A was transported to the ER and admitted to Sparrow hospital where he stayed until his discharge on 03/16. It was determined during this hospitalization that Resident A weighed approximately 100 lbs. According to Mr. and Mrs. Bush, they were certain that due to an increase in Resident A's challenging behaviors, brought on by increased seizure activity, Resident A had lost a significant amount of weight. However, Mrs. Buch argued it was impossible for Resident A to have lost 48 lbs. in five days, as indicated in the written complaint. Mrs. Bush stated that during Resident A hospitalization on 03/12 to 03/16, hospital medical staff members considered leaving Resident A's peg-tube out. According to Mrs. Bush, she advocated for the reinsertion of Resident A's G-tube so that facility staff members could provide tube feedings to Resident A, if needed. Mr. and Mrs. Bush stated that ultimately the decision was made to reinsert the peg-tube and hospital medical staff members worked with Resident A's medical insurance to cover the cost of the prescription formula used for his tube feedings prior to his discharge back to the facility.

Mr. and Mrs. Bush provided me with medical records from Resident A's hospitalization on 03/12 to 03/16, which confirmed that on 03/15 Resident A's peg-tube was reinserted after Resident A pulled it out on 03/12. Due to Resident A's increased seizure activity, Resident A's medications Dilantin and Onfi were increased per recommendations from MSU Neurology. While hospitalized, Resident A tolerated the medication adjustments and experienced no further seizure activity. Documentation on these medical records indicated Resident A had lost 48 lbs. since his last admission.

According to Mrs. Bush, they recently obtained a wheelchair scale and weighed Resident A at the facility on 03/17. Mrs. Bush stated that on 03/17 they determined Resident A's wheelchair weighed 51.4 lbs. and Resident A in his wheelchair weighed 158 lbs., indicating Resident A weighed a total of 106.6 lbs. According to Mr. and Mrs. Bush, Resident A was currently receiving physical, occupational, and speech therapy in the facility via Elara Caring. Mrs. Bush stated that due to Resident A's progressing change in condition, they also obtained a physician's order for Resident A to begin receiving "palliative care" in the facility.

I reviewed documentation on the weight record provided to me by Mr. and Mrs. Bush for Resident A, which confirmed that on 03/17 it was determined Resident A's wheelchair weighed 51.4 lbs. and Resident A in his wheelchair weighed 158 lbs., indicating that on 03/17 Resident A weighed a total of 106.6 lbs.

Due to Resident A being unable to communicate verbally, I was unable to interview him. I observed Resident A resting in his bed. Resident A was awake and alert and did not appear to be agitated and/or experiencing any discomfort.

On 03/22 I conducted a telephone interview with Ms. Stahl who informed me that at this time. she did not have enough evidence to substantiate the allegations.

On 04/25, via email, Mrs. Bush provided me with a written copy of Resident A's diet order obtained by Elara Caring on 02/24. Documentation on this order confirmed that on 02/24, Resident A was ordered to continue oral feedings with thicken liquids, as well as three Boost puddings orally a day, and three Boost or Premiere Protein shakes via peg-tube daily.

I conducted a telephone interview with Mrs. Gross who informed me Resident A continued to improve following his discharge from the hospital on 03/16. According to Mrs. Gross, on 04/02 Resident A weighed 129.2 lbs. Mrs. Gross explained that in addition to a peg-tube, Resident A was discharged from the hospital on 02/19 with a catheter. On 03/28, per Resident A's urologist's suggestion, Resident A's catheter was removed. According to Mrs. Gross, on 04/06 she notified Dr. Marl's office after she and a nurse from Elara Caring noticed Resident A appeared to not be feeling well. Dr. Marl advised Mrs. Bush to arrange for Resident A to be assessed at the ER, which Mrs. Bush stated she did on 04/06. According to Mrs. Bush, while at the ER Resident A was diagnosed with a urinary tract infection and was subsequently discharged back to the facility the same day with a prescription for an antibiotic. Mrs. Bush stated that on 04/14, Elara Caring assessed Resident A for hospice services. According to Mrs. Bush, on 04/17 Resident A passed away in the facility while receiving hospice services.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	According to the written complaint, Resident A lost 48 lbs. in five days. However, based upon my investigation, administrator Eli Bush and home manager Allison Bush provided documentation confirming the timeline of events as indicated in the written complaint were not accurate. It has been established that following his hospital discharge on 02/19, Resident A was provided his special diet, as prescribed. While Resident A had displayed recent challenging behaviors brought on by increased seizure activity, causing him to lose a significant amount of weight, there is not enough evidence to substantiate the allegation Resident A's rapid weight loss was because he was not provided with adequate nutrition at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	The written complainant indicated facility staff members delayed seeking medical treatment for Resident A. However, The written complaint did not specify how Resident A's treatment was delayed. Administrator Eli Bush and home manager Allison Bush provided me with sufficient documentation confirming that on 02/03, 03/07, and 03/12, they obtained needed outside medical care for Resident A. Subsequently, I reviewed documentation confirming Resident A also received additional medical services in the facility from the home health agency Elara Caring. Based upon my investigation, other than what was indicated in the written complaint, there is no evidence to support the allegation facility staff members delayed seeking medical treatment for Resident A when needed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED.**

ADDITIONAL FINDINGS:

INVESTIGATION: During my unannounced investigation at the facility on 03/21, Mrs. Bush stated the facility was previously equipped with a standard floor scale and not a wheelchair assessable scale. Therefore, facility staff members previously had to assist Resident A in standing on the scale to be weighed. For this reason, before March 2022, Resident A's monthly recorded weights were not accurate and were merely estimates. According to Mrs. Bush, they recently obtained access to a wheelchair assessable scale and weighed Resident A at the facility on 03/17.

Upon reviewing Resident A's weigh records, I established there was no record of Resident A's weight for the months of September 2021, January 2022, or February 2022 indicated on his weight record. According to documentation on Resident A's weight record, "*these weights are estimates only. (Resident A) has difficulty standing on the scale*." Documentation on Resident A's weigh record confirmed Resident A was weighed in the facility on 03/17, via the use of a wheelchair accessible scale.

I requested to review Resident A's *Assessment Plan for AFC Residents* to determine the most current documented method for facility staff members to provide Resident A his therapeutic diet and feeding assistance. Mr. and Mrs. Bush informed me the only assessment plan on record for Resident A was an assessment plan created by Community Mental Health (CMH) of Clinton, Eaton, and Ingham Counties on 08/30/2019.

While onsite I observed Resident A laying in his bed, which was equipped with half bed rails.

I reviewed Resident A's CMH of Clinton, Eaton and Ingham Counties assessment plan and confirmed the plan was created on 08/30/2019. While this plan referenced Resident A's use of a feeding tube, there was no therapeutic diet indicated for Resident A, nor was there any documented methods for facility staff members to provide feeding assistance to Resident A. Resident A's CMH of Clinton, Eaton and Ingham Counties assessment plan also did not include Resident A's use of bedrails.

I requested to review Resident A's written physician's order for the use of bedrails. Mr. and Mrs. Bush stated they did not have such an order on record in the facility. I directed Mr. and Mrs. Bush to obtain this order as soon as possible.

On 04/25, via email, Mrs. Bush provided me with a copy of an order written by Dr. Marl on 03/25 authorizing Resident A's use of bedrails for "seizures" until 03/25/2023.

According to a Licensing Renewal Inspection Report (LSR), dated 04/08/2021, the facility was in violation of AFC administrative licensing rules 400.14310(3) and 400.14301(4) when it was established that three resident records reviewed on 04/07/2021 did not contain written documentation that all three residents' weights were recorded monthly nor did they contain written assessment plans completed with each resident and/or his/her designated representative within the last year. An acceptable corrective action plan (CAP) was collected on 04/07/2021.

According to Special Investigation Report #2019A0783020, dated 04/05/2019, the facility was in violation of AFC administrative licensing rule 400.14301(4) when on 03/26/2019 it was established there was no written assessment plan for Resident A on record in the facility. According to the facility's approved CAP, dated 04/13/2019, Mr. Gross would ensure Mr. and Mrs. Bush completed all required department documentation for Resident A, including a written assessment plan, per department guidelines.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based upon my investigation, there were no weight records for Resident A for the months of September 2021, January 2022, or February 2022 on file in the facility. According to home manager Allison Bush, before March 2022 the facility was equipped with only a standard floor scale and not a wheelchair accessible scale. Therefore, facility staff members previously had to assist Resident A in standing on the scale to be weighed. For this reason, prior to March 2022, Resident A's monthly recorded weights were not accurate and were merely estimates.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE LSR, DATED 04/08/2021]**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based upon my investigation, there was no written assessment plan on record in the facility for Resident A.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE LSR, DATED 04/08/2021, SIR #2019A0783020, DATED 04/05/2019, AND CAP, DATED 04/13/2019]**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee. (3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the

	authorization.
ANALYSIS:	Based upon my investigation, there was no written assessment plan on record in the facility for Resident A. Subsequently, Resident A's use of bed rails were not specified in a written assessment plan and agreed upon by Resident A and/or his designated representative and the licensee. It was also established on 03/21 the licensee did not obtain a written physician's order for Resident A's use of bedrails.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/25 I conducted an exit conference with Mrs. Bush and shared with her the findings of this investigation. On 05/02 I left a voicemail message for licensee designee Harry Gross regarding conducting an exit conference. However, Mr. Gross did not return my telephone call.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 05/09/2022

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 05/03/2022

Dawn N. Timm Date
Area Manager